THE GOOD HEALTH HANDBOOK

A Guide for Those Caring for Children

Revised 2023

OKLAHOMA
State Department
of Health

Oklahoma
Human Services

Good Health Handbook Table of Contents

Introduction

If you work with young children, you understand the importance of keeping every child healthy and safe. This handbook will help you by providing up-to-date information on health, safety, and development issues. The Good Health Handbook is **a good resource for all types of child care programs and schools** working with and caring for children.

The Good Health Handbook has been revised and updated and includes information about injury prevention, infection control, childhood conditions, illnesses and infestations. There are also many links to resources that provide updated helpful information on the importance of good nutrition, physical activity, child development, guiding children's behavior, and working with families.

The information in this handbook has been carefully researched and reviewed. Recommendations are made only if there is good evidence that it will help protect the health and safety of the children in your care and their families. However, **this book is only a guideline and is in no way intended to replace the recommendations of health care providers**.

The 2023 revised edition of the ***Good Health Handbook: A Guide for Those Caring for Children*** was developed by a dedicated group of early childhood and public health professionals with funding and support provided by the Oklahoma State Department of Health Maternal and Child Health Service and the Department of Human Services Child Care Services, as well as printing through the OSDH Media and Communications Reopening Schools Grant.

Special thanks to the Good Health Handbook Revisions Committee for their creative ideas and their many hours of research, meetings, and dedicated work!

COVID-19
This revised Good Health Handbook does not include detailed information about COVID-19 due to continual changes and updates on preventing the spread of the virus and the variants that have emerged.

We recommend finding the most up-to-date information about COVID-19 at the Centers for Disease Control and Prevention (CDC) website: www.https://cdc.gov or the Oklahoma State Department of Health at www.https://health.ok.gov/COVID19.html.

Note: The use of the words *parent* and *parents* is used throughout this document to reflect the main caregiver or guardian of the child.

Chapter 1: The Successful Caregiver

Code of Ethical Conduct

Why have a code of ethical conduct?
As an early childhood professional a code of ethical conduct will benefit your work with families and your program. A code of conduct should be a guide and reference to look to in day-to-day decision-making.

A code of ethics provides a vision of what a profession should be and how members of that profession should behave. It builds members' ethical awareness and judgement, provides them with guidance in decision making, gives them moral courage, and gives them a shared identity. It sends a message to society at large describing how it can expect members of that professional group to behave.

The National Association for the Education of Young Children (NAEYC) recognizes that those who work with young children face many decisions that have moral and ethical implications. The **NAEYC Code of Ethical Conduct** offers guidelines for responsible behavior and provides a common basis for resolving ethical dilemmas encountered in early care and education programs.

The primary focus of the Code is on daily practice with children and their families in programs for children from birth through eight years of age, such as infant/toddler programs, preschool and prekindergarten programs, child care centers, hospital and child life settings, family child care homes, kindergartens, and primary classrooms. When the issues involve young children, these provisions apply to specialists who do not work directly with children, including program administrators, parent educators, early childhood adult educators, and officials with responsibility for program monitoring and licensing. ((Note: See the "Code of Ethical Conduct: Supplement for Early Childhood Program Administrators," online at https://naeyc.org/files/naeyc/file/positions/PSETH05_supp.pdf).

Standards of ethical behavior in early childhood care and education are based on commitment to the following core values that are deeply rooted in the history of the field of early childhood care and education. **We have made a commitment to**:

- Appreciate childhood as a unique and valuable stage of the human life cycle.
- Base our work on knowledge of how children develop and learn.
- Appreciate and support the bond between the child and family.
- Recognize that children are best understood and supported in the context of family, culture, community, and society.
- Respect the dignity, worth, and uniqueness of each individual (child, family member, and colleague).
- Respect diversity in children, families, and colleagues.
- Recognize that children and adults achieve their full potential in the context of relationships that are based on trust and respect.

The code provides a framework of professional responsibilities in four sections:

- Ethical responsibilities to children
- Ethical responsibilities to families
- Ethical responsibilities to colleagues
- Ethical responsibilities to community and society

NAEYC Statement of Commitment
The Statement of Commitment is not part of the Code but is a personal acknowledgement of an individual's willingness to embrace the values and moral obligations of the field of early childhood care and education.

As an individual who works with young children, I commit myself to furthering the values of early childhood education as they are reflected in the ideals and principles of the NAEYC Code of Ethical Conduct. To the best of my ability, I, _____ will:

• Never harm children.

• Ensure that programs for young children are based on current knowledge and research of child development and early childhood education.

• Respect and support families in their task of nurturing children.

• Respect colleagues in early childhood care and education and support them in maintaining the NAEYC Code of Ethical Conduct.

•Serve as an advocate for children, their families, and their teachers in community and society.

• Stay informed of and maintain high standards of professional conduct.

• Engage in an ongoing process of self-reflection, realizing that personal characteristics, biases, and beliefs have an impact on children and families.

• Be open to new ideas and be willing to learn from the suggestions of others.

• Continue to learn, grow, and contribute as a professional.

• Honor the ideals and principles of the NAEYC Code of Ethical Conduct.

Advancing Equity in Early Childhood Care and Education

The National Association for the Education of Young Children (NAEYC) ***Advancing Equity in Early Childhood Position Statement*** adopted by the NAEYC National Governing Board April 2019, along with the following recommendations.

All children have the right to equitable learning opportunities that help them achieve their full potential as engaged learners and valued members of society. Thus, all early childhood educators have a professional obligation to advance equity. They can do this best when they are effectively supported by the early learning settings in which they work and when they and their wider communities embrace diversity and full inclusion as strengths, uphold fundamental principles of fairness and justice, and work to eliminate structural inequities that limit equitable learning opportunities.

Recommendations for Early Childhood Educators

Create a Caring, Equitable Community of Engaged Learners

1. **Uphold the unique value and dignity of each child and family**. Ensure that all children see themselves, their daily experiences, and the daily lives of others, within and beyond their community, positively reflected in the design and implementation of pedagogy, curriculum, learning environment, interactions, and materials. Celebrate diversity by acknowledging similarities and differences and provide perspectives that recognize beauty and value across differences.
2. **Recognize each child's unique strengths and support the full inclusion of all children—given differences in culture, family structure, language, racial identity, gender, abilities and disabilities, religious beliefs, or economic class**. Help children get to know, recognize, and support one another as valued members of the community. Take care that no one feels bullied, invisible, or unnoticed.
3. **Develop trusting relationships with children and nurture relationships among them while building on their knowledge and skills**. Embrace children's cultural experiences and the languages and customs that shape their learning. Treat each child with respect. Eliminate language or behavior that is stereotypical, demeaning, exclusionary, or judgmental.
4. **Consider the developmental, cultural, and linguistic appropriateness of the learning environment and your teaching practices for each child**. Offer meaningful, relevant, and appropriately challenging activities across all interests and abilities. Children of all genders, with and without disabilities, should see themselves and their families, languages, and cultures regularly and meaningfully reflected in the environment and learning materials. Counter common stereotypes and misinformation. Remember that the learning environment and its materials reflect what you do and do not value by what is present and what is omitted.

5. **Involve children, families, and the community in the design and implementation of learning activities**. Doing this builds on the knowledge that children and families bring as members of their cultures and communities while also sparking children's interest and engagement. Recognizing the community as a context for learning can model citizen engagement.
6. **Actively promote children's agency**. Provide each child with opportunities for rich, engaging play and opportunities to make choices in planning and carrying out activities. Use open-ended activities that encourage children to work together and solve problems to support learning across all areas of development and curriculum.
7. **Scaffold children's learning to achieve meaningful goals**. Set challenging but achievable goals for each child. Build on children's strengths and interests to affirm their identities and help them gain new skills, understanding, and vocabulary. Provide support as needed while you communicate—both verbally and nonverbally—your authentic confidence in each child's ability to achieve these goals.
8. **Design and implement learning activities using language(s) that the children understand**. Support the development of children's first languages while simultaneously promoting proficiency in English. Similarly, recognize and support dialectal differences as children gain proficiency in the Standard Academic English they are expected to use in school.
9. **Recognize and be prepared to provide different levels of support to different children depending on what they need**. For example, some children may need more attention at certain times or more support for learning particular concepts or skills. Differentiating support in a strengths-based way is the most equitable approach because it helps to meet each child's needs.
10. **Consider how your own biases (implicit and explicit) may be contributing to your interactions and the messages you are sending children**. Also reflect on whether biases may contribute to your understanding of a situation. How might they be affecting your judgement of a child's behavior, especially a behavior you find negative or challenging? What messages do children take from your verbal and nonverbal cues about themselves and other children? Recognize that all relationships are reciprocal, and thus that your behavior impacts that of children.
11. **Use multi-tiered systems of support**. Collaborate with early childhood special educators and other allied education and health professionals as needed. Facilitate each professional establishing a relationship with each child to foster success and maximize potential.

Establish Reciprocal Relationships with Families

1. **Embrace the primary role of families in children's development and learning.** Recognize and acknowledge family members based on how families define their members and their roles. Seek to learn about and honor each family's child-rearing values, languages (including dialects), and culture. Gather information about the hopes and expectations families have for their children's behavior, learning, and development so that you can support their goals.
2. **Uphold every family's right to make decisions for and with their children.** If a family's desire appears to conflict with your professional knowledge or presents an ethical dilemma, work with the family to learn more, identify common goals, and strive to establish mutually acceptable strategies.
3. **Be curious, making time to learn about the families with whom you work.** This includes learning about their languages, customs, activities, values, and beliefs so you can provide a culturally and linguistically responsive and sustaining learning environment. It requires intentionally reaching out to families who, for a range of reasons, may not initiate or respond to traditional approaches (e.g., paper and pencil/electronic surveys, invitations to open houses, parent–teacher conferences) to interact with educators.
4. **Maintain consistently high expectations for family involvement, being open to multiple and varied forms of engagement and providing intentional and responsive supports.** Ask families how they would like to be involved and what supports may be helpful. Families may face challenges (e.g., fear due to immigration status, less flexibility during the workday, child care or transportation issues) that may require a variety of approaches to building engagement. Recognize that it is your responsibility as an educator to connect with families successfully so that you can provide the most culturally and linguistically sustaining learning environment for each child.
5. **Communicate the value of multilingualism to all families.** All children benefit from the social and cognitive advantages of multilingualism and multiliteracy. Make sure families of emergent bilinguals understand the academic benefits and the significance of supporting their child's home language as English is introduced through the early childhood program, to ensure their children develop into fully bilingual and biliterate adults.

Observe, Document, and Assess Children's Learning and Development

1. **Recognize the potential of your own culture and background affecting your judgment when observing, documenting, and assessing children's behavior, learning, or development.** Approach a child's confusing or challenging behavior as an opportunity for inquiry. Consider whether these may be behaviors that work well for the child's own home or community context but differ or conflict with your family culture and/or the culture of your setting. How can you adapt your own expectations and learning environment to incorporate each child's cultural way of being? Also, consider the societal and structural perspectives: How might poverty, trauma, inequities, and other adverse conditions affect how children negotiate and respond to their world? How can you help each child build resilience?

2. **Use authentic assessments that seek to identify children's strengths and provide a well-rounded picture of development.** For children whose first language is not English, conduct assessments in as many of the children's home languages as possible. If you are required to use an assessment tool that has not been established as reliable or valid for the characteristics of a given child, recognize the limitations of the findings and strive to make sure they are not used as a key factor in high-stakes decisions.
3. **Focus on strengths.** Develop the skill to observe a child's environment from the child's perspective. Seek to change what you can about your own behaviors to support that child instead of expecting the child to change first. Recognize that it is often easier to focus on what a child isn't doing compared with peers than it is to see what that child can do in a given context (or could do with support).

Advocate on Behalf of Young Children, Families, and the Early Childhood Profession

1. **Speak out against unfair policies or practices and challenge biased perspectives.** Work to embed fair and equitable approaches in all aspects of early childhood program delivery, including standards, assessments, curriculum, and personnel practices.
2. **Look for ways to work collectively with others who are committed to equity.** Consider it a professional responsibility to help challenge and change policies, laws, systems, and institutional practices that keep social inequities in place.

Taking Care of Yourself: The Importance of Self-Care

People who take care of others often put their own needs last. Does that sound familiar? Caring for yourself is important for your health and wellness, and is directly related to your ability to care for others.

Self-care is anything you do to take care of yourself so you can stay physically, mentally, and emotionally well. Research suggests self-care promotes positive health outcomes, such as fostering resilience, living longer, and becoming better equipped to manage stress. www.Everydayhealth.com

Fill out the ***lifestyle behaviors checklist*** at the end of this section to see how well you're doing.

Below are some ideas to improve your self-care

Develop a Self-Care Plan
To develop a self-care plan, identify what you value and need as part of your day-to-day life (*maintenance self-care*) and the strategies you can employ when or if you face a crisis along the way (*emergency self-care*).

There is no "one-size-fits-all" self-care plan, but there is a common thread: make a commitment to attend to all the areas of your life, including your physical and psychological health, emotional and spiritual needs, and relationships.

Ten Self-Care Tips for Child Care Providers (from Brightstarcare.com)

1. **Take a break**. It's hard to catch a break while caring for children, but you deserve one. Breaks give you a chance to reduce stress, restore energy and keep your life in balance.
2. **Stay on top of your physical health**. It is easy to forget about your own health while caring for children. Schedule regular appointments with your physician. Eat nutritious meals, and don't give in to stress-driven urges for sweets or quick, unhealthy meals.
3. **Set health goals**. One way to stay on top of your physical health is by setting manageable and realistic health goals. Make a habit out of doing a certain exercise or eating a healthy snack once a day. Talk to your physician or health care provider about aspects of your health that could be improved, and set goals on how to get there.
4. **Sleep**. The benefits of sleep are undeniable, and without it, caregiver energy, health and stamina can be affected.
5. **Stop feeling guilty**. Whether you are a family caregiver or not, having a life outside of the children you care for can be difficult. It's common to feel guilty about being away or attending to your own life when you play such a large role in the life of someone else. Remind yourself that you are a loving and caring individual, but you must also care for yourself.

6. **Get yourself organized**. Organize your personal priorities, and try to stay on top of your tasks on a daily basis. The more organized your life is, the more time you can focus your attention on the children you are caring for.
7. **Stay positive**. Caregiving can hold many challenges, but with it comes great reward. As a caregiver, you provide one of the greatest gifts of all to the people you are caring for. If you bring positivity and gratitude into your life, you will find gifts during even the most difficult times.
8. **Find social support**. Isolation can increase stress. Getting together regularly with friends and other social groups can help you relax and keep negative stress and energy away. It's important to find others you can talk to about caregiving as well. Share your experiences and learn from one another's challenges.
9. **Reward yourself**. Being a caregiver can be extremely challenging, but it is one of the most selfless and compassionate jobs. Give yourself a pat on the back, and appreciate yourself for a change. Whether it's lunch out with a friend, a pedicure, or a nature hike, stop and reward yourself for all your hard work.
10. **Don't be afraid to ask for help**. It's hard enough caring for yourself and a classroom of children. Ask for help AND accept it when you need it. There are many caregiver resources available if you ever need a break from caregiving. There is no shame in needing help.

Self-Care Resources:

6 Ways to Weave Self-Care into Your Workday: http://bit.ly/2C8TH4b

Identify your "breathe" supports: http://bit.ly/2cmkbYB

Infographic - *21 Strategies to Lower Your Daily Stress:* https://t.co/FFRifb3atP

45 Simple Self-Care Practices for a Healthy Mind, Body & Soul: http://bit.ly/2iUViUc

Reflective Questions to Support Self Care

Increasing Health and Well-Being:

- What is one thing I did in the past month to support my health?
- What is one thing I can do tomorrow to take a step toward better health? For example, you could call your doctor to schedule a long-overdue appointment, commit to making one healthy food choice, or take a brisk walk to get your heart pumping and boost your energy.
- Do my nutritional choices support my health and well-being? If not, what positive changes can I make?
- What do I need to be happier and healthier?

Promoting Happiness and Reducing Stress:

- Do I experience stress connected to my work? Are there other sources of stress?
- What tools or resources can I use to help me manage stress?
- In what areas of my life could I use some support?

- What resources are available in my community to help me meet these needs?
- What activities make me feel relaxed and happy?
- When can I schedule some “me” time, even just for a few moments, to do something that will help me be balanced and reduce my stress?

Getting Support from Mentors:

- Whom do I know and respect that might serve as a strong mentor to me?
- How can this mentor help me in my work with young children?
- When can I approach this person to schedule a time to talk about a possible mentoring relationship?

Developing Supportive Peer Relationships:

- Which of my friends or colleagues has professional beliefs and philosophies that are like my own? How can I spend more time with this person?
- In what ways can I confide in, listen to, and develop a mutually supportive relationship with this person?
- How might this person’s positive outlook benefit my work with young children and their families?
- How might I positively influence this person’s work?

Be sure to recognize the importance of taking care of yourself. The time you invest in your health and happiness will never be wasted. Make yourself a priority. The work you do with young children and their families is priceless, and you deserve every bit of self-care.

From The Administration for Children & Families, U.S. Department of Health and Human Services https://acf.hhs.gov

Professional Development

Another way to take care of yourself is to maintain your professional development through ongoing classes and training. Professional development is defined as ongoing self-assessment of knowledge, skills, and abilities; the establishment of goals; plans for improvement and meeting professional goals. Utilize the www.CECPD.org website for detailed information. For information regarding the Scholars for Excellence in Child Care scholarships visit https://www.okhighered.org/scholars/.

Place your hand on your heart as an act of self-care

When you feel care dragging you down, try placing your own hand over your heart. This self-care practice is a reminder that when we feel exhausted or resentful, what we really want is to be cared for ourselves. We can give self-care with body posture throughout the day such as placing a hand on our heart, holding our own hands, or folding our arms in a way that feels like a protective gentle hug.

Don’t forget the saying “***Laughter is the best medicine***”. Research shows that people who laugh more are healthier, experience less stress, are less likely to be depressed and may even have an increased resistance to illness or physical problems.

Short-term effects
A good laugh has great short-term effects. When you start to laugh, it doesn't just lighten your load mentally, it actually induces physical changes in your body. Laughter can:

- **Stimulate many organs.** Laughter enhances your intake of oxygen-rich air, stimulates your heart, lungs and muscles, and increases the endorphins that are released by your brain.
- **Activate and relieve your stress response.** A rollicking laugh fires up and then cools down your stress response, and it can increase and then decrease your heart rate and blood pressure. The result? A good, relaxed feeling.
- **Soothe tension.** Laughter can also stimulate circulation and aid muscle relaxation, both of which can help reduce some of the physical symptoms of stress.

Long-term effects
Laughter isn't just a quick pick-me-up, though. It's also good for you over the long term. Laughter may:

- **Improve your immune system.** Negative thoughts manifest into chemical reactions that can affect your body by bringing more stress into your system and decreasing your immunity. By contrast, positive thoughts can actually release neuropeptides that help fight stress and potentially more-serious illnesses.
- **Relieve pain.** Laughter may ease pain by causing the body to produce its own natural painkillers.
- **Increase personal satisfaction.** Laughter can also make it easier to cope with difficult situations. It also helps you connect with other people.
- **Improve your mood.** Many people experience depression, sometimes due to chronic illnesses. Laughter can help lessen your stress, depression and anxiety and may make you feel happier. It can also improve your self-esteem.

“*From the Mayo Clinic Healthy Lifestyles/Stress Management”.*

Is your lifestyle causing you stress?

The way you live your life can have a big impact on your health, well-being, and how well or poorly you handle stress. Below are lifestyle behaviors that affect stress levels. Please check the boxes that apply to you. Doing an honest assessment of how well or poorly you take care of yourself can help you manage your stress in the future.

Lifestyle Behaviors					
When you are under stress, do you:	Yes	No	When you are under stress, do you:	Yes	No
Smoke/use tobacco	☐	☐	Engage in physical activity at least three times a week for 30 minutes each day	☐	☐
Drink a lot of coffee or caffeinated drinks (more than 2-3 cups per day)	☐	☐	Get six to eight hours of sleep every night	☐	☐
Drink alcohol (more than recommended levels of 1-2 per day)	☐	☐	Maintain good eating habits	☐	☐
Overuse over-the-counter medications	☐	☐	Make time to relax	☐	☐
Overeat or under eat	☐	☐	Maintain a sense of humor	☐	☐
Spend too much money (e.g., do you have a lot of credit card debt and have trouble making payments?)	☐	☐	Play	☐	☐
Abuse/overuse tranquilizers or other over-the-counter medications	☐	☐	Maintain healthy rituals and routines	☐	☐
Watch too much television (more than 3-4 hours per day)	☐	☐	Be optimistic. Engage in positive thinking	☐	☐
Have angry outbursts	☐	☐	Spend time with family	☐	☐
Take illegal drugs	☐	☐	Spend time with friends	☐	☐
Withdraw from people	☐	☐	Make plans for the future	☐	☐
Ignore or deny stress symptoms	☐	☐	Figure out ways to manage stress	☐	☐
Engage in self-destructive relationships	☐	☐	Reward yourself for your accomplishments	☐	☐
These are negative self-care behaviors.			**These are positive self-care behaviors.**		

(Source: Unknown)

Working with and Including Families

A child's care is enhanced when families and child care providers establish a strong working relationship.

- It is important to develop a good working relationship with the families of the children in your program.
- Child care providers will have a better understanding of each child's strengths and needs if they develop a good relationship with the families.
- There are many ways to build good relationships that will ultimately benefit the children, their families and the child care environment.

Make families feel welcome

- Greet families by name when they arrive and tell them about your plans for the day, skills the children are working on, and activities the children are involved in.
- Create a welcoming entrance that allows parents to help their child get settled and is ADA compliant to accommodate family members with special needs.
- Ask parents to share advice with you about their child.
- Develop good listening skills that show parents that their concerns and ideas are important and valid.

Get families involved

Parents stay better informed and feel a part of the child care program when there are opportunities for them to get involved. Their involvement helps providers offer a program with more variety and children benefit when key adults in their lives take an interest in their activities.

- Have an open-door policy so parents feel comfortable dropping by.
- Ask for their assistance with field trips or with fund-raising events.
- Host parent events such as potlucks and children's programs.
- Offer parent education by you and your staff sharing your knowledge, and also by bringing in a speaker for special events or classes.
- Encourage parents to share their skills such as carpentry work, gardening, etc.
- Request donations of items needed for art and science projects, dramatic play areas, music and movement activities, etc. Post a list and update it as needed.
- Get feedback by sending out parent evaluations and having a suggestion box available.

Parents bring a unique voice to committees and advisory boards

- Form a Parent Advisory Board and solicit parent participation and input.
- They can participate in parent committees in your program and provide valuable input from a parent's point of view.
- They can share their professional and personal knowledge in areas appropriate to your program (business, marketing, legal matters, fundraising).
- They can participate in community initiatives or organizations as a representative of your program.

Thank parents for being involved.
After a parent visits or volunteers write a thank you note to let them know you appreciate their time and assistance.

Communicate with families on a regular basis
Good communication is the foundation of a strong relationship. Everyone benefits when there is regular communication between child care providers and families.

- Daily communication ideas
  - Verbal communication when children are dropped off and picked up
  - Written communication forms or notes
- Ongoing communication ideas
  - Newsletters • Website • Bulletin boards • Parent mailboxes • Email • Voice mail • Social Media
- Parent conferences

It's important to schedule conferences at least twice a year to provide parents and early childhood providers the opportunity to discuss development, progress, and goals for the coming year. Develop a formal strategy and share ways to make the child care experience satisfactory.

Adapted from Child Care Aware of North Dakota http://www.ndchildcare.org

Resources for Families

You can share information with families about their children, your program, and resources that are available to them. The following are examples of communication with families:

- Day-to-day information on children's activities and development
- Regular conferences on children's progress
- Events to showcase children's work
- Newsletters and websites about activities, goals and fun ideas to try at home
- Family education packets (information about Infant Safe Sleep, communicable diseases, age-appropriate activities, challenging behaviors, etc.)
- Information about parenting classes in the community
- Information about community events
- Information about local resources available for all:
  - Career opportunities or job training
  - Housing assistance
  - Smoke detectors for your home and fire safety planning
  - Health care
  - Food and resource centers

If you have a concern you want to discuss with parents think through what you will say and how you will say it.

Before bringing up the issue:

- Identify the real problem.
- What are the consequences of not doing anything?
- What are the consequences of talking with the family?
- What resources can you suggest for the family?
  - Make copies of brochures of agencies that might help.
  - Remember informal resources such as relatives, neighbors, and friends.
- Choose an appropriate time to schedule a meeting with the parent, if possible.
  - The least stressful and hurried time of the day is best.
  - Ask if parent or parents can stop by during their lunch hour, during nap time, or if they can stay a few minutes late when picking up their child.
- Present the problem in a factual way:
  - "I noticed…"
  - Avoid being judgmental.
  - Do not shy away from stating the obvious.

After stating what you are concerned about:

- Ask the parent if they have seen a similar behavior or concern.
  - This gives the parent an opportunity to share.
  - This also gives the parent an opportunity to agree or disagree with your concern before you move on to discussing solutions.

Discuss the concern in terms of how it affects the child:

- Remember you and the parents are both working toward a common goal; what is best for the child.
- Listen to what the parents say in response:
  - Try to use the same words the parents use as you reply "I hear you saying…is that correct?"
  - This lets the parents know you heard them and value their response.
- Look for a place to compromise.
  - Ask the parent if he or she has ideas for next steps. What can the two of you agree on? What steps or activities can you both work on with the child?

Remember:

- You cannot fix things for other people. Your role is to educate parents, provide support, and link them to resources that might be helpful.
- Be sensitive to cultural differences.
- Always end your conversations with parents on a positive note.
- Finally, don't forget to check in. It's important to check in with parents to see how things are going, how the agreed-upon plan is working, and where you might need to make some adjustments.

Chapter 2: Guiding Children's Behavior

Guiding Children's Behavior

Create a Child Care Environment that Supports Children's Exploration
If children in your child care program are exhibiting challenging behaviors, check to see whether the environment is contributing to the problem. Take a close look at your space, indoors and outdoors. Set up safe spaces to play and learn and provide a wide variety of appropriate toys and activities to keep children interested in learning. This will reduce behavior problems.

Tips to create a space that engages children and encourages safe exploration:

- **Take time to look at the environment from a child's–eye view**.
- **Arrange the space wisely**. Often the way the space is organized can make a difference in how children behave. If a space is too open, children may run wildly. Set up shelves and other furniture to divide the room into separate learning and play areas.
- **Organize toys and supplies to make things easy for children**. Place toys on low shelves and label the shelves with pictures and words so children know where to put them when they are finished.
- **Make sure there are enough toys and the toys match the children's ages and abilities**. Behavior problems often occur when children don't have enough toys or materials to play with, children get bored because the toys are below their developmental level, or frustrated because the toys are above their developmental level.
- **Teach children how to handle toys and materials**. Explain and model how to handle books, toys, and other materials. Even very young children can learn to treasure books, to turn the pages gently, to carry them carefully, and to read them in special places. Repeat this message over and over and give children plenty of opportunities to practice.

Adapted from Extension Alliance for Better Child Care/USDA Cooperative Extension

Provide a supportive environment

- Have duplicates of new and favorite toys to reduce frustration.
- Avoid over-stimulation by making sure all the toys aren't available to the children at once.
- Rotate toys, storing some away for a while, and then bringing them back out. This helps keeps children interested in the environment.
- Provide small, private spaces where children can go to be alone. But remember supervision is important so make sure the child can still be seen and heard.
    Toddlers are working on understanding spatial relationships; that's why they like to try fitting themselves into small spaces. Spaces under lofts, tables, or in shelving units are usually popular.
- Provide several soft areas in the room. Use pillows, rugs, and comfortable upholstered furniture to provide coziness.
- Have safe materials visible and available to children at the children's level so they can use them without an adult having to get them.

- Create a variety of activity centers to discourage toddlers from bunching up in one area.
- Children often want to go where the adults are, so adults need to spread themselves throughout the space.

Positive Guidance and Setting Limits

Guiding children's behavior

Children need adults to teach, guide, and support them as they grow and learn. Child care providers play an important role in guiding children's behavior in positive and supportive ways. The most appropriate ways to guide children's behavior are different at different ages, and will depend on their developmental abilities and needs.

Common strategies for guiding children's behavior

- Keep rules simple and easy to understand. Discuss rules with children and write them down. Repeat the rules often. Remember too many rules set everyone up for failure. A few rules that work well:
    1. Be kind to each other.
    2. Take care of our toys and our room.
    3. Say please and thank you.
    4. Use our walking feet inside.
- Say what you mean. Keep sentences short and simple. Focus on ***what to do*** rather than what not to do. For example, try saying "Slow down and walk" instead of "stop running".
- Talk **with** children – not "**at**" them.

Managing Challenging Behaviors

Provide a consistent, yet flexible schedule

- Keep the daily schedule consistent, so it is predictable for children. Being able to predict what will come next is empowering for children.
- Simplify the daily routine, so children aren't asked to transition from one activity to the next too often.
- Allow for flexibility to meet children's individual needs.
    Children need to eat when they are hungry and sleep when they are tired, regardless of whether it's snack or naptime.
- Talk about unavoidable changes in the schedule and be understanding of children's reactions to them.
- Provide several times each day for children to go outside.
- Don't rush children through activities or routines.
- Keep waiting to a minimum.
    To put waiting time into perspective, take the number of minutes toddlers must wait, put a zero at the end of it, and reflect on how you would react to the waiting time in that situation. For example, if the actual waiting time between an activity and lunch is seven minutes, consider how you would

respond to a seventy-minute wait in a similar situation. Also remember, you would be expected to remain calm and choose “appropriate activities” during those seventy minutes.

Provide a variety of sensory activities and materials

- Provide a wide variety of soothing materials and activities.
  - Scarves and dress-up materials that are soft and silky
  - Painting and play dough
  - Sand and water table, at least several times a week (individual basins can be used if your program doesn’t have a sand and water table)
- Provide many cause and effect toys that toddlers can act upon to make them “do something”.
  - Musical instruments, busy boxes, pounding boards, wind-up toys, jack in the boxes, etc.
- Provide opportunities for toddlers to put collections of small, choking safe objects (clothespins, jar lids, juice can lids, etc.) in containers to carry and dump out.
- Instead of planning teacher-directed activities, offer interesting materials and experiences. Observe the children’s reactions to the materials then plan how to further their interest. Offer the same thing over and over, so that children have many opportunities to experiment.
- Offer adult-initiated activities that are spontaneous, short, and optional, such as songs, stories, and finger plays.
- Do not expect toddlers to have formal circle time or to sit in whole group activities.

Provide gentle and empathetic interactions

- Show children what empathy looks and sounds like; model it in your interactions with them.
- Respond positively to children.
- Help children to identify and name their feelings. Say things such as, “Robin, you look frustrated to me. You really wanted to play with the truck, and Sarah has it.”
- Show and tell children how to use language to express feelings and state their needs and wants. Say things such as, “Robin, you can tell Sarah, ‘my turn next’ that way she knows you are waiting for the truck.”
- Encourage children to comfort themselves by using transitional items such as stuffed animals or blankets brought from home.
- Comfort children with soothing voice tones and physical actions such as hugs, a thoughtful hand on a child’s shoulder, or a pat on the back.
- Help children fix mistakes. For example, if a child looks genuinely upset that she hurt another, you can say, “Sammy, you look upset that Lonetta is crying. I wonder if she’d like a hug?” Other possible ways to fix a mistake; help rebuild a knocked down tower or fetch ice for a bite.

Despite even the best prevention efforts of the best caregivers, biting and other challenging behaviors still happen. When they occur, caregivers must be prepared to respond appropriately and effectively and be willing to ask for help when necessary.

The **Oklahoma Warmline (888-574-5437)** is available to assist caregivers who are dealing with biting and other challenging behaviors.

Preventing Expulsions and Suspensions

Unfortunately, children with behaviors that adults view as “difficult” or “problematic” are sometimes shuffled from one early childhood program to another because of the comfort level of the provider not the individual situation of the child. Adults sometimes forget they are working to serve the children and provide the best care possible. Expulsion does the opposite of that.

The first years of a child’s life are the building blocks of foundation for learning, health, and wellness. High quality care for children, specifically those that are not yet in kindergarten, has a huge impact in the most meaningful way. This is especially true for children in at-risk environments.

Expelling a child (telling a parent their child can no longer attend), can give the child the label of a “bad child”. This may influence how other early childhood programs react to the child and may keep the child from being excited about school. This is a toxic situation, especially for early learners.

If a provider is caring for a child with difficult behavior and is thinking about expulsion or suspension, they should take into consideration the ***child’s social-emotional*** and ***behavioral development*** as well as ***their home situation***.
Ask these questions:

- Why am I considering removing this child from my care?
- Will expelling this child truly help them in their life?
- Am I only interacting with the child when they are misbehaving, or do I encourage them at positive times as well?
- Has a deep conversation about this child occurred more than once with the family of the child?
- Are there any resources available that can help this child and family?

Children with challenging behaviors that then go through a stressful experience like being expelled from preschool will only be pushed back further and further when it comes to their development and self-esteem. Those that don’t benefit from early childhood education are the ones that don’t attend and they aren’t in attendance because they were kicked out.

Ways to eliminate expulsion and suspension from child care, as recommended by The U.S. Departments of Health and Human Services and Education are:

- Develop and clearly communicate preventive guidance and discipline practices.

- Develop and clearly communicate expulsion and suspension policies and implement those policies uniformly and without bias.

- Invest and grow the skills of the early childhood workforce with a focus on:
  - Children's social-emotional and behavioral health
  - Strengthening partnerships with families
  - Employing strategies to prevent and correct biases
  - Conducting universal developmental and behavioral screening and appropriate follow-up

- Make use of free resources to enhance staff training and strengthen family partnerships.

The beginning years of any child's life are critical for building the early foundation of learning, health and wellness needed for success in school and later in life. During these years, children's brains are developing rapidly, influenced by the experiences, both positive and negative, that they share with their families, caregivers, teachers, peers, and in their communities.

A child's early years set the trajectory for the relationships and successes they will experience for the rest of their lives, making it crucial that children's earliest experiences truly foster – and never harm – their development. As such, expulsion and suspension practices in early childhood settings, two stressful and negative experiences young children and their families may encounter in early childhood programs, should be prevented, severely limited, and eventually eliminated. High-quality early childhood programs provide the positive experiences that nurture positive learning and development.

> *From the Administration for Children and Families (ACF), U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Policy Statement on Expulsion and Suspension Policies in Early Childhood Settings*

Biting in the Toddler Years

Biting is a typical behavior often seen in infants, toddlers, and two-year-olds. As children mature, gain self-control, and develop problem-solving skills, they usually outgrow this behavior. While not uncommon, biting can be an upsetting and potentially harmful behavior. It's best to discourage it from the very first episode.

A child might bite to:

- Relieve pain from teething.
- Explore cause and effect ("What happens when I bite?").
- Satisfy a need for oral-motor stimulation.
- Feel strong and in control.
- Get attention.
- Act in self-defense.
- Communicate needs and desires, such as hunger or fatigue.
- Communicate or express difficult feelings, such as frustration, anger, confusion, or fear ("There are too many people here and I feel cramped").

Take the time to understand why a particular child bites:

- ***Watch*** to see when and where biting happens, who is involved, what the child experiences, and what happens before and after.
- ***Ask*** yourself why the child bites others. Is there a pattern to the situations, places, times or other children when biting occurs? What individual or temperamental needs might influence the child's behavior? Have there been changes in the child's health, family or home situation which might affect his/her behavior?
- ***Adapt*** your environment, schedule, or guidance methods to teach gentle and positive ways to handle the child's feelings and needs.

With biting, it's important to deal with the behavior immediately after it happens.
When a child bites another child:

- ***Intervene immediately*** between the child who bit and the bitten child. Stay calm; don't overreact, yell or give a lengthy explanation.
- ***Talk briefly to the child who bit***. Use your tone of voice and facial expression to show that biting is not acceptable. Look into the child's eyes and speak calmly but firmly. Say "It is not ok to bite people", or simply "No biting people." You can point out how the biter's behavior affected the other child. "You hurt him and he's crying."
- ***Help the child who was bitten***. Comfort the child and apply first aid. If the skin is broken, wash the wound with warm water and soap. Apply an ice pack or cool cloth to prevent swelling. Tell the parents what happened and recommend that they have the child seen by a physician if the skin is broken or there are any signs of infection (redness and swelling). Encourage the child who was bitten to tell the biter how they feel.

- ***Encourage the child who bit to help the other child***, such as by getting the ice pack.
- ***Alert other staff*** of the incident.
- ***Notify the parents of all children involved***. Let them know what happened but do not name or label the child who bit. Reassure them by telling how you handled the incident, and involve the parents in planning how to prevent and handle future biting.
- ***Fill out an incident report***.

Create a 'Bite-Free' Environment
Whether you feel like you've made progress with a child's biting habit or it continues to be a work-in-progress, it's important to create a zero-tolerance culture at home, child care, and elsewhere so be sure to discuss the plan with parents.

Some ideas for managing the children's behavior:

- **Be consistent.** Reinforce the "No biting" rule at all times.

- **Use positive reinforcement**. Rather than reward negative actions with attention, make it a point to praise children for their behavior when they are getting along with others. You can use statements such as, "I like how you used your words" or "I like how you're playing gently" to reinforce positive alternatives to biting.

- **Plan ahead**. Toddlers might be more comfortable and not feel the urge to bite if they know what to expect in new or high-energy situations. If biting happens at the same time of day in your program, pay attention to what is happening during that time of day and make some adjustments. Biting could occur more often when children are hungry or in need of a nap.

- **Find alternatives**. As language skills develop, you can help children find better ways to express negative emotions. However, asking children to "use their words" when they're frustrated or upset can be frustrating if they don't know what words to use. Help them put their feelings into language – "Are you frustrated that Brian grabbed your truck and you were still playing with it?" Next time tell Brian – "I'm using the truck. You can have it when I'm done", or more short and simple – "My turn!"

Here are some strategies for addressing a child's biting habit:
- Observe the child to learn where, when, and in what situations biting occurs. Pay attention to signals. Stay close and step in if the child seems ready to bite.
- Suggest acceptable ways to express strong feelings. Help the child learn to communicate his or her wants and needs ("Amy, tell your sister you were still playing with the truck").
- Use a reminder system to help the child learn to express strong feelings with appropriate words and actions ("Tell Manuel that you don't like it when he gets that close to you").

- Reinforce positive behavior by acknowledging child's appropriate words and actions ("You didn't want help zipping your jacket so you used your words to ask me to stop").
- Provide opportunities for the child to make choices and feel empowered.
- Be sure your behavior expectations are age-appropriate and individually appropriate for the child. Expecting a child to do something he or she is not able to do can cause children to feel stress. Stress can lead to biting.
- Teach the child words for setting limits, such as "no," "stop," or "that's mine."

If you have a serious biting issue you may need professional help such as a behavioral health specialist to discuss ways to teach the child to manage strong emotions and express feelings in a healthy way.

Biting is common in babies and toddlers, but it should stop when kids are about three or four years old. If it goes beyond this age, is excessive, seems to be getting worse rather than better, and happens with other upsetting behaviors, discuss with the child's parents. They may want to talk to the child's doctor or a behavioral health specialist. Together you can find its causes and ways to deal with it.

https://www.kidshealth.org/en/parents/stop-biting.html
https://www.naeyc.org/our-work/families/understanding-and-responding-children-who-bite
https://oklahoma.gov/content/dam/ok/en/health/health2/documents/cgs.pub.bitingtodyears.pdf

Understanding Early Childhood Sexual Development

Adapted from Sexual Development and Behavior in Children, The National Child Traumatic Stress Network.

Like all forms of development, sexual development begins at birth. Sexual development includes not only the physical changes that occur as children grow, but also the sexual knowledge and beliefs they come to learn and the behaviors they show. Any given child's sexual knowledge and behavior is strongly influenced by:

- The child's age
- Observed behaviors of family and friends
- Cultural and religious beliefs that are taught

Common Sexual Behaviors in Childhood

Preschool Children (less than 4 years old)	• Exploring and touching private parts, in public and in private. • Rubbing private parts (with hand or against objects). • Showing private parts to others. • Trying to touch mother's or other women's breasts. • Removing clothes and wanting to be naked. • Attempting to see other people when they are naked or undressing (such as in the bathroom). • Asking questions about their own and others' bodies and bodily functions. • Talking to children their own age about bodily functions such as "poop" and "pee".
Young Children (approximately 4-6 years)	• Purposely touching private parts (masturbation), occasionally in the presence of others. • Attempting to see other people when they are naked or undressing. • Mimicking dating behavior (such as kissing or holding hands). • Talking about private parts and using "naughty" words, even when they don't understand the meaning. • Exploring private parts with children their own age, such as playing "doctor", "I'll show you mine if you show me yours," etc.

School-Aged Children (approximately 7-12 years)	• Purposely touching private parts (masturbation) usually in private. • Playing games with children their own age that involve sexual behavior, such as "truth or dare", "family", or "boyfriend/girlfriend". • Attempting to see other people naked or undressing. • Looking at pictures of naked or partially naked people. • Viewing/listening to sexual content in media (television, movies, games, the internet, music, etc.). • Wanting more privacy (for example, not wanting to undress in front of other people) and being reluctant to talk to adults about sexual issues. • Beginning of sexual attraction to/interest in peers.

Just because a behavior is typical doesn't mean the behavior should be ignored. Often, when children participate in sexual behavior it indicates that they need to learn something. Teach what the child needs to know, given the situation.

Although parents often become concerned when a child shows sexual behavior, such as touching another child's private parts, these behaviors are not uncommon in developing children. Most sexual play is an expression of children's natural curiosity and should not be a cause for concern or alarm. In general, "typical" childhood sexual play and exploration:

- Occurs between children who play together regularly and know each other well
- Occurs between children of the same general age and physical size
- Is spontaneous and unplanned
- Is infrequent
- Is voluntary (the children agreed to the behavior, none of the involved children seem uncomfortable or upset)
- Is easily diverted when parents tell children to stop and explain privacy rules

Some childhood sexual behaviors indicate more than harmless curiosity, and are considered sexual behavior problems. Sexual behavior problems may pose a risk to the safety and well-being of the child and other children. (For more on this topic, see the National Child Traumatic Stress Network's factsheet, Understanding and Coping with Sexual Behavior Problems in Children: Information for Parents and Caregivers at http://nctsn.org/nctsn_assets/pdfs/caring/sexualbehaviorproblems.pdf.)

Sexual behavior problems include any act that:

- Is clearly beyond the child's developmental stage (for example, a three-year-old attempting to kiss an adult's genitals)
- Involves threats, force, or aggression
- Involves children of widely different ages or abilities (such as a 12-year-old "playing doctor" with a four-year-old)
- Provokes strong emotional reactions in the child—such as anger or anxiety

Too often, children get the majority of their sexual education from other children and from media sources such as television shows, songs, movies, and video games. Not only is this information wrong, it may have very little to do with sexual values that parents want to convey.

Controlling media exposure and providing appropriate alternatives is an important part of teaching children about sexual issues. Get to know the rating systems of games, movies, and television shows and make use of the parental controls available through many internet, cable and satellite providers.

Additional information and resources can be requested by contacting the Oklahoma Warmline at 888-574-5437.

Chapter 3: Child Abuse

CHILD ABUSE

Reporting Child Abuse and Neglect

STATEWIDE 24-HOUR CHILD ABUSE HOTLINE 1-800-522-3511

Child abuse is defined by law as **harm** or **threatened harm** to a child's health and safety by a person responsible for the child's health and safety. This includes a parent, a legal guardian, a foster parent, or a person 18 years of age and older with whom the child's parent cohabitates, or any other adult residing in the home of the child.

Harm or threatened harm includes:

- **Physical Abuse:** non-accidental physical injury to a child under 18 years of age. Even though the injury is not an accident, there may not have been intent to hurt the child. Physical abuse indicators may be:
  - Physical Indicators - questionable bruises, welts, burns, abrasions, fractures or lacerations.
  - Behavioral Indicators - extreme aggressiveness or withdrawal, being frightened of parents, or afraid to go home.
- **Neglect:** failure or omission to provide food, clothing, shelter, medical care, supervision, or special care made necessary by the physical or mental condition of the child. Neglect indicators may be:
  - Physical Indicators - consistent lack of supervision, unattended medical needs, or physical problems.
  - Behavioral Indicators - frequently absent or tardy.
- **Sexual Abuse or Exploitation:** includes, but is not limited to, rape, incest, lewd or indecent acts or proposals, and allowing, permitting, or encouraging a child to engage in prostitution or pornography. Sexual abuse indicators may be:
  - Physical Indicators – torn, stained, or bloody underclothing.
  - Behavioral Indicators – bizarre or unusual sexual behavior or knowledge; detailed and age-inappropriate understanding of sexual behavior; or suicide threats or attempts.
- **Emotional Abuse:** mental injury from incessant rejecting, terrorizing, isolating, exploiting, corrupting, and denying emotional responsiveness. Indicators may be:
  - Behavioral Indicators - overly compliant or demanding, extreme passivity or aggression, inappropriately adult, or infantile.
  - Caretaker Indicators - blames or belittles the child, treats child as the family scapegoat, unreasonable demands, or impossible expectations without regard to the child's development capability.

State law requires every health care professional, teacher, and every **OTHER** person who has **reason to believe** that a child under 18 years of age is being abused or neglected, or is in danger of being abused or neglected, must report the **suspicion** of abuse or neglect promptly to the Oklahoma Department of Human Services (DHS).

- **Failure to report** suspected abuse or neglect is a crime. No person, regardless of their relationship to the child or family, is exempt from reporting suspected abuse or neglect. However, a person reporting in good faith is immune from both civil and criminal liability.
- By law, reporting child abuse or neglect is an **individual responsibility**. As the individual who suspects abuse or neglect, **you** are legally responsible for making certain that the report is made to DHS.
- If you have obtained the information leading to your suspicions from a professional relationship, your legal responsibility is **NOT** satisfied by merely reporting your suspicions to a supervisor. If applicable, it is important to follow your agency or school procedures regarding informing a supervisor of your concerns, but permission to report is not necessary. You must not let organizational procedures or policies obstruct your duty to report **PROMPTLY** to DHS.

A report is a **request for a safety evaluation** to gather facts and protect the child. The individual making the request does not need proof of the abuse or neglect prior to reporting. Investigation and validation of child abuse and neglect reports are the responsibility of DHS or law enforcement officials. If you become aware of additional incidents after the initial report was made, another report to DHS with the additional concerns and information should be made.

DHS policy and state law require **strict maintenance** of the confidentiality of reporters of child abuse or neglect. If the incident does become court involved, information on the reporter could be requested by the court. It is rare, however, for the reporter's identity to be made known in court. Anonymous reports are also accepted, but providing your name and contact information may help the child welfare worker contact you in regards to obtaining more information or with additional questions.

To report a suspicion of Child Abuse – promptly contact DHS, Child Welfare Services by calling the statewide, 24-hour Hotline number, **1-800-522-3511**. Accurately reporting the nature of the abuse or neglect is critical. Do not overstate or minimize the extent of the suspected abuse or neglect.

Information to have ready to report:

- The names, addresses, ages and whereabouts of the child and the child's parents, or other persons responsible for the child's welfare, such as the school, work, child care, or hospital;
- Information pertaining to support systems for the family, other individuals who may be aware of the abuse or neglect, or any safety-related issues child welfare may need to be aware of prior to making contact with the family, such as domestic violence, presence of weapons, or use of illegal substances;
- The nature and extent of the suspected abuse or neglect;
- Any historical information on the family related to the safety and well-being of the children and their parents or other identified caretakers;
- Any other information you believe might be helpful in establishing the cause of the injuries and the identity of the person responsible; and

- If a reporter does not have all of the information listed above, he or she should go ahead and report details of what is known concerning the suspicion of abuse or neglect.

After the report is made:
The report is screened to determine if the allegation meets the statutory definition of abuse and neglect and if the report falls within the scope of DHS' responsibility. If the alleged abuse is perpetrated by someone other than a caretaker, DHS is required to forward the report to law enforcement. DHS is mandated to investigate or conduct assessments regarding allegations of abuse or neglect by a parent or caretaker. DHS established the following timeframes to determine the urgency of the response.

- **Priority One** – The report indicates the child is in present danger. The situation is responded to immediately the same day the report is received.
- **Priority Two** - The response time is based on the child's vulnerability and risk of harm. A report designated as an investigation is responded to in a shorter time period than an assessment. An investigation is initiated in no more than five-calendar days from acceptance, unless a special circumstance exists that prevents the initiation. An assessment is initiated in no more than ten-calendar days from acceptance.

A child protective services (CPS) **investigation** is conducted when the allegations in the report indicate there is serious abuse or neglect resulting in an immediate safety threat to a child. An investigation is accepted and assigned by the two different priorities.

After a report is accepted for investigation, as much information as possible is gathered about the reported allegations and family dynamics that jeopardize the child's safety and the protective capacity of the family is assessed.

During the investigation, each alleged child victim is seen or interviewed first, followed by each sibling, each family member responsible for the child's health, safety, or welfare, the alleged perpetrator, and other persons with information. The CPS investigation determines the findings and identifies if child abuse or neglect is:

Ruled Out
Unsubstantiated
Substantiated

All reports are submitted to the District Attorney's office upon completion. When the child or children are deemed unsafe, a safety plan can be implemented to control the safety threats or court action may be recommended. DHS can submit a request to the District Attorney's office for the court to order removal of the child or children from the home. They can also be placed in protective custody by the police. **DHS staff does not have the authority to remove a child from their home.**

A CPS **assessment** means a comprehensive review of child safety and an evaluation of family functioning and protective capacities conducted in response to a child abuse or neglect referral that does not allege a serious and immediate safety threat to a child. A CPS assessment is conducted when the report concerns abuse or neglect that is not serious or extremely dangerous. A report assigned as an assessment is responded to in 10-calendar days or less after acceptance. No findings are made on CPS assessments. There are situations that do not meet the legislative mandate for a DHS investigation. Usually, this is because:

- Insufficient information was provided to locate the family and child;
- The report does not meet the legal definition of abuse and neglect; or
- The alleged perpetrator is a person other than a parent or caretaker, such as a neighbor or teacher.

Examples of screened-out reports may include: adolescents with behavioral problems, such as delinquency or truancy, which is not related to abuse or neglect; parent/child conflicts where no abuse or neglect is occurring; or overreactions to poor parenting practices.

After a report is made, the reporter may obtain information on the report's status, which may include whether the case was investigated, assessed, or screened out. When the report was screened out, reporters may be informed of the reason for this decision. When the report was accepted for investigation or assessment, reporters may be told the investigation's finding or that the assessment was concluded. Investigation findings and concluded assessments are forwarded to the District Attorney's office in accordance with Oklahoma law. Reporters are **not**, however, entitled to investigation or assessment details. Anonymous reporters are not entitled to receive information on the status of the report since child welfare has no way of verifying their identity.

If you are unsatisfied with the way an investigation was handled, you can provide critical **feedback** through the supervised structure of an investigating agency. Within DHS, first contact the child welfare supervisor on the investigation. If you are still unsatisfied, proceed through the **chain of command** to the district director and the regional deputy director.

The Difference between Abuse and Discipline

For children to grow up and become productive members of society subject to society's norms, values, and rules, all children need discipline. **Discipline** is a **learning process designed to teach appropriate behaviors**. Unlike discipline, ***abuse is not a learning process***. ***Abuse inflicts pain to stop behavior***. It does not teach alternative, correct behavior. Therefore, abused children do not learn correct behavior. They learn to avoid punishment.

The intent of the **reporting law** is not to interfere with appropriate parental discipline, but to respond to extreme or inappropriate parental actions. ***Actions that are excessive or forceful enough to leave injuries or cause damage to the psyche are considered abusive***.

Caring for Children who have been Abused and Neglected

Abused children can be at risk for cognitive delays and emotional difficulties. The lasting effects are massive and can lead into adulthood. Caregivers take on much responsibility when working with children who have been abused or neglected. It is possible to help children find healing after a traumatic experience but there are some issues the children may be dealing with as a result of the abuse:

- Aggression
- Developmental delays
- Emotional issues (depression or anxiety)
- Inappropriate modeling (overly sexual/playing the parent)
- Odd eating behaviors
- Odd soothing behaviors (scratching or rocking themselves)

Providing a calm, safe environment for children and receiving training from professionals is the first step in working with children with a complicated past. Available resources include:

- The National Child Traumatic Stress Network: http://www.nctsn.org/resources/audiences/parents-caregivers/what-is-cts
- Child Welfare Information Gateway: https://childwelfare.gov/
- The Centers for Disease Control and Prevention, Child Abuse and Neglect Prevention Strategies: https://cdc.gov/violenceprevention/childabuseandneglect/

Helpful Tips for Caring for Children Who Have Been Abused and Neglected

- Listen to what the child has to say.
- Let the child know he or she is not alone.
- Let the child know what is happening is not his or her fault.
- Provide a calm, safe environment.
- Treat each child with respect.
- Encourage creativity and fun activities.
- Write down and explain rules.
- Be consistent with the consequences of not following the rules.
- Be there! Prove that some adults can be trusted.
- Set an example. Remember every word you say and every action you take is modeling behavior for all of the children in your care.

Child Abuse Prevention

When the Baby Won't Stop Crying

Crying is an important means of communication for babies during early infancy. At this stage in their development, infants depend almost entirely on caregivers to meet their needs. As a result, infant crying can assume an important role in ensuring the survival, health and development of the child.

Persistent crying that seems to have no reason can make parents and caregivers feel worried, upset, or even out of control. It's important to remember to not take the baby's crying personally and **NEVER SHAKE THE BABY! Shaking an infant can cause blindness, brain damage or even death!**

The *Period of PURPLE Crying* program is an evidence-based shaken baby syndrome/abusive head trauma (SBS/AHT) prevention program available since 2007. The program has two aims:

1. To support parents and caregivers in their understanding of early increased infant crying.
2. To reduce the incidence of SBS/AHT.

It's a way to help parents and caregivers understand the time in a baby's life which is a normal part of every infant's development. The Period of PURPLE Crying begins at about 2 weeks of age and continues until about 3-4 months of age. There are other common characteristics of this phase, which are described in the PURPLE acronym. It is during this time that some babies can cry a lot and some far less, but they all go through it. When babies are going through this period, they seem to resist soothing. Nothing helps. Even though certain soothing methods may help when they are simply fussy or crying, bouts of inconsolable crying are different.

During this phase of a baby's life, they can cry for hours and still be healthy and normal. Parents often think there must be something wrong or they would not be crying like this. However, even after a check-up from the doctor which shows the baby is healthy, they still go home and cry for hours, night after night. Often parents say their baby looks like he or she is in pain. They think they must be, or why would they cry so much. Babies who are going through this period can act like they are in pain even when they are not.

Listening to your baby cry can be heart-wrenching. We are brought up to feel not just responsible for our children, but also to relate to their emotions, and when they cry, we can get sucked into their distress. Researchers call this emotional contagion and it is an important part of how humans relate to one another, especially in infancy. However, it is hard to stay focused on caring for the baby well when you can feel your baby's despair, your heart rate is climbing, and your mind is speeding through all the questions that come with an inconsolably crying baby. **Are you hungry, baby? Do you hurt? What's wrong? Why are you crying? Why won't you stop?**

The best thing that caretakers can do is stay calm. It may sound simple, but it can be hard to do when you are tired, frazzled, and worried about your baby. Taking care of a crying infant is a lot of work, and feeling frustrated, drained, and a little desperate is a normal reaction to a hard situation. It is okay to feel those things; the trick is to not let your feelings shape how you treat your baby. Keeping your emotions in check – **staying calm** – is important for your own sake, but also for your baby. When you can soothe your crying baby without adding your own distress to the mix, the baby gets the message that you are confident, collected, and can ride out the storm right there with them. Your calmness is reassuring, in fact it can be contagious, and is far more helpful to a crying baby than the alternative.

The acronym PURPLE is used to describe specific characteristics of an infant's crying during this phase and lets parents and caregivers know that what they are experiencing is normal, and although frustrating, is simply a phase in the child's development and that it will pass. This is only temporary and will come to an end.

Period of PURPLE Crying: http://www.purplecrying.info/

Working with Families – the Strengthening Families Protective Factors

The Center for the Study of Social Policy (CSSP), introduced the Strengthening Families™ Approach and Protective Factors Framework in 2003. Strengthening Families™ is a research-informed approach to:

- Increase family strengths
- Enhance child development
- Reduce the likelihood of child abuse and neglect

This framework focuses on strengthening protective factors and building family and social networks to reinforce the ability of parents to care for their children.

Early childhood programs can help prevent child abuse and neglect by using the following program strategies:

- Facilitate friendships and mutual support
- Strengthen parenting
- Respond to family crises
- Link families to services and opportunities
- Facilitate children's social and emotional development
- Observe and respond to early warning signs of child abuse and neglect
- Value and support parents

These program strategies build the following **protective factors**, which are known to reduce child abuse and neglect.

- ***Parental resilience***: managing stress and functioning well when faced with challenges, adversity, and trauma.

- ***Social connections***: having a sense of connectedness with constructive, supportive people and institutions.

- ***Knowledge of parenting and child development***: understanding parenting best practices and developmentally appropriate child skills and behaviors.

- ***Concrete support in times of need***: identifying, accessing, and receiving needed adult, child, and family services.

- ***Social and emotional competence of children***: forming secure adult and peer relationships; experiencing, regulating, and expressing emotions.

For more information about Strengthening Families visit the CSSP website: https://www.cssp.org/our-work/projects/strengthening-families/

Find Protective Factors Conversation Guides at https://childwelfare.gov/topics/preventing/preventionmonth/resources/conversation-guides/

Chapter 4: Childhood Injury Prevention

Alphabetical Listing of Injury Prevention Topics & Resources

Injury Prevention is the understanding that injuries are not random uncontrollable events, but preventable, with identifiable risk factors. Many injuries happen in predictable, preventable ways.

As a child care provider, you are responsible for the health and safety of the children in your care. A healthy and safe environment for children means they can live and play in your facility or home free from harm.

Keys to a SAFE environment

- **S**upervise – close supervision of children at all times.
- **A**nticipate – ask yourself "What are the possible hazards?"
- **F**ormulate – make a plan by asking "What do I do if……..?"
- **E**ducate – educate all providers and children of possible hazards.

Teach children safety rules and awareness throughout the day, every day.

Steps to prevent injuries:

- Never leave infants or young children alone on changing tables, beds, couches, any surface from which they can fall.
- Never leave children alone in motor vehicles or with access to vehicles.
- Use only cribs and portable cribs that meet current federal safety guidelines.
- Keep a harness or safety strap on babies and toddlers in high chairs.
- Keep play areas uncluttered.
- Keep playground equipment in good condition.
- Remove poisons and toxic products or keep in locked cabinets out of reach.
- **SUPERVISE! SUPERVISE! SUPERVISE!** Provide adequate staff on the playground and in classrooms to supervise all activities.
- Learn and practice CPR and relief of airway obstruction.

Bicycle Safety (and all riding toys, scooters and skateboards)

"Use your head, wear a helmet."

The single most effective safety device available to reduce head injury and death from bicycle crashes is a bicycle helmet.

- Enforce the rule that **children must wear a helmet EVERY TIME** they ride a bike, riding toy, scooter and skateboard. This includes motorized riding toys.
- Make sure the helmet sits flat atop the head, has strong, wide straps that fasten snugly under the chin, and meets the Consumer Product Safety Commission Standard (it should have a CPSC sticker).
- The wheeled toy should be the right size for the child – when sitting on the seat their feet should rest flat on the ground with the handlebars or steering wheel within reach.
- Keep a lookout for obstacles in the riding path.
- Be aware of the traffic flow.
- Inflate tires properly.
- Be a role model and wear a helmet when you ride.
- Remove the helmet when done riding – it could get caught in playground equipment.

A reminder from the U.S. Consumer Product Safety Commission:

Children should always wear helmets while riding their bikes. But when a child gets off the bike, take off the helmet. There is a "hidden hazard" of strangulation if a child wears a helmet while playing on playground equipment.
https://www.safekids.org/bike

Burn Prevention

Unintentional burn injuries can occur from fireplaces, appliances, grills, chemicals, electrical outlets, fires, hot water, and other hot liquids. More than one half of all burn center admissions for young children in Oklahoma are for a scald injury from hot water or other hot liquids such as coffee, tea or soups like instant soup or ramen.

Unintentional scalds can be prevented by following these tips:

- Take simple steps to reduce risks in the kitchen, such as cooling soups before serving, pour microwaved soup or noodles into a more stable container or bowl, and supervise children during food preparation and mealtime.
- Set hot water heater thermostat to 120 degrees Fahrenheit.
- Always check the temperature of the water with your wrist or elbow before placing a child in the bath.
- Keep hot beverages out of children's reach.
- Never hold a child while drinking a hot beverage.

- When cooking, keep children out of the kitchen and place pan and pot handles toward the back of the stove where little hands cannot reach them.
- Allow food to cool slightly before serving to children.

Other burn prevention tips:

- Do not allow electrical cords to hang off counters or other surfaces; children may pull the appliance (and the hot food) onto themselves.
- Keep clothing irons, curling and flat irons, and their cords out of reach of children.
- Cover electrical outlets so that children are unable to insert objects.
- Keep children out of the midday sun and off hot surfaces.
- Use a safety gate around your fireplace.
- Test smoke alarms and practice fire drills and safely exiting the building each month. https://safekids.org/safetytips/field_risks/burns-and-scalds

Button Battery Safety

Thousands of children are treated in emergency departments each year after ingesting button or lithium coin batteries. Small, shiny, and appealing to children, button batteries can cause major injury and even death when swallowed or stuck in a child's nose or ear. When it comes into contact with body fluids, the battery generates a current that produces small amounts of sodium hydroxide, which is lye. If the battery gets stuck somewhere in the body, the lye burns a hole at that spot. Infection usually follows. The result can be serious injury and illness, long-term disability, or even death.

Facts about button batteries:

- Children love to explore, and when they find something new and shiny, they will pick it up, play with it, take it apart if possible, and possibly put it in their mouth, nose or ear.
- When a child swallows a button battery it can burn through the esophagus in as little as two hours.
- The scary part is that it may not be obvious at first that there is something wrong, since kids can still breathe and act normally after ingesting a battery. It may seem like the child has a cold or the flu.
- Repairing the damage from battery ingestion is painful and often involves multiple surgeries. Even after a battery is removed, kids can experience terrible side effects to their vocal cords and windpipe.

Keep button batteries out of reach:

- Keep coin lithium battery-controlled devices out of sight and reach of children or place a piece of duct tape over the battery compartment. These can include remote controls, musical greeting cards, digital scales, watches, hearing aids, thermometers, calculators, key fobs, flameless or tea light candles, flashing holiday jewelry, and even some children's toys.
- Keep loose batteries locked away.

- When replacing a button or lithium coin battery, keep in mind that it stops powering a device way before it runs out of a charge. So, what we think of as a “dead" battery still has the charge to harm a child should it get caught in their ear, nose, and throat or swallowing passage. The higher the voltage of the battery (3V vs. 1.5V), the faster the injury.

To safely dispose of button and lithium coin batteries – wrap them in tape and promptly recycle or put them in an outside garbage can.
www.nsc.org/community-safety/safety-topics/child-safety/button-batteries

Carbon Monoxide Poisoning Prevention

Carbon monoxide (CO) is a gas that you cannot see, taste or smell and because of this, is often called the “invisible killer.” Carbon monoxide poisoning can result from faulty furnaces or other heating appliances, portable generators, water heaters, clothes dryers, or cars left running in garages.

Young children process CO differently than adults, so they may experience more severe side effects and show signs of poisoning quickly. Symptoms of carbon monoxide poisoning include headache, nausea and drowsiness. At its worst, CO can cause severe side effects or even death.

Top tips for carbon monoxide safety:

- **Install carbon monoxide (CO) alarms.** Make sure there is one on every level of your home or business, especially around sleeping areas.
- **Test CO alarms every month.** Replace them according to the manufacturer’s instructions.
- **Avoid using gas appliances inside your home or facility.** Use generators and grills outside away from windows and doors. Warm up vehicles outside of your garage.
- Never use your oven or stovetop to heat your building.
- On the outside of your building, make sure vents for the dryer, furnace, stove, and fireplace are clear of snow and other debris.
- **In a CO emergency, leave your home or facility immediately.** If the CO alarm sounds, quickly evacuate everyone (including pets) from the building and move to a safe location outside where everyone can breathe in fresh air. **Call 911**. Emergency responders are trained to identify and treat symptoms of CO poisoning. Firefighters are equipped to find the source of Carbon Monoxide leaks and stop them.

Each year, 184 children in the United States die due to carbon monoxide poisoning and more than 20,000 children visit the emergency room.
https://www.poison.org/articles/carbon-monoxide

Choking Hazard Safety

A choking hazard is any object that could be caught in a child's throat blocking their airway and making it difficult or impossible to breathe.

Food is a common choking hazard. Foods commonly linked to childhood choking:

- Whole grapes
- Nuts and seeds
- Chunks of meat or cheese
- Hot dogs
- Chunks of peanut butter
- Raw vegetables
- Raisins
- Popcorn
- Chips and pretzels
- Hard or sticky candy
- Marshmallows
- Chewing gum

Cut food into small pieces that are NOT round in shape, enforce the rule that all children must remain seated while eating, and provide continual supervision.

Common objects that can be a choking hazard for children:

- Latex balloons
- Coins
- Buttons
- Magnets
- Batteries
- Bandages
- Pen and marker caps
- Small balls and marbles
- Hair barrettes, rubber bands and beads
- Toys with small parts
- Toys that can fit entirely into a child's mouth

Keep floors swept and continually monitor for small parts. Invest in a small parts tester, also called a "choke tube" to see which toys are too small for the children three years and younger. Toys are designed to be used by children within a certain age range. The age guidelines take into account the safety of a toy based on any possible choking hazard. Don't let young children play with toys designed for older children.

Always have staff on site with current certification in CPR and Airway Obstruction.
https://www.kidshealth.org/en/parents/safety-choking.html

Concussions in Children - What Educators Need to Know

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move rapidly back and forth. This sudden movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging brain cells.

Children and teens who show or report one or more of the signs and symptoms listed below, or simply say they just "don't feel right" after a bump, blow, or jolt to the head or body, may have a concussion or more serious brain injury.

Concussion Signs Observed:

- Can't recall events *prior to* or *after* a hit or fall.
- Appears dazed or stunned.
- Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent.
- Moves clumsily.
- Answers questions slowly.
- Loses consciousness *(even briefly)*.
- Shows mood, behavior, or personality changes.

Concussion Symptoms Reported:

- Headache or "pressure" in head.
- Nausea or vomiting.
- Balance problems or dizziness, or double or blurry vision.
- Bothered by light or noise.
- Feeling sluggish, hazy, foggy, or groggy.
- Confusion, or concentration or memory problems.
- Just not "feeling right," or "feeling down".

In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body that may squeeze the brain against the skull. **Call 9-1-1 right away, or take the child or teen to the emergency department if he or she has one or more of the following danger signs after a bump, blow, or jolt to the head or body.**

Dangerous Signs & Symptoms of a Concussion:

- One pupil larger than the other.
- Drowsiness or inability to wake up.
- A headache that gets worse and does not go away.
- Slurred speech, weakness, numbness, or decreased coordination.
- Repeated vomiting or nausea, convulsions or seizures (shaking or twitching).
- Unusual behavior, increased confusion, restlessness, or agitation.

- Loss of consciousness. Even a brief loss of consciousness should be taken seriously.

Dangerous Signs & Symptoms of a Concussion for Toddlers and Infants:

- Any of the signs and symptoms listed in the Dangerous Signs & Symptoms of a Concussion list.
- Will not stop crying and cannot be consoled.
- Will not nurse or eat.

Most children with a concussion feel better within a couple of weeks. However, for some, symptoms will last for a month or longer. Concussion symptoms may appear during the normal healing process or as the child gets back to their regular activities. If there are any symptoms that concern you or are getting worse, be sure to discuss with the parents and ask them to seek medical care as soon as possible.

Recovery Delays

Factors that might delay recovery include the child having:

- A history of a previous concussion or other brain injury.
- Neurological or mental health disorders.
- Learning difficulties.
- Family and social stressors.

Ways to help reduce the risk of a concussion:

- **Car seats** – Always use age- and size-appropriate car seats and booster seats that are properly installed.
- **Helmets** – Make sure the child always wears the right helmet for their activity and that it fits correctly. Wearing a helmet is a **must** to help reduce the risk of a serious brain injury or skull fracture. However, helmets are not designed to prevent concussions. **There is no "concussion-proof" helmet.**
- **Stair gates** – Use gates at the top and bottom of stairs to prevent serious falls in infants and toddlers.
- **Soft surfaces** – Use appropriate impact material in your playground area.

https://oklahoma.gov/health/health-education/injury-prevention-service/concussions.html

Dog Bite Safety

Each year, more than 4.5 million people in the U.S. are bitten by dogs. Children are the most common victims of dog bites and are far more likely to be severely injured. Most dog bites affecting young children occur during everyday activities and while interacting with familiar dogs.

Preventing dog bites

Almost 1 in 5 people bitten by dogs require medical attention. For children, the injuries are more likely to be serious. Parents and caregivers should be aware of some simple steps that can prevent dog bites:

- Never leave a small child and a dog alone together, no matter if it is the family dog, a dog that is known to you, or a dog that you have been assured is well behaved. Any dog can bite.
- Do not allow children to play aggressive games with a dog, such as tug-of-war or wrestling, as this can lead to bites.
- Teach children to ask a dog owner for permission before petting any dog.
- Show children how you let a dog sniff you before petting, and stay away from the face and tail. Pet the dog gently, and avoid eye contact, particularly at first.
- Never bother a dog that is sleeping, eating, or caring for puppies. Dogs in these situations are more likely to respond aggressively, even with a person who is familiar to them.
- Do not allow a child to run past a dog, because dogs may be tempted to pursue the child.
- Teach children that if a dog is behaving in a threatening manner—for example, growling and barking—to remain calm, avoid eye contact with the dog, and back away slowly until the dog loses interest and leaves.
- If you or your child is knocked over by a dog, curl up in a ball and protect the eyes, face, and neck with arms and fists.
  https://www.healthychildren.org

Emergency Preparedness

As a child care provider, it is important that you prepare for all types of emergencies in order to keep children safe. Your best protection is knowledge and preparation. In addition to fire and tornado drills and preparing for medical emergencies, it is necessary to ***develop an emergency plan*** for a wide range of emergency situations.

Your Emergency Plan should be in writing and include details about:

- How you will account for each child's location during and after an emergency.
- Relocation procedures for situations that require you to move everyone to an alternate location.
- Whether you will continue to take shelter until emergency crews arrive.
- What will happen after the emergency is over – how will children be reunited with their parents.
- How to handle situations caused by the emergency; such as damage to a structure.

It's important to be careful not to slip into a routine when conducting drills. Each drill should be taken seriously every time it is done. Providers should also think outside the box when preparing to conduct drills and developing their Emergency Plan because emergencies are never routine.

Conduct drills at different times of the day with all your staff members and prepare for "uncommon" emergencies like intruders or explosions not just the "more typical" fire and tornado emergency drills. For example, a situation threatening the safety of the children

and personnel, such as shootings, hostages, or intruders would require a lock down procedure. Take special consideration for children with special needs and infants. Staff may need extra preparation when helping these children during an emergency.

Conduct drills so that all staff members and children become familiar with the procedures.

Prepare an emergency supply kit that all staff know about and take it on your practice drills. Provide information about your ***Emergency Plan*** to families whose children attend your child care program. As always, review your licensing requirements for specific instructions on what is needed in your emergency plan and talk with your licensing worker if you have any questions.

Types of emergencies to cover in your Emergency Plan

- Serious illnesses or injuries.
- Poison exposure, including exposure to toxic substances.
- Outbreaks of communicable disease.
- Weather conditions, including tornados, blizzards, floods, and ice storms.
- Fires, including wildfires.
- Human threats such as active shooters, bomb threats, or hostage situations.
- Lost or abducted child.
- Natural disasters such as an earthquake.
- Potentially violent situations in the program, including individuals with threatening behaviors.
- Power failure or water failure.

Ways caregivers and children can plan for and practice procedures for Emergency Preparedness:

- Caregivers maintain current First Aid and CPR training.
- Children and caregivers practice drills and handling of all different types of emergencies.
- Children and caregivers know at least two exits from the rooms and the building.
- Caregivers have at least two evacuation location sites (one nearby, one farther away) and at least two ways to reach the alternate sites.
- Caregivers develop lockdown procedures and practice with the children.
- Discuss your plans, evacuations, locations, lockdowns, and drills with staff members, children, and families.

You can do all of these around the same time each year to ensure compliance with licensing requirements and keep your program safe and in order:

- Emergency equipment and first aid kits are regularly tested and restocked or replaced.
- Review Emergency Plans with everyone.
- Update families' emergency information.

Communicate your Emergency Plan:

- Share your Emergency Plan with families upon enrollment and at least yearly thereafter.
- Help families update their personal information like phone numbers and emergency contacts at least yearly.
- Train staff at least yearly on your Emergency Plan.
- Give copies of all changes or updates in your Emergency Plan to staff members and families.
- Share your Emergency Plan with local emergency responders such as the fire department.

Emergency Plans will vary for each program. It is important to have a plan that is specific for your child care facility that all staff members are aware of. Some available tools and resources for developing your Emergency Plan are listed below.

- Federal Emergency Management Agency (FEMA) http://www.ready.gov/
- Child Care Aware http://www.childcareaware.org

Fall Prevention

Young children are independent, curious, and like to climb. They should be supervised at all times and kept off high surfaces to prevent fall injuries. Falls in children are often due to the presence of external hazards, such as stairs, open windows, or playground equipment, and to children's inability to understand the risks and to their lack of fully developed motor skills and coordination.

Infants

- Never leave an infant alone on a counter, bed, table, couch, or other high place.
- Always keep at least one hand on the infant when changing diapers or dressing.
- Lower the crib mattress as the child grows. If the child is climbing out of the crib, consider if it is time to move to a toddler bed.
- Keep safety straps securely fastened when using a stroller, high chair, swing, carrier, or shopping cart.
- Keep play area clear of hard, sharp-edged objects and toys.
- **Get rid of your baby walkers** if you haven't already. Walkers are involved in more injuries than any other piece of baby equipment.
- Don't let other children hold or carry an infant unless closely supervised.

Young children

- Install safety gates at the top and bottom of stairs and keep stairs free of clutter.
- Use anti-slip mats and rugs.
- Install window guards - screens keep bugs out, not children in.
- Keep windows locked when closed.
- Keep doors to balconies and fire escapes locked.
- Place outdoor equipment in a safe location.

- Outdoor play equipment such as swings, slides and climbing toys should be placed on impact absorbing surfaces such as wood chips or chipped rubber.
- Anchor all outdoor play equipment not designed to be portable.
- Playground equipment should be in good repair and age appropriate.
- Watch children closely when they play on slides, swings, and climbing toys.
- Hold the child's hand while climbing stairs or riding escalators; teach the child to hold onto handrails to avoid falling.
- Bicycles should be in good repair and the correct size for the child.
- Never let children ride a bicycle without a helmet. If the child is riding on a bicycle with an adult, the child should be in a rear-mounted seat and wearing a helmet.
- A child with a disability needs more attention and supervision to avoid falls.

https://www.childrenssafetynetwork.org/child-safety-topics/falls

Fire Safety

Top Tips for Fire Safety:

- **Check smoke alarms.** Make sure there is a working smoke alarm on every level of your home, inside bedrooms and near sleeping areas. Test smoke alarms every month, replace batteries every six months, and replace smoke alarms every 10 years.
- **Create and practice a fire escape plan.** Create a fire escape plan with two ways out of every room. Choose a place to meet outside that is a safe distance away from your building.
- **Practice a fire drill monthly.** Practice a fire drill at different times of the day. Practice escaping in under two minutes. Sometimes that is all the time you will have to get out of the building safely.
- **If there is a fire, leave immediately.** If there is a lot of smoke, get low and crawl out as quickly as possible. Practice this in your drills with the children and staff. Call 911 after you are a safe distance away from the building.

https://safekids.org/fire

According to the CDC, fires and burns are the third leading cause of unintentional injury fatalities in the U.S.

Personal fire safety depends upon:

- Safe storage of matches, lighters, and gasoline.
- Not allowing smoking in the facility.
- Not leaving stoves, grills, or burning candles unattended.
- Performing proper maintenance on furnaces, fireplaces, and chimneys.
- Installing smoke detectors and changing batteries annually.
- Developing and practicing a fire evacuation plan.

https://childrenssafetynetwork.org

Frostbite/Hypothermia

Children are more at risk from the cold than adults. Because their bodies are smaller, they lose heat more quickly and if they're having fun, they may be less likely to come inside when they're getting cold.

Children exposed to extreme cold for too long and without warm, dry, breathable clothing can get frostbite or even life-threatening hypothermia.

Frostbite

Frostbite happens when the skin, and sometimes the tissue below it, freezes. Fingers, toes, ears, and noses are most likely to get frostbite. Frostbitten skin may start to hurt or feel like it's burning, then quickly go numb. It may turn white or pale gray and form blisters.

What to do:

- If you suspect frostbite, bring the child indoors to gently warm up. Don't rub the affected area, and don't pop any blisters.
- Avoid placing anything hot directly on the skin. Soak frostbitten areas of the body in warm (not hot) water for 20 to 30 minutes. Warm washcloths can be applied to frostbitten noses, ears and lips.
- After a few minutes, dry and cover the child with blankets. Give the child something warm to drink.
- If the pain or numbness continues for more than a few minutes, contact the child's parent and ask them to call their pediatrician.

Hypothermia

When the body's temperature drops below normal from the cold, dangerous hypothermia begins to set in. A child may start shivering, a sign the body is trying to warm itself up, but then become sluggish, clumsy, or slur his words.

What to do:

Hypothermia is a medical emergency, so call 911 right away.

- Until help arrives, bring the child indoors. Remove any wet clothing, which draws heat away from the body.
- Wrap the child in blankets or warm clothes, and provide something warm to drink. Be sure to cover core body areas like the chest and abdomen.
- If the child stops breathing or loses a pulse, give mouth-to-mouth resuscitation or CPR.

Safety Steps to Prevent Frostbite and Hypothermia

Check the wind chill

In general, playing outside in temperatures or wind chills below -15° Fahrenheit should be avoided. At these temperatures, exposed skin begins to freeze within minutes.

What to wear
Several thin layers will help keep kids warm and dry. Insulated boots, mittens or gloves, and a hat are essential. Make sure children change out of any wet clothes right away.

Take breaks
Set reasonable limits on the amount of time spent playing outside to prevent hypothermia and frostbite. Make sure kids have a place to go for regular indoor breaks to warm up.

Heatstroke Safety – Kids in Hot Cars

Kids in hot cars are a deadly combination. These deaths are preventable. Here are some tips to make sure it doesn't happen:

- **Never leave a child or children alone in an unattended vehicle**, even with the windows rolled down, or air conditioning on. Children's body temperature can heat up to 3 to 5 times faster than adults. A core temperature of 107 is lethal.
- **Be sure that all occupants leave the vehicle when unloading**. Don't overlook sleeping children.
- Make **"look before you leave"** a routine whenever you get out of the vehicle.
- **Always lock your car** and ensure children do not have access to keys or remote entry devices. Teach children that vehicles are never to be used as a play area.
- Heatstroke can occur in temperatures as low as 57 degrees. On an 80-degree day, temperatures inside a vehicle can reach deadly levels in just 10 minutes.

If dropping your child off is not part of your normal routine come up with some ways to remind yourself that your child is in the car:

- Place an item that you take with you, like a purse or briefcase (or your left shoe) in the back seat so you'll check the back seat before you leave the car.
- Write a note and place it on the dashboard of the car.
- Set a reminder on your cell phone or calendar. You can also download the Baby Reminder App for iPhones.
- Ask your child care provider to call you if your child doesn't show up.

If you see a child alone in a hot vehicle, call 911 or your local emergency number immediately!

Kids in hot cars are a deadly combination. Don't take the chance.
LOOK BEFORE YOU LOCK!

National Highway Traffic Safety Administration – www.nhtsa.gov/road-safety/child-safety
No Heat Stroke – www.noheatstroke.org
Safe Kids Worldwide – www.safekids.org/heatstroke

Infant Safe Sleep: Reduce the risk of sudden infant death syndrome (SIDS) and other sleep-related causes of infant death

SIDS is the sudden, unexpected death—that doesn't have a known cause even after a full investigation—of a baby between one month and one year of age. About half of the sudden, unexpected infant deaths that occur in the United States each year are from SIDS.

Other sleep-related causes of infant death are those related to how or where a baby sleeps or slept. These can include:

- Suffocation: when something, such as a pillow, or someone covers the baby's face and nose, blocking the ability to breathe.
- Entrapment: when the baby gets trapped between two objects, such as a mattress and a wall, and can't breathe.
- Strangulation: when something presses on or wraps around the baby's neck, blocking baby's airway.

There is no sure way to prevent SIDS, but parents and caregivers can take steps to reduce the risk of SIDS and other sleep-related causes of infant death:

- Always place baby on his or her back to sleep, for naps and at night. The back sleep position is the safest position for all babies until they are one year old. Preemies (infants born preterm) should be placed on their backs to sleep as soon as possible after birth.
- Use a firm, flat, non-inclined sleep surface such as a mattress in a safety-approved crib*, covered by a fitted sheet with no other bedding or soft items in the sleep area. Sleep surfaces with inclines of >10 degrees are unsafe for infant sleep.
- Never place baby to sleep on soft surfaces, such as on a couch, sofa, waterbed, pillow, quilt, sheepskin, or blanket. These surfaces can be very dangerous for babies.
- Do not use a car seat, stroller, swing, infant carrier, infant sling, or similar products as baby's regular sleep area. Following these recommendations reduces the risk of SIDS and death or injury from suffocation, entrapment, and strangulation.
- Never place a crib near a window with mini-blind or curtain cords, or near baby monitor cords; babies can strangle on cords.
- Do not put soft objects, toys, crib bumpers, or loose bedding under baby, over baby, or anywhere in baby's sleep area. Keeping these items out of baby's sleep area reduces the risk of SIDS and suffocation, entrapment, and strangulation. Crib bumpers are linked to serious injuries and deaths from suffocation, entrapment, and strangulation. Keeping these and other soft objects out of baby's sleep area is the best way to avoid these dangers.
- Do not let baby get too hot during sleep. Dress baby appropriately for the environment, and do not over-bundle. It is advised not to place hats on infants when indoors except in the first hours of life or in the NICU. Watch for signs of

overheating, such as sweating or the baby's chest feeling hot to the touch. Keep the baby's face and head uncovered during sleep.
- Weighted blankets, weighted sleepers, weighted swaddles, or other weighted objects should not be placed on or near the sleeping baby.
- Breastfeeding has many health benefits for mother and baby. Babies who breastfeed, or are fed breastmilk, are at lower risk for SIDS than babies who were never fed breastmilk. The longer a baby is exclusively breastfed or fed breastmilk, the lower the risk.
- Baby should be up-to-date on all immunizations.
- Baby should not be exposed to smoke or nicotine.

*A crib, bassinet, portable crib, or play yard that follows the safety standards of the Consumer Product Safety Commission (CPSC) is recommended. For information on crib safety, contact the CPSC at 1-800-638-2772 or http://www.cpsc.gov.

Give baby plenty of tummy time when he or she is awake and someone is watching. Supervised tummy time helps strengthen baby's neck, shoulder, and arm muscles. It also helps to prevent flat spots on the back of baby's head.

Promote infant safe sleep practices
- Develop a written policy on infant safe sleep to share with parents when they enroll their child in your program.
- Train all staff on infant safe sleep practices.
- Distribute infant safe sleep information to all staff and families.
- Display infant safe sleep posters.
- Tell everyone caring for babies about infant safe sleep practices.

In child care settings, swaddling is not necessary or recommended.
- There is evidence that swaddling can increase the risk of serious health outcomes, especially in certain situations.
- The risk of sudden infant death is increased if an infant is swaddled and the infant can roll over from back to stomach.
- Loose blankets around the head can be a risk factor for SIDS or suffocation.
- With excessive swaddling, infants may overheat.
- With swaddling, there is an increased risk of developmental dysplasia of the hip, a hip condition that can result in long-term disability. Hip dysplasia is felt to be more common with swaddling because infants' legs can be forcibly extended.

Visit the Safe to Sleep Public Action Campaign for more information on Infant Safe Sleep: http://www.nichd.nih.gov/sts/.

Motor Vehicle Safety

Car crashes are the second-leading cause of death for children under the age of one and the leading cause of death for kids and young adults from ages 1-24, according to

the National Safety Council. Children need special protection in vehicles to keep them safe in the event of a crash.

Safe Kids Worldwide recommends:

- All infants and toddlers should ride in a **rear-facing car seat** as long as possible, until they reach the highest weight or height allowed by their car seat manufacturer. Most convertible seats have limits that permit children to ride rear-facing for two or more years. As a child grows, you might have to switch from using a smaller **rear-facing-only car seat** to using a bigger **rear-facing convertible car seat** that can hold a larger child, first rear-facing then forward-facing. After you turn the seat forward, adjust the harness, make it more upright, and attach the top tether.

Why keep your child in a rear-facing seat for as long as possible? *When a child rides rear-facing, the head, neck, and spine are all supported by the hard shell of the car safety seat, allowing the car seat to absorb most of the crash forces, and protecting the most vulnerable parts of the body.*

- Children who have outgrown the rear-facing weight or height limit for their car seat should move to a **forward-facing car seat** with a 5-point harness and top tether. Use this seat for as long as possible, up to the highest weight or height allowed on the seat's label.
- It is safer to move from a forward-facing car seat to a belt-positioning booster seat only after the child reaches the weight or height limit of the seat you are using. A child in a forward-facing car seat with a harness and top tether is more protected than one in a booster seat with lap and shoulder belt or when using just a seat belt alone.
- After a child outgrows the weight or height limits of the forward-facing car seat, put the child in a **booster seat** used with the vehicle lap and shoulder seat belt.
- Keep the child in a booster seat until he or she is big enough to fit in a **seat belt** properly. For a seat belt to fit properly the lap belt should lie across the upper thighs and be snug across the shoulder and chest to restrain the child safely in a crash.

USING A SEAT BELT: ***a child is ready to ride with only a lap and shoulder seat belt when they are at least 8-years-old AND:***

- The shoulder belt should lie on the collar bone and across the middle of the chest.
- The lap belt should be snug and lie across the upper thighs/pelvic bones.
- The child should be able to sit with his/her back against the vehicle seat back with knees bent comfortably over the vehicle seat and feet on the floor.
- **Children under the age of 13 should ride in the back seat.**

Always refer to your vehicle owner's manual and child safety seat manual for correct installation instructions or **contact a Certified Child Passenger Safety Technician** for help learning how to correctly install a child's car seat. Go to the National Child

Passenger Safety Certification website at https://cert.safekids.org and click on “Find a Tech”.

Never leave a child alone in or around cars and lock your vehicle when it is not in use. Any of the following situations can happen when a child is left alone in or around a vehicle. A child can:

- Die of heatstroke because temperatures can reach deadly levels in minutes.
- Be strangled by power windows, retracting seat belts, sunroofs, or accessories.
- Knock the vehicle into gear, setting it into motion.
- Be backed over when the vehicle backs up.
- Become trapped in the trunk of the vehicle.

https://www.safekids.org/car-seat

Poison Prevention

Each year, approximately three million people – many under age five – swallow or have contact with a poisonous substance. Most poisonings occur when parents or caregivers are there, but not paying attention. **To help prevent poisonings**:

- Store medicine, cleaning and laundry products, in their original packaging in locked cabinets or containers out of sight and reach of children.
- Try to reduce the number of cleaning products used and substitute nontoxic products for poisonous ones when possible.
- Check all children’s art supplies to make sure they are nontoxic. The label should have a statement that the product complies with ASTM D4236 (a label created by the American Society for Testing and Materials), and the label has the seal of The Art and Creative Materials Institute.
- Some pet supplies are poisonous and must be stored as such – aquarium chemicals, flea sprays and pet medications.
- Move all dangerous items to a cabinet or closet a minimum of four feet above the floor, out of the reach of children, and install cabinet and drawer latches.
- Never refer to medicine as “candy” or another appealing name. Avoid taking medication in front of children.
- Liquid nicotine e-cigarette refills can be extremely dangerous, even fatal for a child. Keep all nicotine products, including traditional cigarettes, out of sight and reach of children.
- Be sure all purses and backpacks are inaccessible to children.
- Maintain working smoke and carbon monoxide detectors.
- Keep natural gas-powered appliances, furnaces, and coal, wood or kerosene stoves in safe working order.

What to do in case of poisoning

If you find a child with an open or empty container of a dangerous nonfood item, the child may have been poisoned.

1. Stay calm and act quickly.

2. Get the item away from the child. If there is still some in the child's mouth, make the child spit it out or remove it with your fingers. Keep this material along with anything else that might help determine what the child swallowed.
3. Do not make the child vomit because it may cause more damage.

If the child is unconscious, not breathing, or having convulsions or seizures, call 911 or your local emergency number right away.

If the child does not have these symptoms, **call Poison Help at 1-800-222-1222**. You may be asked for the following information:

- Your name and phone number.
- The child's name, age, and weight.
- Any medical conditions the child has.
- Any medicine the child is taking.
- The name of the item the child swallowed.
- The time the child swallowed the item (or when you found the child), and the amount you think was swallowed.

If the poison is very dangerous, or if the child is very young, you may be told to take the child to the nearest hospital. If the child is not in danger, the Poison Help staff will tell you what to do to help the child at home.
https://www.poison.org

Suffocation and Strangulation Prevention

- Never tie strings or ribbons to pacifiers or toys.
- Always remove bibs before naptime or bedtime.
- Plastic bags, including garbage and dry-cleaning bags, should be kept out of the reach of children.
- Keep balloons, including uninflated balloons, out of the reach of young children. Immediately pick up and dispose of pieces of broken balloons.
- Tie up or clip off blind and drapery cords; keep cribs and cots away from cords.
- Don’t hang anything with strings or ribbon over infant cribs.
- When feeding a child in a high chair, use the safety straps, including the crotch strap. This will prevent the child from slipping down, which could cause serious injury or even death.
- Avoid the use of hoods with drawstrings in the clothing of young children. The drawstrings could catch on something and strangle a child.
- Remove bike helmets when done riding bikes or riding toys.
- Never attach ropes, clotheslines, or pet leashes to playground equipment because children can strangle on them.

https://www.childrenssafetynetwork.org/child-safety-topics/choking-strangulation

Sun Safety

Prolonged exposure to sun, repeated sunburn, and even one severe sunburn may lead to skin cancer later in life. Sunscreen is just one of the defenses against the harmful effect of UV radiation. Other strategies such as seeking shade and dressing in sun-protective clothing are just as important. Remember that young skin is delicate, thinner, and produces less melanin, a skin protecting pigment.

- Keep babies younger than six months out of direct sunlight. Avoid using sunscreen on young babies because the chemicals may be too strong for their skin.
- For children over six months of age apply a broad-spectrum sunscreen with an SPF of 30 or higher. Broad-spectrum sunscreen provides protection from both UVA and UVB rays.
- Apply enough sunscreen to cover all skin not covered by clothing. Don't forget the tops of ears, the neck, the head if there is a part in the hair, and the tops of feet for those wearing sandals.
- Apply 15-30 minutes before going outside.
- Reapply sunscreen every 30 minutes, even on cloudy days.
- Wear lightweight, loose-fitting clothing in the sun.
- In the hottest part of the summer, children should do most of their outdoor play before 10 a.m. and after 3 p.m.
- All outdoor playgrounds should have shaded areas.
- Receive parents' written permission to apply sunscreen to their children. (This can be done using the same permission form for medication).
- Use extra caution near water, snow, and sand, as they reflect the damaging rays of the sun, which can increase the chance of sunburn.

Remember – we all need some sunlight to stay healthy. Sun exposure helps our skin produce vitamin D, which helps us absorb calcium for healthy bones. The amount of time in sunlight needed to produce enough Vitamin D is only 10 to 15 minutes per day a few times a week, depending on skin tone.

https://www.skincancer.org
https://www.naeyc.org/our-work/families/tips-sun-safety

TV and Furniture Tip-Over Prevention

When you think about keeping children safe, you may not consider the possibility of furniture or TVs tipping over on them. Unfortunately, tip-over incidents happen more than many of us realize. They can cause serious injury and even death. In fact, a child is rushed to the emergency department at least once every single hour of every single day with injuries from a furniture or TV tip-over.

How to prevent tip-overs:

- **Secure TVs**. Mount flat-panel TVs to the wall. Place older, box-style TVs (CRTs) on low, stable furniture that can hold the weight.
- **Attach furniture to the wall**. Use anti-tip brackets, braces or wall straps to secure furniture to the wall. Install stops on dresser drawers to keep them from being pulled all the way out.
- **Rearrange items on the shelves or in the drawers.** Store heavy objects on lower shelves or in lower drawers. Avoid placing remote controls, toys or other items in places where kids might be tempted to climb up or reach for them.
- **Recycle old TVs.** To find a location that safely and easily recycles unwanted TVs, go to www.GreenerGadgets.org.

Go to www.anchorit.gov to find details on how to make furniture and TVs secure. You can also find the Safe Kids Furniture and TV Tip-Over Prevention Tips at www.safekids.org.

Water Safety

Children less than five years of age have the highest rate of drowning and near drowning of all age groups. **Children can drown in just a few seconds**. It's quick and it's silent.

- Always stay close and watch children when they are in or near water. Be sure there are adequate personnel during water play and when taking the children swimming.
- Constantly supervise children involved in water play or in a bathtub.
- No standing water! Check for standing water on the playground after a rain.
- Keep toilet lids down and empty buckets and containers immediately after use.
- Never take a child swimming if his/her parents have not given written consent.
- Never take children to a pool that does not have trained lifeguards on duty.
- Swimming pools should have a fence on all sides that is at least four feet high, non-climbable, and has a self-latching, self-closing gate.

https://www.safekids.org/watersafety

Weapons and Ammunition Safety

Accidental gunshot deaths by children handling a gun jumped 31% during the start of the COVID-19 pandemic compared to a year earlier, new data from the advocacy group *Everytown for Gun Safety* shows.

Everytown has been tracking unintentional shootings by kids for over six years. Their most recent report sheds light on commonalities of each of the reported cases of children playing with a gun, or grabbing the weapon, and shooting themselves or others:

- 91% of the victims in unintentional shootings by children were also under 18.
- More than one in every four of these shootings are by kids age five and younger.
- One in every four of the victims are also five and younger.
- Boys make up a majority of the shooters and the victims. About 83% of the child shooters are young boys.
- The most likely age group to be both shooters and victims are teenagers ages 14 to 17, followed by preschool aged children.

Myths about Guns *from Nationwide Children's Hospital:*

- Some parents believe that hiding their guns will prevent children from accessing them. However, 75% of children who live in homes with guns know where they are stored.
- Many parents think their children are not capable of firing a gun. However, **children as young as three years old may be strong enough to pull the trigger** of a handgun.
- Parents believe their children know the difference between real guns and toy guns, but in 16% of unintentional firearm deaths among children younger than 13 years of age, the gun was mistaken for a toy.
- Parents often believe their child would not touch a gun because "he knows better." However, studies have found that most children will handle a gun if they find one, even if they have been taught not to.
- Some parents consider non-powder guns, like BB, pellet, and paintball guns, to be toys. These guns, which can fire at the speed of traditional guns, lead to nearly 22,000 injuries each year, especially eye injuries.

Keep all weapons and ammunition, such as firearms, cap pistols, bows and arrows, and hunting knives, in an inaccessible area. In addition:

- Weapons are kept unloaded in locked containers or cabinets.
- Ammunition is kept in locked containers or cabinets, separate from weapons.
- Keys, combinations, and codes used for locked storage are inaccessible.
- Parents are informed of weapons upon enrollment.

https://www.safekids.org/tip/gun-safety-tips

Chapter 5: Managing Childhood Illnesses & Infestations

Daily Health Check

Conduct health checks daily in a relaxed and comfortable manner as each child enters the program and before the parent has left the building. The health check is a way to identify possible concerns about a child's health including recent illness or injury. **If a possible communicable disease is discovered during the Daily Health Check, the parent may be asked to take the child home.** Also do a health check whenever you notice a change in a child's behavior or appearance during the day.

Upon arrival each family will be greeted by a staff member who will spend a few minutes with the parent and child while **conducting a daily health check**. The caregiver should be at the child's level.

Here is a list of possible ***visual signs*** and symptoms to check:
____ Face and head (cuts, bruises, sore spots)

____ Eyes, ears, nose (redness, discharge, swelling, pain)

____ Hair (clean; check for lice or ringworm)

____ Arms and legs (cuts, bruises, burns, sores or wounds, pain)

____ Hands (sores, wounds, burns, unusual scars)

____ Feet (limping, pain, wounds, burns)

____ Skin (rashes, irritation, insect bites)

____ General appearance (body, hair and clothing clean; energy level)

____ Obvious signs of illness (droopy appearance; listless; upset stomach)

____ "Hidden" areas (check for obvious signs of physical or sexual abuse during first bathroom break - bruising, pain during urination or bowel movement, bleeding)

____ Other _____

The tactile (***touch***) health check involves gently rubbing your hand on the child's back, shoulder, or head as you greet him or her.
____ General feeling of warmth, indicating possible fever
____ Possible bruising or soreness; the child may flinch or pull away from your touch
***Smell* for unusual odors**: Is the child's breath fruity or does it smell bad? Do you notice any other foul smells?

Verbal communication as you greet each child may provide clues to possible illness or injury. Talk to child and ask questions such as:

- How are you today? Did you get a good night's sleep?
- If an injury or apparent sore is observed, ask the child "How did you get hurt?"

Also communicate with the parent:

- Did child sleep normally? _____
- Is child eating and drinking normally? _____
- When was the last time child ate or drank? _____
- How did child seem to feel and act at home? _____
- Have bowel movements and urine been normal? _____
- When was the last time child used the toilet or had diaper changed? _____

Note (in writing) any evidence of illness or injury since child was last in care. Discuss any concerns with parent and keep a written record of observation, date and time, and the discussion.

Infection Control

Communicable or infectious diseases are infections transmitted from an infected person, animal or reservoir to another person. These infections can be spread from direct or indirect contact. Knowing how infectious diseases are spread can help minimize the risk of infection.

Common methods of spreading diseases:

- Droplets from the nose and mouth
- Fecal-oral transmission
- Direct contact
- Indirect contact

Adopting healthy behaviors can reduce illness. There are simple things you can do to prevent illness.

1. **Wash your hands often!** Hand washing is the most important way to reduce the spread of infection. All staff, volunteers, and children should wash hands at the following times:
   a. **Upon arrival** for the day, after breaks, or when moving from one child care group to another.
   b. **Before and after**:
      - Preparing food or beverages
      - Eating, handling food, or feeding children
      - Giving medications or applying a medical ointment or cream
      - Playing in water that is used by more than one person
      - Diapering
   c. **After**:
      - Using the toilet or helping a child use a toilet
      - Handling bodily fluid (mucus, blood, vomit), from sneezing, wiping and blowing noses, from mouths, or from sores
      - Handling animals and cleaning up animal waste
      - Playing in sand, on wooden play sets, and outdoors
      - Cleaning and handling the garbage

2. **Routinely clean, sanitize, and disinfect surfaces**.
   Programs should follow a routine schedule of cleaning, sanitizing, and disinfecting. Cleaning, sanitizing, and disinfecting products should not be used in close proximity to children, and adequate ventilation is needed during use.

   We sometimes use these terms interchangeably, but they are not the same. Here is how the United States Environmental Protection Agency (EPA) defines them:

   To clean means to physically remove dirt and debris from the surface by scrubbing, washing, wiping, and rinsing. This can be done with water and a mild soap or detergent.

To sanitize means to apply a product that reduces germs to safer levels. Sanitizing surfaces destroys enough germs to reduce the risk of becoming ill from contact with those surfaces. Sanitizing is recommended for food surfaces (dishes, utensils, cutting boards, high chair trays) and other objects intended for the mouth like pacifiers and teething toys.

To disinfect means to apply a product that destroys nearly all germs when applied to hard, nonporous surfaces. Disinfecting is a higher level of germ killing and is recommended for hard nonporous surfaces such as toilets, changing tables, and other bathroom surfaces; blood spills and other potentially infectious body fluids like vomit, urine and feces.

3. **Keep immunizations up to date.**
   Keep records of all immunizations for the children and the staff and be current on vaccinations.

4. **Keep pets healthy**.
   All pets should be routinely cared for by a veterinarian.

5. **Handle and prepare food safely**.
   - Plan carefully when purchasing your food. Buy perishable foods, such as dairy products or fresh meat, at the end of your shopping trip. Refrigerate as soon as possible.
   - Store food properly. Don't allow juices from meat, seafood, poultry, or eggs, to drip on other foods. Use containers to keep these products from contaminating other foods. Don't leave perishable food out for more than two hours.
   - Use care when preparing and cooking food. Wash your hands and clean and disinfect all kitchen surfaces and utensils before, during, and after handling, cooking, and serving food. Wash raw fruits and vegetables. Avoid eating raw eggs or partially cooked eggs. Cook all poultry and meat until the juices run clear. Use different **cutting boards**, dishes and utensils for raw foods and cooked foods. Keep cold foods cold and hot foods hot.
   - Store leftovers properly. Avoid leaving leftovers out for more than two hours. Promptly refrigerate or freeze perishable items.

Recommendations for Exclusion

Preparing for managing illness

Caregivers should:

- Encourage all families to have a backup plan for child care in the event of short- or long-term exclusion.
- Develop procedures for handling children's illnesses, including care plans and inclusion and exclusion policies.
- Review the inclusion and exclusion policies with families before enrollment. Clarify that program staff (not families), will make the final decision about whether children who are ill may stay based on the program's inclusion and exclusion criteria and their ability to care for the child without compromising the care of the other children.
- Rely on the family's description of the child's behavior to determine whether the child is well enough to return, unless the child's status is unclear from the family's report.
- Request a health care provider's note to re-admit a child if needed to determine whether the child is a health risk to others, or if the health care provider's guidance is needed about any special care the child requires.

Key criteria for exclusion of children who are ill:

When a child becomes ill but does not require immediate medical help, a determination must be made regarding whether the child can remain in care, or should be sent home and temporarily "excluded" from child care. Most illnesses do not require exclusion. The caregiver should determine if the illness:

- Prevents the child from participating comfortably in activities.
- Results in a need for care that is greater than the staff can provide without compromising the health and safety of other children.
- Poses a risk of spread of harmful diseases to others.

If any of the above criteria are met, the child should be excluded.

The child should be removed from direct contact with other children and should be cared for in an area where the toys, equipment, and surfaces will not be used by other children until after the ill child leaves and after the surfaces and toys have been cleaned and disinfected. The child will be cared for by a staff member known to the child until the parent arrives to take the child home.

Conditions that require exclusion include:

- When the child appears to be severely ill, is not responsive, irritable, persistently crying, having difficulty breathing, or having a quickly spreading rash.
- Fever (temperature above 101°F [38.3°C] by any method) and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, or diarrhea). For infants less than two months of age, an unexplained fever should be evaluated by a health professional. For these infants younger than two months of age, get

urgent medical advice for temperature above 100.4°F [38.0°C], whether or not other symptoms are present.

- Diarrhea exclusion is required for all diapered children whose stool is not contained in the diaper and toilet-trained children if the diarrhea is causing "accidents," and for children whose stool frequency exceeds two stools above normal per 24-hours for that child while the child is in the program or whose stool contains more than a drop of blood or mucus. Diarrhea is defined by stool which is occurring more frequently and/or is less formed in consistency than usual in the child, and not associated with changes of diet.
- Vomiting two or more times in the previous 24 hours, unless the vomiting is determined to be caused by a non-communicable/non-infectious condition and the child is not in danger of dehydration.
- Abdominal pain that continues for more than two hours or intermittent abdominal pain associated with fever or other signs or symptoms.
- Mouth sores with drooling that the child cannot control unless the child's primary health care provider or local health department authority states that the child is noninfectious.
- Rash with fever or behavioral changes, until a primary care provider has determined that the illness is not a communicable disease.
- Skin sores that are weeping fluid and are on an exposed body surface that cannot be covered with a waterproof dressing.

Other conditions with specific diagnoses, as follows:

- Streptococcal pharyngitis (i.e., strep throat or other streptococcal infection), until the child has had two doses of a course of an appropriate antibiotic 12 hours apart.
- Head lice, scabies, ringworm until after the first treatment (Exclusion is not necessary before the end of the program day.) Treatment may occur between the end of the program day and beginning of the next day—not requiring any exclusion.
- Chickenpox (varicella) until all lesions have dried or crusted (usually six days after onset of rash) and no new lesions have showed for at least 24 hours.
- Rubella, until seven days after the rash appears.
- Pertussis, until five days of appropriate antibiotic treatment (21 days if untreated).
- Mumps, until five days after onset of parotid gland swelling.
- Measles, until four days after onset of rash.
- Hepatitis A virus infection, until one week after onset of illness or jaundice or as directed by the health department. **Note**: Protection of the others in the group should be checked to be sure everyone who was exposed has received the vaccine or receives the vaccine immediately.
- Any child determined by the local health department to be contributing to the transmission of illness during an outbreak.

When Children Get Sick While in Care

Young children enrolled in child care have a high incidence of illness such as upper respiratory tract infections, including ear infections and other temporary conditions such as rash, diarrhea and asthma that may not allow them to participate in the usual activities. Most child care settings will need to provide at least temporary care for ill children. If a child becomes ill during the day after the daily health check, providers can help manage the illness and keep the child comfortable until a designated adult arrives.

1. Monitor children for:
    a. Participation in activities.
    b. Need for additional care.
2. If participation decreases or need for care increases, then check for other symptoms.
3. If other symptoms are present:
    a. Make a decision about exclusion.
    b. Notify parent or designated family member.
    c. Care for the child until parent or family member arrives.

Basic issues for decision making:

- Set policies and know when to be flexible.
- Prepare families for inevitable illnesses ahead of time.
- Review the inclusion and exclusion criteria in the program's written policies with families upon enrollment.
    1. Make clear to family members that designated program staff members (not families) make the decision about whether children who are ill may stay.
    2. Such decisions are based on inclusion and exclusion criteria and the staff member's ability to care for the child who is ill without compromising the care of other children in the program.
- Develop procedures for handling children's illnesses, including care plans.
- Only ask for a health care provider's note to re-admit a child if the health care provider's advice is needed to determine whether the child is a health risk to others or to provide information about special care the child requires.

When you consider whether to keep a mildly ill child at your child care setting ask these questions:

- Do you have sufficient staff to change the program for a child who needs some modifications such as quiet activities, staying inside or extra liquids?
- Are staff willing and able to care for a sick child (wiping a runny nose, checking a fever, providing extra loving care) without neglecting the care of other children in the group?
- Is there a small space where the mildly ill child can rest if needed?
- Are parents able or willing to pay extra for sick care if other resources are not available, so that you can hire extra staff as needed?
- Have parents made arrangements prior to illness for pick up and care of ill children if they are not available?

Medication Administration

Administration and Storage of Medication in Child Care

If you care for children, it is likely that you will care for a child with an acute or chronic health condition that requires giving medication. It is important to develop plans to assure that medications are given safely and stored correctly, and to seek advice when needed. All staff who work with children should have training on medication storage and administration practices.

Medication should be given at home whenever possible, but there will be times when it must be given to the child while attending the child care program. Guidelines for each child care provider in Oklahoma must reflect current state regulations. Medications are given in child care to:

a. Maintain the health of the child.
b. Allow a child who is not acutely ill to attend the program.
c. Comply with state and national laws, regulations, and best practice.

There are **three categories** of medications given to children in the child care setting:

Typical and routine medications	**Medications for regular treatment of a chronic health condition**	**Emergency medications**
Acetaminophen Ibuprofen Antibiotics	Asthma inhalers Insulin for children diagnosed with diabetes Medication for children diagnosed with seizures	Epinephrine auto injector for management of life-threatening allergies Glucagon for management of severe low blood sugar Diastat for management of severe seizure

There are **three basic types** of medication:

Prescription	**Over the counter**	**Non-traditional (alternative medicines)**
Can only be prescribed by a health care provider such a M.D., D.O. Nurse Practitioner or Physician Assistant Is dispensed by a licensed pharmacist	Can be purchased without a prescription and includes vitamins, acetaminophen, antihistamines, mild cortisone cream, or ibuprofen Many do not have dosing information for children under the age of 24 months	Herbal (made from plants or plant parts) Homeopathic (made from plants, minerals, or animals) These are purchased as over the counter medications without specific written orders from a health care provider.

All medications must be given according to the prescription or product label directions. Permission and instructions must be provided by the parent for each medication. Instructions should not conflict with the label directions and should be filed in the child's record.

The child care provider must have a plan in place to record administration of medication and to inform the parent of daily medication administration. When the medication is no longer needed, all remaining medication is returned to the parent.

Resources

Caring for our Children 3.6.3.1. Medication Administration
https://nrckids.org/CFOC/Database/3.6.3

Key points for medication administration

- **ALWAYS WASH YOUR HANDS BEFORE ADMINISTERING ANY TYPE OF MEDICATION!**
- Medication must be provided by the parent in the original container and clearly labeled with the child's name and directions.
- Medication is accompanied with written dated permission from the parent, giving the exact dosage and times to be administered.

It is helpful to assign one person to give all medications to avoid omissions and duplications. The person who administers the medication should record the time given, initial or sign, and have the form readily accessible to parents.

- Make sure all medication brought to the child care facility has a label with the child's name, the date, and the name of the medication.
- Medication should only be administered to the child for whom it is intended.
- All medications are stored separately from food and kept in a safe place out of children's reach.
- Medication is either returned to the parent or disposed of properly when it is out-of-date or the child has withdrawn from the facility.

Safeguards to prevent errors

- Assign a staff member to administer medications at the right time.
- If a medication is crucial and was left at home, ask the parent to return home and get medication before the child is admitted for the day.
- Establish a system to ensure that medications are returned each day for the family to use at home. (Some pharmacies will divide the prescription into two containers – one for home and one for child care or school.)
- Develop a system to alert staff members that a child has medication.
- Use measuring devices such as medicine caps or oral syringes for liquid medications, rather than household utensils.
- If a medication error is made, notify the parent immediately and consider seeking advice from the child's pharmacist or health care provider. Also fill out a *Medication Incident Report*.

The Seven Rights of Medication Administration:

1. **Right child** – check the name on the medication label to be sure the name on the label is the name of the child receiving the medication.
2. **Right medication** – read the label when receiving the medication and read it again when measuring out the medication for the child.
3. **Right dose** – read instructions for amount of dosage, and measure with an accurate measuring device.
4. **Right route (*mouth, nose, ears, airway, etc.*)** – read label and instructions to verify the route. For example; ointments and drops can go in the nose, ears, or eyes.
5. **Right time** – read instructions for time of administration of medication. Check with parent to see when the last dose was given to be sure when the next dose is due.
6. **Right to refuse –** if the child will not take the medication do not force the issue, but document the event and notify the child's parents.
7. **Right documentation –** verify the parent has filled out and signed a medication administration form and develop a form to document the date and time medication is administered, and the initials of the staff person administering the medication.

Always check:

- **Parental Permission** - must be in writing and filed in child's record.
- **Medication Label** – must have the child's name, dosing instructions, special instructions.
- **Parent Notification** – use standard form to notify parents of medication given.
- **Allergies and Reactions** – check before giving medication if the child has allergies and watch for reactions afterward.

Remember that when you administer medication, you are accepting responsibility for knowing the appropriate actions to take if a major adverse reaction occurs. It is a good policy to require parents to administer the first dose of a new medication at home so they will be aware of the child's reaction.

Contact the child's parent if:

- The child vomits the medicine.
- You are unable to get the child to take the medicine, or are unable to administer the medication.

The parent will probably need to contact the child's health care provider.

All medication incidents (e.g., child refusal, spilled medicine, partial dosage due to spitting up, or spillage) must be recorded and reported to the parent, who may, in turn, decide to inform a health care professional.

Bedbugs

What are bedbugs?

Bedbugs are small, oval-shaped, wingless, brownish, flattened insects that feed on human blood by biting through the skin. They get their name because they like to live and feed in beds, mainly at night.

What are signs or symptoms?

- Itchy insect bites that often occur in a row, on areas of skin that are exposed during the nights.
- Bites often have a red dot where the bite occurred in the middle of a raised red bump.
- Bites typically occur on face, neck, arms, and hands.
- Look for specks of blood, rusty spots from crushed bugs, or dung spots the size of a pen point on bedsheets and mattresses.
- Look for reddish/brown live bugs, about 1/8 of an inch, in crevices or seems of bedding.

Are they contagious – how are they spread?

- Bedbugs do not reproduce on humans like scabies or lice. They bite humans at night, and hide in cracks or crevices on mattresses, cushions, or bed frames during the day.
- Children or staff may bring bedbugs to school in book bags, backpacks and clothing.
- Bedbugs do not spread on people – they are not a sign that people are dirty. They feed on people and may hide in their belongings or clothing and that is a way they may spread to others in a group care setting.

How do you control them in a group setting?

- Avoid overreacting. One bedbug is not an infestation. It is not necessary to send a child home.
- Educate staff members and families about bedbugs.
- Reduce clutter and limit items that travel back and forth between homes and the facility.
- Seal cracks. Clean up any bedbug debris with detergent and water.
- Provide enough space between coat hooks so each child's belongings do not touch those of another child.
- Empty and clean cubbies, lockers, and child storage areas at least once every season.
- Extermination involves vacuuming and one of the following approaches:
  - Application of the least toxic products (preferably bio-based).
  - Heat the living area to 122 degrees for about 90 minutes.
  - Freeze infested articles, or (if necessary) use synthetic chemical insecticides.
- Launder bedding and clothing (hot water and hot drying cycle for 30 – 60 minutes).

- Vacuum with special attention to cracks and crevices in furniture, equipment, walls, and floors. Dispose of the vacuum cleaner filter and bags in a tightly sealed plastic bag.

Campylobacter

What is it?
Campylobacter infection is a contagious disease caused by bacteria. The intestinal infection usually causes diarrhea.

What are the signs or symptoms?
- Major symptom is diarrhea
- Stomach cramps
- Fever
- Nausea and vomiting
- Generally, “not feeling well”

The bacteria can be identified through submitting a stool (poop) sample to the CHD or hospital.

How long does it take from exposure to development of Campylobacter?
Symptoms usually start two to five days after infection.

When is it contagious?
Campylobacter infections should be considered contagious from a few days to several weeks, after being infected.

How is it spread?
Eating food or drinking water, contaminated by the feces (poop) of infected people or animals spreads the bacteria. Hand washing before and after food preparation limits this kind of spread.

What should be done?
- Isolate the child if there is diarrhea with illness, fever, or vomiting, or if the stool is not contained in the diaper or is causing toileting accidents.
- Notify the parents to pick up the child.

When can the child be re-admitted?
The child can be re-admitted upon approval from health care provider or the local health department.

What can be done to prevent the spread of Campylobacter?
- Wash hands properly with soap, after each diaper change and bathroom use.
- Clean all diaper changing surfaces with soap and water, then disinfect with an EPA registered disinfectant, such as a bleach solution.
- Teach children to wash hands.
- Carefully wash hands before and after preparing foods and always refrigerate meat products.

Who should be notified?
Notify the local health department. They will provide you with further information.

Chickenpox (Varicella)

What is it?
Chickenpox is a contagious disease caused by the Varicella-Zoster virus.

What are the signs or symptoms?
The four stages of the rash are:

- A red bump.
- A clear blister appears on top of the bump.
- The clear blister becomes a pustule (its content becomes gray).
- The pustule dries into a crust.

They appear in crops, over a period of up to four days. Several stages may happen at the same time. The child may have bumps, blisters, and pustules up to four days. They may leave permanent scars, especially if the blisters get infected by bacteria. Fever can be anywhere from none to very high and may start a few days before the rash.

How long does it take, from exposure to development of the disease?
Two to three weeks.

When is it contagious?
From five days before the rash appears until six days after the appearance of the first blisters, OR until the spots are all dried and crusted, whichever is longer.

How is it spread?
The virus is spread by droplets from the nose, mouth or throat, usually from a cough or sneeze. It can also be spread by direct contact, such as eating, drinking, or sharing personal items, or from the fluid from the blisters of an infected child (respiratory and direct contact spread). The scabs are *not* contagious.

What should be done?

- Isolate the child from the other children.
- Notify the parents to pick up the child.
- Wash articles soiled by discharge from the nose, throat, and blisters.
- Watch closely for early symptoms in others for up to three weeks.

When can the child return?
The child can be re-admitted six days after the appearance of the first crop of blisters, or when all blisters are scabbed over and dry.

What can be done to prevent the spread of Chickenpox?

- Make sure all children have received the Varicella vaccine:
  - First dose at age 12 through 15 months
  - Second dose at age 4 through 6 years
- Anyone coughing or sneezing should cover his or her nose and mouth.
- Do not allow eating or drinking after others.
- Careful hand washing may help prevent the spread.

Common Cold (Upper Respiratory Infections)

What is it?
The common cold is a mild infection of the upper respiratory tract (nose, throat, ears, and eyes) which is caused by over 100 different types of viruses. The most common of these is the rhinovirus (nose virus).

What are the signs or symptoms?
Runny or stuffy nose, sneezing, coughing, watery eyes, mild sore throat, and sometimes chills and fever.

How long does it take from exposure to development of a cold?
Between 12 and 72 hours.

When is it contagious?
For about two days before symptoms begin and during the first five days of illness.

How is it spread?
Colds are spread by coughing and sneezing and by contact with contaminated hands, tissues, and other items that come in contact with nose and throat droplets (respiratory and direct contact spread).

What should be done?
- No specific treatment is available. Nothing can shorten the duration of a cold.
- Ibuprofen or Acetaminophen-containing medications should be used only if the child has a fever, sore throat, or muscle aches, and you have written parental permission.
- Do not give Aspirin. Aspirin appears to increase the risk of Reye's syndrome; a serious disorder characterized by sleepiness and vomiting that can lead to coma and death.

Should people with this illness be excluded?
There is no need to exclude these children and staff if they feel well enough to attend and do not require more care and attention than the program can provide.

What should be done to prevent the spread of the common cold?
- Make sure all children and staff use good hand washing practices.
- Wipe noses with clean tissues, dispose of them properly and wash your hands.
- Don't share food, cups, bottles, or toothbrushes.
- Don't kiss children on the mouth.
- Teach children to cough into their elbow and away from people.
- Open windows and maximize outdoor play.
- Keep the environment clean.
- Limit physical contact between young infants and infected children.

Who should be notified?
Because the common cold is very common and is not considered dangerous, it is not necessary to notify all parents of every exposure.

Conjunctivitis (Pink Eye)

What is it?
Conjunctivitis or pink eye is a common, mild eye infection or irritation. It can be caused by germs (infectious conjunctivitis) and often occurs with a cold or ear infection. Allergies, chemicals or irritants can also cause it.

What are the signs or symptoms?
- It involves one or both eyes and usually lasts three to five days.
- The white parts of the eyes become pink, and the eyes produce lots of tears and discharge.
- Eyes can be itchy, sore, and sensitive to light.
- In the morning the discharge may make the eyelids stick together. Bacteria usually cause thick yellow or green pus.

How long from exposure until the disease develops?
One to three days.

When is it contagious?
As long as discharge is present, the child should be considered contagious.

How is it spread?
It is spread by direct contact. Children often pass the infection by rubbing their eyes then touching someone or something. Conjunctivitis can also be spread when staff wash, dry, or wipe a child's face and then use the same washcloth on another child's face.

Exclude from group setting?
No, unless:
- The child meets other exclusion criteria, such as fever or behavior change.
- The child is unable to participate, and the caregiver cannot care for the child without compromising the health and safety of the other children.

What should be done?
- Notify parents if child develops a fever and is unwilling to participate in activities. Encourage a visit to the child's health care provider.
- Practice frequent hand washing, especially when wiping a child's face or eyes.
- If the disease is determined to be bacterial in origin, the other parents should be notified that pink eye has occurred and encourage them to watch closely for signs of the illness in their children.

When can the child be re-admitted?
- When exclusion criteria are resolved, and the child can participate in activities.
- For bacterial conjunctivitis – 24 hours after antibiotic treatment has begun.

What can be done to prevent the spread of pink eye?

- Encourage the child not to rub his or her eyes.
- Keep children's eyes wiped free of discharge and always wash your hands after wiping a child's eyes.
- Use disposable tissues and towels.
- Teach children to wash their hands after wiping their eyes.

Coronavirus Disease (COVID-19)

What is it?
Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus.

How is it spread?
The virus can spread from an infected person's mouth or nose in small liquid particles when they cough, sneeze, speak, sing or breathe. These particles range from larger respiratory droplets to smaller aerosols.

> Due to new variants of this virus developing continually, and immunizations and booster shot guidelines changing, we recommend finding the most up-to-date information at the Centers for Disease Control and Prevention (CDC): https://cdc.gov/coronavirus/2019-nCoV/index.html or the Oklahoma State Department of Health at https://oklahoma.gov/covid19.html.

Cradle Cap (Seborrhea)

What is it?

- Cradle Cap is an oily, yellow scaling or crusting on the scalp.
- It is common in babies and is easily treated.
- It most often affects the scalp, but can also occur on the forehead, eyebrows, and the creases behind the ears.
- Cradle cap is not part of any illness and does not imply that a baby is not well cared for.

What causes cradle cap?
Cradle cap is the normal buildup of sticky skin oils, scales, and old skin cells.

How is cradle cap treated?
Home treatment is usually all that is needed.

- An hour before shampooing, rub baby's scalp with baby oil, mineral oil, or petroleum jelly to help lift the crusts and loosen scales.

- When ready to shampoo, first wet the scalp, and then gently scrub the scalp with a soft-bristle brush (a soft toothbrush works well) for a few minutes to remove the scales. You can also try gently removing the scales with a fine-tooth comb.

Then wash the scalp with baby shampoo, rinse well, and gently towel dry.

When is it time to contact a health care provider?
If the above measures do not work, talk to a health professional before using a dandruff shampoo, such as *Selsun Blue*, *Head and Shoulders*, or *Sebulex*. If these products get in your baby's eyes, they can cause irritation. The health care provider may prescribe other medications.

Cradle cap is not harmful to baby and usually goes away by baby's first birthday.

Cryptosporidiosis

What is it?
Cryptosporidia is a parasite that lives in the intestinal tract of humans and animals and is passed through stool (poop) and causes the diarrheal illness cryptosporidiosis. Cryptosporidiosis is one of the most common diseases spread through drinking or recreational water.

What are the signs or symptoms?
The major symptom of cryptosporidiosis is diarrhea. Other symptoms can include:

- Stomach cramps and loss of appetite
- Fever and fatigue
- Nausea and vomiting (less common)

Symptoms usually last about two weeks and may appear in cycles in which a person may seem to get better for a few days, then feel worse, before the illness ends. Some people infected with Cryptosporidium have no symptoms of illness but can infect others.

How long does it take from exposure to development of the disease?
The incubation period of cryptosporidiosis is not known exactly. One to 12 days is most likely with an average of seven days.

When is it contagious?
Cryptosporidium is passed through the feces (poop) of a sick person at the start of symptoms and can continue to be shed in the feces for several weeks after symptoms stop. Outside the body, the parasite can live for two to six months in a moist environment.

How is it spread?
Cryptosporidiosis is passed in the feces (poop). People can be infected with Cryptosporidium by eating food, drinking water, or placing objects in their mouth that have been contaminated with feces from an infected person or animal. It can also be spread through recreational water such as swimming pools, hot tubs, fountains, lakes, rivers, springs or streams that have been contaminated with sewage or feces.

What should be done?
- Isolate the child from the other children.
- Notify the parents to pick up the child.
- Wash articles soiled by discharge from the nose, throat, and blisters.
- Watch closely for early symptoms in others for up to three weeks.

Should an infected person be excluded from school or work?
If a person is employed as a food handler, works in a child care program, or has direct contact with ill persons or the elderly, they should not work until 24 hours after the diarrhea has stopped. Children with diarrhea should not attend child care or school until 24 hours after diarrhea has stopped.

What can be done to prevent the spread of cryptosporidiosis?

- Wash hands with soap and water after every diaper change, even if wearing gloves.
- Keep diaper-changing areas separate from children's play areas.
- Refrain from using swimming pools, water tables and other water-based activities while the outbreak is ongoing. If you have cryptosporiosis, wait two weeks after diarrhea has stopped to go swimming.
- Avoid swallowing recreational water and drinking water from shallow wells, lakes, rivers, ponds, and streams.
- Avoid food that might be contaminated by washing in contaminated water.
- Peel all raw fruits and vegetables before eating.
- Work with children so they wash hands thoroughly with soap and water after using the toilet and before handling or eating food.
- Keep diapering and food-handling areas and responsibilities separated.
- Clean and disinfect faucet handles, toilet handles, toys, tabletops, and highchairs more frequently than usual.
- Handle soiled clothing appropriately. Store clothing in a labeled plastic bag and return home with parents.
- Instruct parents to wash hands carefully after handling soiled items.

Who should be notified?

- Notify the parents of children who have been in direct contact with a child who has diarrhea.
- Cases should be reported to the local county health department or Acute Disease Service Epi-On-Call at 405-426-8710.

Cytomegalovirus (CMV)

What is it?
Cytomegalovirus (CMV) is a common virus that infects most people at some time during their lives but rarely causes illness.

What are the signs or symptoms?
Most children and adults who are infected with CMV do not become ill. Those who do may have fever, swollen glands, and feel tired. Immuno-compromised people (such as AIDS patients or those receiving cancer treatments) may have a more serious illness like pneumonia.

How long does it take from exposure to development of the disease?
CMV may remain in the body throughout the person's lifetime. The virus may be found in the urine or saliva of infected people who may or may not be ill. The person is contagious as long as the virus is shed.

How is it spread?
CMV is spread from person to person by direct contact. It can be found in the urine, saliva, breast milk, blood, semen, and possibly in other body fluids. The virus can spread from an infected mother to her fetus or newborn baby. Children aged one to three years shed CMV in highest rates.

What is the treatment for CMV infections?
There is usually no treatment for CMV infections.

Should an infected person be excluded from school or work?
There is no reason to exclude a child from care.

What precautions should pregnant women take?
Pregnant women should carefully wash their hands after handling wet diapers or having contact with urine or saliva. CMV can cause problems for pregnant women. If a woman gets CMV for the first time, while pregnant, the risk of disease in the fetus is greater. Young women who may be or may become pregnant should ask their health care provider about CMV. It is recommended that pregnant staff members not work in classrooms with young children still in diapers.

What can be done to prevent the spread of CMV?

- Good hand washing is the best way to prevent infection with CMV.
- Disinfect toys and surfaces in toddler and infant rooms daily or more frequently, if needed.

Diarrhea

What is it?
Diarrhea is an illness in which someone develops more watery and frequent stools than is typical for that person. Diarrhea can be caused by changes in diet, an allergy to certain foods, food poisoning, emotional upset, or the use of some medications. Sometimes diarrhea is a contagious disease caused by a virus, bacteria, or parasite.

What are the signs or symptoms?
- Frequent loose or watery stools (poop)
- Abdominal cramps and tenderness
- Fever
- Generally, not feeling well
- Blood in stool

Following are some of the organisms known to cause diarrhea:

• Rotavirus • Norwalk Virus • Hepatitis A Virus • Salmonella • Giardia	• Shigella • Campylobacter • Clostridium Difficile • Cryptosporidiosis • E-coli

How long does it take from exposure to development of disease?
After exposure, another person may develop diarrhea from one day to weeks later, depending on the specific infection.

When is it contagious?
It depends on what is causing the diarrhea. Diarrhea should always be considered contagious until a health care provider determines that it is not.

How is it spread?
- Diarrhea is spread by the fecal-oral route. Fecal-oral means the germs in one person's bowel movement wind up in another person's mouth, usually by way of unwashed hands.
- Water or food contaminated by human or animal feces.
- Contact with raw or undercooked poultry.
- Contact with animals in the child's environment or during trips to sites with animals.

Exclude from group settings if:
- Stool is not contained in the diaper, or diarrhea is causing accidents for children who don't wear diapers.
- Stool frequency exceeds two or more above normal for that child.
- Stool is all black, or there is blood or mucus in stool.

What should be done?

- Notify the parent of the child.
- The most important treatment for a young child with diarrhea is to replace fluids. The child should be encouraged to drink small amounts of clear fluids frequently.
- If the child has other signs of illness, such as fever or vomiting, or the diarrhea is frequent and the child is less than two years old, have the parent contact the child's health care provider for specific recommendations.
- If the child has an appetite, it is advisable to offer a normal diet but provide extra fluids.
- **If the onset is abrupt and the diarrhea is severe with evidence of blood or high fever, an immediate visit to the child's health care provider is necessary**.

When can the child be re-admitted?

- Once stool frequency has reduced to fewer than two stools above normal for that child, even if the stools remain loose.
- Once diapered children have their stool contained by the diaper and when toileting children do not have toileting accidents.
- When the child is able to participate and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

What can be done to prevent the spread of diarrhea?

- Hand washing is the most important line of defense for both caregivers and children in preventing the spread of diarrhea. Staff and children wash their hands:
  - Upon arrival at the child care facility.
  - After returning from playing outdoors.
  - After using the toilet or helping a child use the bathroom.
  - After each diaper change.
  - Before and after preparing, serving, or eating food.
- Disinfect toys, bathrooms and food preparation surfaces daily.
- Use disposable paper towels for hand washing.
- Use disposable table liners on changing tables and wash and disinfect tables after each use.

Who should be notified?

- Notify parents of children who have been in direct contact with a child who has diarrhea. Parents should contact their child's health care provider if their child develops diarrhea.
- Notify the local health department if two or more children in one child care facility have diarrhea within a 48-hour period.
- Also notify the local health department if you learn that a child in your care has diarrhea due to Shigella, Campylobacter, Salmonella, Giardia, Cryptosporidium, or E coli. A health care provider or public health official must clear the child for readmission in these cases.

Diphtheria

What is it?
Diphtheria is a rare but serious bacterial disease which is spread person to person by infected droplets. Diphtheria causes inflammation of the throat, nose and tonsils, and a high fever. It can interfere with swallowing and cause blockage of the airway, making it impossible to breath. It can also cause heart and nerve problems.

What are the signs or symptoms?
The symptoms of diphtheria vary depending on what part of the body is infected. The most common infection occurs in the throat and tonsils.

- Slight fever
- Chills
- Sore throat
- Other symptoms which might occur include hoarseness, barking cough, runny nose, scaly rash, and open skin sores.

When is it contagious?
An infected person can spread diphtheria for two to four weeks after symptoms start. The rare chronic carrier (a person with continual infection) can spread for six months or longer.

How is it spread?
Diphtheria is spread through the air from the mouth, throat, or nose of an infected person through coughing or sneezing. Rarely, diphtheria is spread by contact with articles soiled with discharges from skin sores of an infected person.

What should be done?
- Isolate the child and have a parent pick them up immediately.
- Identify close contacts.
- Disinfect all areas the child has been in contact with.

When can the person be re-admitted?
The person can return to the program after being treated, with permission from a health care provider.

What can be done to stop the spread of Diphtheria?
The best way to stop the spread of diphtheria is to ensure everyone is vaccinated:

- A child needs 4 doses of DTaP (diphtheria, tetanus, pertussis) vaccine by two years old.
- A child should receive a DTaP booster sometime between four and six years old.
- A child should receive a Tdap booster sometime between 11 to 12 years old.
- Td (tetanus and diphtheria) is recommended for all adults every 10 years.
- One does of Tdap should be substituted for one dose of Td for adults.

Who should be notified?
Diphtheria is an immediately notifiable disease and should be reported to the Acute Disease Service Epi-on-call at 405-426-8710.

Ear Infection (Otitis Media)

What is an ear infection?

Infection of **the middle ear**, or ***otitis media***, is an infection of the part of the ear behind the eardrum.

- It is usually a complication of an upper respiratory infection, such as a cold.
- It can be acute (new), chronic (persistent), or serious (associated with fluid that does not contain germs).
- Otitis media is more common in young children because the tube that connects the middle ear to the nasal passages is very short and straight, making it easy for bacteria in the mouth and nasal passages to reach the inner ear.
- Most ear infections are caused by bacteria.

What are the signs or symptoms?

- Pain inside the ear or when moving the earlobe
- Repeated tugging at the ear
- Irritability or fussiness
- Crying
- Poor feeding
- Disturbed sleep
- Fever
- May have ear drainage

Who gets it and how?

- Middle ear infections are common in children between the ages of one month and six years, and most common under age three.
- Some children develop ear infections a few days after a cold starts.
- Conditions that increase a child's risk of ear infections are:
  1. Frequent colds
  2. Bottle propping
  3. Exposure to smoke
  4. Attendance in a child care program.

Effects of ear infections

- If an ear infection does not clear up quickly, or does not respond to treatment, a temporary hearing loss can occur.
- A hearing loss for only two or three months may impair a child's language and learning.
- A ruptured eardrum or other serious complications can also occur.
- The age of birth to three years is a very important period of development.
- A child that has many ear infections may hear muffled speech.
- This may affect his ability to repeat sounds and words in order to learn normal speech and may delay language development.

Other signs

- A child frequently doesn't look up when someone enters the room.
- The child doesn't hear you call, but a nearby friend does.

Exclude from group setting?

Since ear infections themselves are not contagious, there is no reason to exclude a child with one from your program unless they have a high fever or cannot participate in activities because of pain.

How to prevent ear infections

- Prevent the spread of colds and other upper respiratory infections which may lead to otitis media.
- Breastfeeding reduces the number of ear infections so remember to support your breastfeeding moms.
- Make sure all children and staff use good hand washing practices.
- Don't allow children to share food, utensils, or toothbrushes.
- Wash toys regularly, especially the ones that young children put in their mouths.
- Do not bottle-feed infants lying on their backs. Keep infants upright or inclined while feeding. The liquid can back up into the Eustachian tube, creating a breeding ground for bacteria.
- Provide a smoke-free environment.

Be alert for any sign of hearing or speech problems that may develop. Refer the child to his or her health care provider.

Ebola

What is Ebola Virus Disease?

Ebola Virus Disease (EVD) is a serious illness caused by infection with the *Ebolavirus*. It is a severe, often fatal disease in humans and non-human primates (such as monkeys, gorillas, and chimpanzees). The viruses that cause EVD are located mainly in sub-Saharan Africa. People can get EVD through direct contact with an infected animal (bat or nonhuman primate) or a sick or dead person infected with Ebola virus.

What are the signs or symptoms?

- Fever
- Severe headache
- Muscle pain
- Vomiting
- Diarrhea
- Stomach pain
- Unexplained bruising or bleeding

How long does it take from exposure to development of the illness?

Symptoms may appear anywhere from two to 21 days after exposure, although eight to 10 days is most common.

How is Ebola Spread?

Ebola virus is spread through direct contact with the blood or body fluids (including but not limited to feces, saliva, sweat, urine, vomit, breast milk, and semen) of a person who is sick with Ebola. The virus in blood and body fluids can enter another person's body through broken skin or unprotected mucous membranes in, for example, the eyes, nose, or mouth.

- Ebola virus is not spread through air or by water, or by any food grown or approved for consumption in the United States.
- You cannot be infected by someone who has been exposed to Ebola but does not have symptoms.

Who is at Risk?

Health workers and the family and friends in close contact with Ebola patients are at highest risk because they may come in contact with the blood or body fluids of sick patients while caring for them.

Children are at greater risk from seasonal influenza (flu) than they are from the Ebola virus.

What Can Child Care Providers Do to Help?

Child care providers should continue to use good infection control practices. The same steps that prevent the spread of many other diseases help to prevent Ebola transmission:

- Wash hands often with soap and water for 20 seconds.
- Avoid touching eyes, nose and mouth with unwashed hands. Avoid close contact such as kissing, hugging, and sharing cups or eating utensils with people who are sick.
- Proper cleaning of equipment, toys, and surfaces such as countertops, doorknobs, sinks, and toilets help to prevent the spread of illnesses.
- Child care providers should separate soiled bedding from cribs, mats, cradles, or cots from other used laundry to avoid contamination. Soiled bedding should be washed separately using regular “hot” or “cold” washing cycles and regular drying cycles.
- Child care providers should wear gloves in cases where they may come into contact with blood or body fluids (e.g., treating a scrape or changing a diaper), and these gloves should be removed and disposed of properly to avoid contact. After removing gloves, staff should wash their hands again.
- Child care providers should follow their standard protocols for dealing with sick children. Children with a fever, vomiting, or diarrhea should remain home until they no longer have symptoms.
- Providers can also help by sharing prevention information with the families they serve.

- **Support Child Care Staff:** In the unlikely case that center-based staff had contact with an Ebola patient, these employees may be asked by public health authorities to stay at home for 21 days. Providers should review their staffing plans to ensure adequate coverage, if needed. In the unlikely case that home-based providers have had contact with an Ebola patient and are asked by public health authorities to remain at home, they should refrain from caring for children during this period.

Who should be notified?
If you have a child or staff member in your program confirmed to have the Ebola Virus Disease, contact the OSDH Acute Disease Service Epi-On-Call at 405-426-8710 for more detailed information.

E. coli (*Escherechia coli*), Toxin-producing
Also called Shiga toxin-producing *E. coli* (STEC), *E. coli* O157:H7, *E. coli* O111, etc.

What is it? Many forms of *E. coli* are harmless and part of normal intestinal bacteria. Some types, called STEC, can cause mild to severe disease. It can even affect the kidneys and other organs.

What are the signs or symptoms? The symptoms are mild to severe diarrhea, which may be watery or bloody.

How is it spread? *E. coli* is in the stool (feces) of animals and people who are ill. Animals that can carry it without having symptoms include certain farm animals (cows, sheep, goats or deer).

How long does it take from exposure until the disease develops? The time ranges from two to 10 days, usually three to four days.

When is it contagious? It can be spread in the feces until up to three weeks after diarrhea starts in children (usually one week in adults). It is very easily spread within households, in child care settings, and in group living facilities.

What should be done? When a child has diarrhea, remove him or her from contact with others and call the parents to take the child home when:

- Stool is not contained in the diaper, or diarrhea is causing accidents for children who don't wear diapers.
- Stool frequency exceeds two or more above normal for that child.
- Stool is all black, or there is blood or mucus in stool.

If diarrhea persists, the child should be taken to see a healthcare provider.

How is it treated? There is not a specific medication to treat *E. coli* infections, but fluids and other supportive care will help the person recover.

When can the child be re-admitted? When a laboratory confirms one of the STEC types of *E. coli* in a patient, the health department is notified. The health department then works with the parent to determine when it is safe for the child to return. The child should be free of diarrhea for at least 24 hours, plus have two lab tests that are negative for STEC before returning to the child care setting.

What can be done to prevent the spread of *E. coli*?

- Focus on thorough hand hygiene at appropriate times for children and employees.
- Supervise children in hand washing after using the bathroom and before meals.
- Eliminate access to shared water play areas.
- Follow safe food handling practices.
- Clean and disinfect diaper-changing surfaces after each use.

Who should be notified? Certain types of *E. coli*, specifically the ones causing STEC will be reported to the health department, and an investigation will take place. If you have a question about a child's illness, contact the Acute Disease Service Epi-on-call at 405-426-8710.to discuss the situation and determine any recommendations.

Fever

What is fever?

A fever is an elevation of the normal body temperature. Fever is most commonly the body's natural response to an infection caused by virus or bacteria.

It is generally accepted that a temperature of **100.4 degrees F or more in a young infant** or **101 degrees F in older infants and children** is ***a fever*** no matter what method you use to take it.

Factors that can cause a mild elevation in body temperature

- Exercise – including active play and exertion
- Time of day (late afternoon)
- Teething
- Environmental temperature caused by
  - A hot room
  - A hot day
  - Child bundled up excessively

These factors do not represent a true fever.

Other signs of fever

- The skin appears flushed.
- Fatigue – child is tired and listless.
- Child is irritable.
- Child has a decreased appetite.
- A child's forehead or abdomen may feel quite warm, but taking the temperature is the only way to know for sure if there is a fever.

The Do's and Don'ts for a child who has a fever

- **DON'T** use ice packs or alcohol rubs. These can bring the fever down too quickly and cause problems. These methods are also very uncomfortable for a child.

- **DO** use lukewarm water to cool him or her down if the child is uncomfortable. Offer cool fluids, popsicles or slushies made with crushed ice and clear 100 percent juice.

- **DON'T** give aspirin to children under the age of 12 years unless prescribed by a health care provider. Aspirin in children is associated with a sometimes deadly disease called Reye's syndrome.

- **DO** give Tylenol or Motrin if you have a medication administration policy, written parental permission, and written instructions from the health care provider. These medications generally help bring the fever down within 20 to 40 minutes.

- **DON'T** bundle children up in blankets or heavy clothing.

- **DO** allow children to cool down more easily with light clothing and covers.

When should a child with a fever be excluded from child care or sent home?

- If fever is noted in an infant younger than two months.
- If fever is associated with behavior change or other signs of illness.
- If the child is unable to participate and staff members determine they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group.

What can be done to prevent the spread of the fever?

- Make sure all children and staff use good hand washing practices.
- Teach children to wash their hands after blowing their nose or coughing.
- Keep the environment clean.
- Do not allow sharing of mouthed toys, bottles, cups or pacifiers.
- Clean and disinfect toys and hard surfaces frequently. Mouthed toys should be cleaned and sanitized after each use, or removed until cleaning takes place.
- Open windows and maximize outdoor play.

Fifth Disease

What is it?
Fifth Disease is a contagious disease spread by a virus and it's also known as "Slapped Cheek." It is usually a mild rash illness of children. There is some risk to unborn babies, so if a pregnant woman is exposed to Fifth Disease, she should consult her health care provider.

What are the signs or symptoms?
- A red rash that generally appears on the face giving a "slapped face" appearance.
- A low-grade fever.
- Rash may spread to the rest of the body.

How long does it take from exposure to development of Fifth Disease?
One to two weeks, but it may be that the first symptom will be the rash in two to three weeks.

When is it contagious?
People with Fifth Disease can spread the illness during the week before the rash appears. By the time the rash is seen, the virus can no longer be spread to others.

How is it spread?
The virus is spread by contact with airborne droplets produced by coughing or sneezing. These droplets may be inhaled by someone or touched by another person who then takes the droplets into their mouth.

What should be done?
There is no treatment and this is usually a mild illness. Treatment may be given to relieve some symptoms such as itching or fever.

When can the child be re-admitted?
The child does not need to be excluded, because by the time the rash appears, it is no longer contagious.

What can be done to prevent the spread of Fifth Disease?
- Make sure all children and staff use good hand washing practices.
- Keep the environment clean.
- Do not allow sharing of mouthed toys, bottles, cups or pacifiers.
- Clean and disinfect toys and hard surfaces frequently. Mouthed toys should be cleaned and sanitized after each use, or removed until cleaning takes place.
- Make sure the facility is well ventilated. Open windows and maximize outdoor play.

Who should be notified?

Notify parents of the child, as well as other parents and staff members. Pregnant women and parents of children who have a weakened immune system may want to consult their health care provider.

Flu (Influenza)

What is it?
The flu is a contagious disease caused by a group of respiratory viruses called influenza viruses. The flu mainly affects the respiratory tract (nose, throat, and lungs).

What are the signs or symptoms?
Symptoms of the flu include:

- Sudden onset of fever
- Headache
- Chills
- Muscle aches and pains
- Sore throat
- Nasal congestion
- Cough
- Decreased energy
- Abdominal pain
- Croup, bronchiolitis, or pneumonia

How long does it take from exposure until the disease develops?
Usually, one to five days after exposure.

When is it contagious?
It can be spread from the day before symptoms begin, to four days afterwards.

How is it spread?

- It is spread when someone with the flu coughs, sneezes, or does anything that releases the nose and throat secretions outside their body.
- This can directly spread from one person to another, or someone can touch a surface or object that has been coughed on, and infect themselves by touching their eyes, noses or mouths.

What should be done?
When a child develops these symptoms, remove him/her from contact with others and call the parents to take the child home. If the symptoms continue at home, the child may need to be taken to see a health care provider.

How is it treated?
In certain circumstances, antivirals (NOT ANTIBIOTICS, which only treat bacteria) are prescribed by a health care provider.

When can the child be re-admitted?
The child can return when the fever has gone away for 24 hours <u>without</u> the use of any fever-reducing medication, and the other symptoms have improved enough that the child can participate in the usual activities.

What can be done to prevent the spread of flu?

These actions are all important in preventing the spread of flu:

- Encourage **annual flu vaccination of children and employees**, which prevents the flu in most cases. Even if the flu still happens, it is usually a much milder illness.
- Focus on thorough hand hygiene at appropriate times for children and employees.
- Teach children and employees to "Cover Your Cough" using a tissue (followed immediately by hand hygiene) or by covering their coughs or sneezes with their sleeves.
- People with flu symptoms should stay home until the fever has gone away for 24 hours without the use of any fever-reducing medication, and the other symptoms have improved enough to return to general activities.

Who should be notified?

The flu in just one person is not reportable to the health department, but if even a small a group of people (children and/or adults) have the flu or symptoms of the flu near the same time, contact the Acute Disease Service Epi-on-call at 405-271-4060 to discuss the situation and determine any recommendations.

Comments: Flu can spread quickly in child care centers. During flu season, watch for symptoms of flu and call the health department as soon as you notice any increase in flu associated with your program.

Giardiasis

What is it?
Giardiasis is a chronic diarrhea illness caused by a parasite (Giardia lamblia). It is diagnosed by a doctor.

What are the signs or symptoms?
Some infected people have no symptoms. These people are called carriers. People who feel sick may experience some or all of the following:

- Foul-smelling greasy diarrhea
- Gas and bloating
- Abdominal cramping
- Nausea and vomiting
- Weight loss and weakness

Bloody stools are **not** usually seen with Giardia infections. Animals such as beavers, cats, dogs, and cattle are infected the same way as humans.

How long does it take from exposure to development of Giardiasis?
After exposure, it usually takes one to two weeks for symptoms to start.

When is it contagious?
As long as the parasite is present in the stool (poop). In most cases the germs will be completely gone in four to six weeks.

How is it spread?

- Giardia is spread from person to person when a person touches the stool or an object which has been contaminated by the stool of an infected person, and then touches their face around the mouth, nose and eyes.
- Infection is often spread by not properly washing hands after going to the bathroom, after changing diapers or before preparing foods.
- Giardia may also be transmitted through contaminated water, such as in water play tables.
- Outbreaks have also been linked to portable wading pools and contaminated water supplies.
- Drinking water from lakes, streams, or ponds that are contaminated by infected animals and humans can cause infection.

When should people with Giardiasis be excluded?
Exclude if there is diarrhea with illness, fever, or vomiting. After diarrhea stops, the person may return to child care.

How is it treated?
Most health care providers agree that persons with Giardia who are ill and/or have diarrhea should be treated with medication.

What can be done to prevent the spread of Giardiasis?

- Exclude any child or adult with diarrhea.
- Make sure that all children and adults practice good hand washing techniques.
- In a large child care facility, the person preparing food should not change diapers.
- In a small child care facility, the child care provider should carefully wash hands after changing diapers and before handling foods.
- If possible, keep diapered children apart from toilet trained children.
- Wash and disinfect toys that can be put in a child's mouth after each child's use.
- Use diapers that can contain liquid stool or urine.
- Make sure that diapers have waterproof outer covers or use plastic pants.
- Children should wear clothes over diapers.
- Wash children's hands before and after they use water play tables.

Who should be notified?

Notify the local health department. They will provide you with further information.

Haemophilus Influenzae Type b (Hib)

What is it?
Hib is a type of bacteria that can causes infections of the ears, eyes, sinuses, throat, skin, lungs, blood, joints, and coverings of the brain, and is a major cause of meningitis. These are very serious, ***sometimes fatal***, illnesses in susceptible children. There are many types of Haemophilus Influenzae, and Type b is the most severe.

What are the signs or symptoms?
Depending on the site of the infection, ***early symptoms*** may include:

- Sore throat
- Earache
- Fever
- Coughing
- Difficulty breathing
- Joint pain
- Skin lesions
- Headache

Symptoms that may appear suddenly:

- High fever
- Irritability
- Intense headache
- Nausea or vomiting
- Stiff neck

How long does it take from exposure to development of the disease*?*
Two to four days.

When is it contagious?
A person with Hib is contagious from the week before start of symptoms until 24 to 48 hours after starting antibiotic treatment.

How is it spread?
Hib can be spread from one person to another by coughing or sneezing, or by contact with mucus or fluids from the nose and throat of a person with Hib.

What should be done?

- Exclude children and staff that are ill with the disease until the local health department recommends that they return.
- Exclude all children and staff exposed until preventive treatment has been given, if indicated and prescribed by a health care provider.
- Review your immunization records to determine which children have not been vaccinated for Hib and may need to be depending on contact.

When can the child or staff member be re-admitted?
The child or staff member may return after being cleared by a health care provider.

What can be done to prevent the spread of Hib?

- To prevent disease, make sure the children in your care (beginning from two months up to five years of age) are vaccinated.
- It is important to carefully observe those who are exposed, but who have not been vaccinated or completely immunized. Exposed children who develop an illness with fever need to be seen by a health care provider.
- All contacts should receive prophylaxis (preventive treatment), including those who have received the Hib vaccine.
- Make sure all children and staff use good hand washing practices.
- Do not allow sharing of mouthed toys, bottles, cups or pacifiers.
- Clean and disinfect toys and hard surfaces frequently. Mouthed toys should be cleaned and sanitized after each use or removed until cleaning takes place.

Who should be notified?
Notify the local health department. They will provide you with further information.

Hand, Foot, and Mouth Disease

What is it?
Hand, foot, and mouth disease (HFMD) is a viral infection caused by Coxsackie virus.

What are the signs or symptoms?
- Tiny blisters in the mouth and on the fingers, palms of hands, buttocks, and soles of feet that last a little longer than a week.
- Poor appetite – blisters in the mouth and throat make it difficult to eat or drink.
- May see common cold signs or symptoms with fever, sore throat, runny nose, and cough.
- Vomiting and diarrhea can occur but are less frequent.

How long does it take from exposure to development of disease?
Three to six days

When is it contagious?
The virus may be shed for weeks to months in the stool (poop) after the infection starts; respiratory shedding of the virus is usually one to three weeks.

How is it spread?
- Respiratory route: contact with large droplets that form when a child talks, coughs, or sneezes.
- Direct contact with respiratory secretions from objects contaminated by children who carry the virus.
- Fecal-oral route: contact with feces of children who are infected.

What should be done? Should children with this illness be excluded?
- Children with HFMD usually don't need treatment and will get better on their own within a week.
- There is no reason to exclude children with HFMD if they feel well enough to attend and do not require more care and attention than the program can provide.

What should be done to prevent the spread of HFMD?
- Follow strict hand washing and personal hygiene procedures.
- Always wash hands, especially after using the bathroom, diapering or assisting children in the bathroom, and before eating or handling food.
- Wash and disinfect all articles contaminated with stool or mucus.

Who should be notified if an outbreak of HFMD occurs in the child care setting?
- Notify parents and staff members.
- Make sure all children and adults use good hand washing technique.

Head Lice (Pediculosis)

What are head lice?

- Lice are parasites that live on the surface of the human body. An infestation of lice is called “pediculosis”.
- Head lice are wingless, crawling insects which live on the human scalp. They cannot reproduce without the warmth of the human head, nor can they survive without the blood provided by the scalp.
- Head lice are not a sign of poor hygiene, and ***they do not carry disease***.
- Head lice should not be confused with body lice or crab lice.
- Head lice are found only on humans – not on dogs, cats, or other pets.

What are the signs or symptoms?

- Excessive scratching of the head.
- A tickling feeling or sensation of something in the hair.
- Irritability and sleeplessness.
- Sores on the head caused by scratching.

How long does it take from exposure to infestation?

One to two weeks.

When are they contagious?

As long as there are live lice and eggs.

How to look for head lice:

- Lice eggs, called ***nits***, are found by close examination of the hair. Nits look like white or dark ovals, and are most noticeable on the back of the neck and around the ears at the base of the hair shaft.
- Nits attached firmly within ¼ inch of the base of the hair shaft suggests a person could be infected.
- Adult lice may be seen crawling on the scalp. Lice are about the size of a sesame seed. They can crawl, but they cannot jump or fly.
- In severe cases of infestation, head lice may also infest eyebrows and eyelashes.

How are lice spread?

Head lice are spread through direct and indirect contact with infested objects or people:

- Head-to-head contact (very common in children as they play closely).
- Sharing combs, brushes, and hair accessories.
- Sharing hats and head coverings – like dress up play.
- Storing children’s coats and jackets in a small area where they touch.
- Sharing bedding or providing a comfortable area with pillows where children might rest their heads.

When should children be excluded from care and when can children be re-admitted?

- When head lice are discovered on children it is not necessary to send them home immediately or exclude them from child care or school.
- Contact the parents of the child to inform them their child has head lice and let them know they will have to treat their child and the child's environment that evening.
- At the end of the day provide the parents with educational materials on proper treatment and nit removal.

Treat the person

- People with head lice and nits are treated with medication and manual removal.
- Read and follow the instructions on ALL products and treatments (over the counter OR prescription).
- It is important to remove as many lice and nits as possible. Careful combing of hair in small sections at a time with a fine-tooth comb (one will come with the treatment) helps.

Treat the environment

- Machine wash on the hot cycle (130 degrees or hotter) all bed linens, clothing, and towels that have been in contact with the infested person within the last three days. Also wash the soft toys and stuffed animals that the child plays with and cuddles.
- Use a hot dryer setting for at least 20 minutes to dry clothes, linens, towels, soft toys, and stuffed animals after washing.
- Non-washable items can be vacuumed or dry-cleaned.
- If there are items which cannot be washed, vacuumed or dry-cleaned, these items can be "bagged" and sealed in plastic garbage bags for a period of two weeks. "Bagging" objects that can't be washed, dry-cleaned or vacuumed should be done with care and under parental supervision. Lice and nits cannot survive off the human body for this length of time without a blood meal.
- Vacuum carpet, upholstered furniture, mattresses, box springs, and car seats.
- All of the person's brushes, combs, and hair accessories (headbands, barrettes, and ponytail holders) must be treated as well.
  The following methods are suggested:
  Soak items in a mild bleach solution, rubbing alcohol, or Lysol for one hour, OR
  Scrub items with soap and hot (130 degree) water. Rinse well.

What can be done to prevent the spread of head lice?

- Make head checks part of the daily health check. The earlier lice are found, the easier they are to treat and keep from spreading further.
- Head lice are treated with medication and manual removal. Thorough combing with a nit comb is important.
- Provide space for children's coats, sweaters, hats, and other personal belongings to be stored separately.

- Teach children the importance of not share clothing, hats, hairbrushes, or combs with other children.

Treatment precautions

- ***Only use licensed and approved products for treatment of head lice***. Home remedies such as mayonnaise, Vaseline, and tea tree oil are not consistently proven to be effective for the treatment of head lice. Tea tree oils can be irritating to the skin and are toxic to the liver in high doses.
- The treatment times of over-the-counter lice shampoos and rinses must not be extended beyond the package insert recommendations.
- The over-the-counter and prescription shampoos and rinses should not be applied too frequently.
- Gasoline, kerosene, or any other petroleum-based products which could be flammable **must not be used** for head lice treatment or nit removal.
- Products containing insecticides that are not labeled for use on humans **must not be used** for head lice treatment of nit removal.

Headaches

What is a headache?

Headaches are thought to be caused by changes in chemicals, nerves, or blood vessels in the area. These changes send pain messages to the brain and bring on an aching in the head.

Headache triggers

In general, children get the same types of headaches as adults. Headaches can also be hereditary, so if a parent gets them, their children might too.

Some of the potential headache triggers include:

- Too little sleep or sudden changes in sleep patterns
- Extreme hunger or thirst
- Certain medications
- Being under a lot of stress
- Having a minor head injury
- Using the computer or watching TV for a long time
- Eye strain, including sun glare
- Smelling strong odors
- Taking a long trip in a car or bus
- Listening to really loud music
- Clenching or grinding teeth
- Tooth infections or abscesses
- Noisy, hot, stuffy environments
- Consuming certain foods or food additives (chocolate, caffeine, cheese, nuts, fried foods, aspartame, MSG)
- Changes in the weather
- Hormonal changes during a girl's menstrual cycle
- Physical exertion

In some cases, headaches are caused by certain infections, such as:

- Ear infections
- Viral infections, like the flu or common cold
- Strep throat
- Sinus infections
- Lyme disease

Two common types of headaches are tension headaches and migraines.

Fairly common in kids, ***tension-type headaches can cause***:

- A pressing tightness in the muscles of the head, radiating down the neck.
- Constant dull ache on both sides of the forehead.
- Pain that doesn't get worse with physical activity.
- A headache that's not accompanied by nausea or vomiting.

Tension headaches are characterized by a contraction of the muscles at the back of the head. Young children may withdraw from regular play and want to sleep more. Tension-type headaches can last from 30 minutes to several hours.

***Migraines can cause*:**

- Throbbing, stabbing, or pounding pain on one or both sides of the front part of the head.
- Pain that worsens with exertion.
- Nausea.
- Vomiting.
- Abdominal pain.
- Dizziness.
- Extreme sensitivity to light, noise, and smells.
- Seeing spots or halos.

Migraine pain is caused by chemicals produced in the brain that alter blood vessels in the brain. The head pain typically lasts for several hours or even overnight. Some people with migraines get **auras**, a warning that a migraine is on the way. Common auras include blurred vision, seeing spots, flashing lights or smelling a certain odor.

What should be done?
Inform the child's parents of any headache symptoms. Keep written notes of other symptoms that accompany the headaches, as well as what the child was doing at the onset and anything he or she ate or drank.

Suggest that the parents call the child's health care provider if the child's headaches:

- Occur once a month or more.
- Don't go away easily.
- Are particularly painful.

Notify parents to pick up child and contact the child's health care provider if the child has any of these symptoms in addition to the headache:

- Decreased level of alertness
- Vomiting
- Headache when the child wakes up, or one that is so painful it wakes the child up
- Headache following a head injury or loss of consciousness
- Headache with seizure
- Visual changes
- Tingling sensations
- Weakness
- Clumsiness or difficulty walking or standing
- Difficulty speaking
- Neck pain or stiffness
- Unable to participate in everyday activities

- Fever or other signs of infection
- Change in personality
- Very thirsty – drinking a lot and/or urinating a lot

Should a child with a headache be sent home?
There is no reason to exclude the child if he or she feels well enough to attend and does not require more care and attention than the program can provide. If the headache becomes so severe that the child does not feel well enough to participate in activities, it would be best to contact the parents.

How headaches are diagnosed
- A physical examination is done, as well as taking a thorough medical history.
- More involved and invasive procedures such as CT scan, MRI scan, lumbar puncture, would be performed only if a serious condition was suspected.

Treatment for headaches
Treatment for a child's headaches will depend on what the doctor determines is the likely cause. Most everyday headaches can be cared for at home with little medical intervention.

To help ease a child's pain, have him or her:
- Lie down in a cool, dark, quiet room.
- Put a cool, moist cloth across the forehead or eyes.
- Relax.
- Breathe easily and deeply.

Make sure the child has had something to eat and drink.

Children with migraines may just want to sleep and may feel better when they wake up. A big part of treating migraines is avoiding the triggers that may have caused them. The child's health care provider may have asked the parent to keep a diary of all food and drink taken in that day, as well as what activities the child was participating in.

The parents of a child with headaches may want you to give the child an over-the-counter pain reliever such as acetaminophen or ibuprofen. Make sure they have filled out and signed the Medication Administration form.

Hepatitis A

What is it?
Hepatitis A is an infection of the liver caused by the Hepatitis A virus.

What are the signs or symptoms?
Symptoms may include:

- Mild fever
- Loss of appetite
- Fatigue
- Nausea and vomiting
- Stomach pain
- Clay colored stool (poop)
- Dark urine
- Yellow coloring of eyes and skin (jaundice)

Young children often have no symptoms or very mild symptoms. Adults and older children are more likely to have typical symptoms of the disease.

How long does it take from exposure to development of infection?
It can take from two to six weeks.

When is it contagious?
It is contagious from two weeks before symptoms start to one week or more after jaundice (yellowing of eyes and skin). Some people spread the disease without being noticeably sick. Most children under three years of age have no symptoms when they have Hepatitis A.

Who gets it and how?

- Anyone who has not had a Hepatitis A immunization can get this infection, which spreads quickly in groups of children who are not yet toilet-trained and who cannot wash their own hands well.
- Hepatitis A is spread through the fecal-oral route. This means the disease is spread by putting something in the mouth that has been contaminated with the stool (poop) of an infected person. It can also be spread when a person eats food or drinks beverages which have been handled by a person infected with Hepatitis A.
- Poor hygiene practices among staff with diaper-changing responsibilities and those who prepare food can contribute to the spread of Hepatitis A.

What should be done?
If a child or adult in your child care program is diagnosed with Hepatitis A:

- Immediately notify your local health department and they will provide you with further information.
- Find out who in the facility has not had the Hepatitis A vaccine and provide that information to the health department.

When should people be excluded and when can they return?
Exclude the person from child care until one week after the start of symptoms.

What can be done to prevent the spread of Hepatitis A?

- **Hepatitis A is vaccine preventable**. Children should be vaccinated with their first dose of Hepatitis A vaccine at 12 months and their second dose 6 – 18 months after their first dose.
- Children not previously vaccinated should receive two doses of the Hepatitis A vaccine with a 6-month interval in between doses. Child care providers should discuss with their doctor whether it is appropriate for them to receive the Hepatitis A vaccine.
- Strictly enforce good hand washing.
- Clean and sanitize objects and surfaces regularly.
- Make sure all parents and child care personnel notify the program if any person in their household is diagnosed with Hepatitis A.
- When outbreaks occur in child care settings, gamma globulin may be administered to unimmunized children, providers, and families of child care attendees to limit the transmission of Hepatitis A.

Who should be notified?
Notify the local health department. They will provide you with further information.

Hepatitis B

What is it?
Hepatitis B is a viral infection of the liver caused by the Hepatitis B virus. The virus is found in the blood of an infected person and sometimes in other body fluids. It is more common in adults than in children.

What are the signs or symptoms?
Symptoms include:
- Abdominal discomfort
- Loss of appetite
- Nausea
- Fever
- Tiredness
- Joint pain
- Dark urine
- Yellow skin or eyes (jaundice)

Only about 10% of children who become infected with Hepatitis B virus show any symptoms.

How long does it take from exposure to development of the disease?
Usually 45 to 180 days, average 60-90 days.

When is it contagious?
- A person can spread the virus as long as it is still in their blood.
- Hepatitis B is usually contagious from about one month before until one month after the start of jaundice.
- In rare cases, some people carry and transmit the virus for life.

How is it spread?
Hepatitis B is most often spread from person to person through contact with infected blood, semen, or vaginal secretions. Spreading can occur when infected blood or saliva enters through a cut or scraped area on the skin, or mucous membranes (eyes, nose and mouth). Infected mothers can transmit it to a newborn during birth.

When should people with this illness be excluded?
- A staff person with this illness should stay home until she or he feels well, and fever and jaundice are gone.
- A child or staff person with chronic hepatitis B infection who has open sores that cannot be covered should not attend child care until the sores are healed. Hepatitis B is usually contagious from about one month before until one month after the start of jaundice.
- You do not have to exclude a child who is a carrier of the Hepatitis B virus as long as she or he does not have uncontrolled biting or oozing skin lesions that cannot be covered.

What can be done to prevent the spread of Hepatitis B?

- **Hepatitis B is vaccine preventable**. Infants should be vaccinated with three doses of Hepatitis B vaccine during the first 18 months of life. Children not previously vaccinated should receive three doses of vaccine by the age of 11 or 12 years. Child care providers should discuss with their doctor whether it is appropriate for them to receive the Hepatitis B vaccine.

To reduce the spread of hepatitis B:

- Verify children and staff immunizations.
- Make sure all children and adults use proper hand washing practices.
- Wear disposable gloves to create a barrier when caring for open sores, wounds, cleaning up vomit that may have blood in it, and when changing a soiled diaper with bloody stools. Wash hands well after properly disposing of your gloves.
- Clean up all blood spills and diaper changing surfaces with soap and water, then disinfect with an EPA registered disinfectant, such as a bleach solution.
- Place disposable items contaminated blood or body fluids in sealed plastic bags in covered containers.
- Store clothing or other personal items stained with blood or discharges separately in a sealed plastic bag to be sent home with the child for appropriate cleaning. Ask parents to wash and then bleach these items.
- Do not allow sharing of personal items which may become contaminated with blood or bodily fluids such as toothbrushes, food, or any object that may be mouthed; and discourage aggressive behavior (biting, scratching) at the facility.

Who should be notified?

Notify the local health department. They will provide you with further information.

Hepatitis C

What is it?
Hepatitis C is a viral infection of the liver caused by the Hepatitis C virus (HCV).

What are the signs or symptoms?
Children usually don't show any signs or symptoms. Adults often suffer from:

- Tiredness
- Loss of appetite
- Nausea
- Abdominal pain
- Fever
- Yellow skin or eyes (jaundice)
- Dark brown urine or pale-colored stools

Who gets it and how?

- The viruses that cause Hepatitis C are spread through blood (exposure to blood and blood products from HCV infected persons) or other body fluids.
- It is also spread by infected mothers to newborn infants through blood exposure at birth.

When should people with this illness be excluded?

- You do not have to exclude a child who is a carrier of the Hepatitis C virus as long as he or she does not have uncontrolled biting or oozing skin lesions that cannot be covered.
- A staff person with this illness should stay home until he or she feels well, and fever and jaundice are gone.

What can be done to prevent the spread of Hepatitis C?

- Make sure all children and adults use proper hand washing practices.
- Protect staff and children by following special procedures for cleaning and handling of all body fluids.
- Wear disposable gloves to create a barrier when caring for open sores, wounds, cleaning up vomit that may have blood in it, and when changing a soiled diaper with bloody stools. Wash hands well after properly disposing of your gloves.
- Clean up all blood spills and diaper changing surfaces with soap and water, then disinfect with an EPA registered disinfectant, such as a bleach solution.
- Place disposable items contaminated with blood or body fluids in sealed plastic bags in covered containers.
- Store clothing or other personal items stained with blood or discharges separately in a sealed plastic bag to be sent home with the child for appropriate cleaning. Ask parents to wash and then bleach these items.
- Do not allow sharing of personal items which may become contaminated with blood or bodily fluids such as toothbrushes, food, or any object that may be mouthed; and discourage aggressive behavior (biting, scratching) at the facility.

Who should be notified?
Notify the local health department. They will provide you with further information.

Herpes Simplex

What is it?
Herpes Simplex is a virus that can cause a variety of infections in different age groups. In early childhood, herpes simplex most commonly causes blister-like sores in the mouth and around the lips, and on skin that is in contact with the mouth, such as a finger or thumb that is sucked.

What are the signs or symptoms?
- Fever
- Irritability
- Runny nose
- Tender swollen lymph nodes
- Painful, small fluid-filled blisters in the mouth, on the gums and lips
- Blisters may weep clear fluid and bleed and are slow to crust over
- Often there are no signs or symptoms

How long does it take from exposure to development of infection?
It can take from two days to two weeks.

When is it contagious?
During the first infection:
- People shed the virus for at least a week.
- Some continue to shed the virus for several weeks after symptoms appear.

After the first infection:
- The virus may be reactivated from time to time producing cold sores.
- People with cold sores shed the largest amount of virus for 3 to 4 days after symptoms appear.
- Virus shedding occurs at lowest levels in infected people who have no symptoms.

How is it spread?
- Direct contact through kissing and contact with open sores.
- Contact with saliva (when children share mouthed toys).

What should be done?
- Notify parents to watch for symptoms.
- Take extra precautions to control transmission of infected secretions.

Should people with this illness be excluded?
- Only exclude a child with open blisters or mouth sores if the child is a biter, drools uncontrollably, or mouths toys that other children may put in their mouths.
- Exclude staff with open, oozing sores that cannot be covered.
- ***Do not exclude*** children or staff with skin blisters that can be covered.
- Children and staff that are excluded may return when blisters are crusted over.

What can be done to prevent the spread of Herpes Simplex?

- Make sure all children and adults use good hand washing practices.
- Wash and sanitize mouthed toys, bottle nipples, and utensils that have come in contact with saliva or have been touched by children who are drooling.
- Do not allow children to share toys that can be put in their mouths, as the virus may be present even when sores and symptoms are not noticeable.
- Do not kiss the child or allow the child to kiss others where direct contact with the sore may occur.
- Use gloves if applying medicated ointment to the sores.

Who should be notified?

Notify families whose children may have been exposed to watch for symptoms.

Human Papillomavirus (HPV)

What is it?
HPV is a common family of viruses that causes infection of the skin or mucous membranes and is spread through sexual contact. There are over 100 different types of HPV viruses and different types affect different areas of the body.

What are the signs or symptoms?
- Warts or bumps in the genital area. They can be flat or raised, small or large, smooth or bumpy like cauliflower.
- Warts in the throat or mouth.
- Abnormal cells on the cervix, vulva, penis, mouth and throat, sometimes leading to cancer.

HPV is the cause of almost all cervical cancers in women and has been linked to the rise of oral health cancers in young people.

How is it spread?
The virus is spread by direct sexual contact, even when there are no signs of warts.

How long does it take from exposure until the disease develops?
It can take anywhere from a few months to over a year to develop signs of HPV after having contact.

When is it contagious?
HPV can be spread when someone is carrying the virus, whether warts are present or not. It also can be spread even after warts have been treated and are no longer seen.

What should be done?
- Inform parents about the HPV vaccine and recommend it for their boys and girls 11 – 12 years old.
- Inform and educate staff members about HPV and urge staff members to get the vaccine if they are under the age limit (men through age 21, women through age 26).
- A health care provider can diagnose and treat HPV.

How is it treated?
There is no treatment for the virus itself, but the warts may be treated with prescribed creams or ointments that are applied in the health care provider's office or at home. Other treatments include removal of the warts with a laser or surgery.

What can be done to prevent the spread of HPV?
- ***The HPV vaccine is recommended for all boys and girls ages 11 or 12***.
- HPV vaccines are given in three shots over six months. It is important to get all three doses.
- Catch-up vaccines can be given for males through age 21 and females through age 26.

- For more information about who should receive the vaccine, see www.immunize.org.
- It is always important to avoid direct unprotected contact with warts. People can spread HPV even when they don't have warts, so it is recommended that sexually active people use latex condoms correctly every time they have sex.
- Women between 21 and 65 years of age should be routinely screened for cervical cancer.

Malaria

What is it?
Malaria is a disease that is rare to the United States. It is commonly found in Africa and Southeast Asia. Most cases of Malaria in the U.S. are from people who have recently traveled.

What are the signs or symptoms?
The most common symptoms of malaria are

- Fever
- Chills
- Sweats
- Headache
- Nausea
- Vomiting
- Body aches
- General not feeling well

How long does it take from exposure to development of disease?
Symptoms usually begin 10 days to four weeks after infection, although a person may feel ill as early as seven days or as late as one year later.

When is it contagious?
A person who is sick with malaria cannot spread it to another person.

How is it spread?
Malaria is spread by mosquito bites.

What should be done?
If a child develops these symptoms, notify the parents to pick up the child and consult with the child's health care provider.

When should people be excluded and when can they return?
Children or staff should be excluded until symptoms have resolved.

What can be done to prevent the spread of Malaria?
Malaria is not spread person to person so there is low risk for transmission between children.

Who should be notified?
Because it is not spread person to person, cases of Malaria identified in a child care setting are not required to be reported to the local health department.

Measles

What is it?
Measles is a highly contagious viral disease caused by the measles virus.

What are the signs or symptoms?
- Fever, cough, runny nose, and red, watery eyes.
- Small red spots in the mouth.
- Appearance of a rash at the hairline spreading downward over the body.
- Diarrhea or ear infection.
- Complications may be serious and result in pneumonia, brain inflammation, convulsions, deafness, permanent disability or death.
- Miscarriage or premature delivery in pregnant women who have never had the disease and become infected.

How long does it take from exposure to development of the disease?
It takes eight to 12 days from exposure to start of signs and symptoms.

When is it contagious?
It is contagious from one to two days before the first symptoms appear (four days before the rash) until four days after the appearance of the rash.

How is it spread?
- **Respiratory route**: contact with large droplets that form when a child talks, coughs, or sneezes. These droplets can land on or be rubbed into the eyes, nose, or mouth.
- **Airborne route**: breathing small particles containing virus floating in the air. These particles travel along air currents and can infect children in another room.

What should be done?
- Isolate the child.
- Notify the child's parents to pick up the child and ask them to contact the child's health care provider immediately.

When can the child be re-admitted?
A person with measles should stay home until four days after the rash appears and until feeling well enough to participate in regular daily activities again.

What can be done to prevent the spread of measles?
- **Measles is vaccine preventable**. Measles vaccine is usually administered as part of the MMR vaccine (measles, mumps, and rubella). Immunization of all children at 12 to 15 months, with a booster at ages four to six years, is required by state immunization laws for school and child care.
- Staff who have never had measles or been immunized for it should consult their health care provider. Adults born after 1957 may need a measles booster.

- Keep the ill child away from the child care program and away from pregnant women, infants and people with immune problems.
- Make sure all children and staff use good hand washing practices.
- Clean and disinfect toys and hard surfaces frequently.
- Review immunization records to ensure that children are up to date with recommended immunizations.

Who should be notified?

Measles is an immediately notifiable disease and should be reported to the Acute Disease Service Epi-on-call at 405-426-8710.

Meningitis

What is it?
Meningitis means swelling of the spinal cord and the covering of the brain. It is a diagnosis from a health care provider and can be caused by many different things like a virus, bacteria, fungus or parasite.

What are the signs or symptoms?
Symptoms can include:

- Fever
- Rash
- Headache
- Stiff neck
- Nausea and vomiting
- Fatigue

Infants may be irritable, very drowsy, very fussy, or refuse to eat.

How long does it take from exposure to development of the disease?

- Viral meningitis can start about three to seven days after being exposed.
- Bacterial meningitis is usually from one to ten days.

When is it contagious?

- Viruses can be spread to others from about three days after someone is infected until about 10 days after they become sick.
- Bacteria can be spread to others from about seven days before symptoms start until the ill person has been on antibiotics for at least 24 hours.

How is it spread? Different forms of meningitis are spread in different ways.

- Viral meningitis is more common and is spread through direct or indirect contact with feces of an ill person, usually by unclean hands.
- Bacterial meningitis is spread through direct or indirect contact with fluids from the nose or mouth of an ill person, usually by having close contact that includes coughing, kissing, or sharing items such as drinking or eating utensils.

What should be done? When a child develops these symptoms, remove him or her from contact with others and call the parents to take the child home. If the symptoms persist, the child should be taken to see a health care provider.

How is it treated?

- Viral meningitis is treated with rest and fluids; antibiotics will not help someone recover from viral meningitis.
- Bacterial meningitis must be treated with appropriate antibiotics, prescribed by a health care provider.

When can the child be re-admitted?

- For viral meningitis, when the symptoms are gone, when the treatment is completed, and when the child is able to participate in daily activities.
- For bacterial meningitis, when a child is cleared to return by their health care provider.

What can be done to prevent the spread of meningitis?

- Make sure hand hygiene is encouraged at appropriate times for children and employees.
- Teach children and employees to "Cover Your Cough" using a tissue (followed immediately by hand hygiene) or by covering their coughs or sneezes with their sleeves.
- ***Clean surfaces and items such as toys every day, and when saliva or nose and throat fluids are on them. In settings such as child care centers, wash objects with soap and warm water, removing visible soil, then disinfect with an EPA registered disinfectant, such as a bleach solution.***

Who should be notified? Most types of meningitis are not reportable to the health department. Two types of bacterial meningitis are reported to the health department by hospitals and laboratories. If you have a question about a child in care or an employee who was told they have meningitis, please call the Acute Disease Service Epi-On-Call at 405-426-8710.

Comments:
There are only two types of bacterial meningitis (*Neisseria meningitidis* and *Haemophilus influenza* type b) for which other exposed child care attendees and employees may be recommended to receive antibiotics. The health department will notify you if this happens.

The routine **childhood vaccines** protect children from most common causes of meningitis such as *Haemophilus influenzae* type b (Hib) and *Streptococcus pneumoniae*. Meningococcal vaccines are also recommended for children and some adults. For more information on these vaccines, call your health care provider or the local health department.

Molluscum Contagiosum

What is it?
Molluscum contagiosum is a virus that causes small bumps on the surface of the skin.

What are the signs or symptoms?
Molluscum appear as separate, round bumps or lesions that are:

- Usually yellow, pink or flesh-colored
- Smooth, firm and dome-shaped
- Flat or slightly indented at the top
- Sometimes itchy, but not painful

They can occur in clusters and are frequently seen on the face, neck, trunk, arms, and hands.

How is it spread?

- Through direct contact with the affected area on another person.
- It is also spread by using items such as towels, which were used by someone else with Molluscum contagiosum.
- A person can also spread infection to themselves by touching the bumps, then scratching other parts of the body.

How long does it take from exposure until the disease develops?
It can take between one week and six months before symptoms appear.

When is it contagious?
Probably as long as the bumps are present.

How is it treated?
These usually heal without treatment, but in some situations may be removed by medical freezing, drainage, lasers or medications.

When can the child be re-admitted?
Excluding the child is not recommended.

What can be done to prevent the spread of molluscum contagiosum?

- Avoid direct contact with the skin bumps.
- Do not share towels, washcloths or clothing.
- Explain, model, and direct frequent hand hygiene.
- Covering the lesions is usually not necessary unless a child is picking or scratching them.
- Applying ice packs to itchy areas can help reduce the urge to scratch.

Mononucleosis

What is it?
Mononucleosis is a mildly contagious viral infection caused by the Epstein-Barr virus (EBV). It is commonly known as *mono*.

What are the signs or symptoms?
Symptoms can include:

- Fever
- Sore throat, sometimes white patches on throat
- Fatigue
- Loss of appetite
- Swollen lymph nodes
- Enlarged liver and spleen
- Occasional skin rash

How long does it take from exposure to development of the disease?
It's estimated to be 30 to 50 days.

When is it contagious?
Experts think people with mono are most contagious from the time they first get infected and then for the next 18 months. The EBV stays in the body for life. The virus can show up in a person's saliva from time to time, and there's a chance that person may be contagious during these times. Some people have the virus in their bodies and never have any symptoms, but it is still possible to pass it to others.

How is it spread?

- Person-to-person contact
- Kissing on the mouth
- Sharing objects contaminated with saliva (toys, toothbrushes, cups, bottles)
- May be spread by blood transfusion

Should children with this illness be excluded from group settings?
No, unless

- The child is unable to participate and staff members determine they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group.
- The child meets other exclusion criteria, such as fever with behavior change.

General exclusion of those with mononucleosis is not practical.

When can children be re-admitted to group settings?

- When exclusion criteria are resolved, the child is able to participate, and staff members determine they can care for the child without compromising their ability to care for the other children in the group.
- School-age children should avoid contact sports if they have an enlarged spleen, until their health care provider clears them.

What can be done to prevent the spread of mononucleosis?

- Practice proper hand washing techniques.
- Teach children to use tissues, or cover mouth and nose when coughing or sneezing.
- Ensure that all children have their own toothbrushes, cups and eating utensils.
- Disinfect toys and surfaces in infant or toddler rooms daily and after use; especially chew toys.
- Avoid kissing children on the mouth.

Mpox

What is it?
Mpox is caused by a virus that is rarely seen in the United States. It is closely related to the smallpox virus. In 2022, an outbreak occurred in the U.S., but risk to the general public is low.

What are the signs or symptoms?
Mpox may cause these symptoms:

- Fever
- Swollen lymph nodes (neck, armpits, and groin area)
- Headache
- Muscle aches
- Backache
- Chills
- Exhaustion
- A painful rash starts and goes through several stages including fluid and pus-filled blisters that eventually get crusty, scab over and fall off.

How long does it take from exposure to development of disease?
It usually takes five to 13 days for symptoms to start but they can start as late as 21 days after exposure.

When is it contagious?
Mpox can be spread from the time the rash starts until all the blisters have crusted over, fallen off and new skin has grown underneath. This process typically takes anywhere from two to three weeks.

How is it spread?
Mpox is spread from direct close contact with a person who is sick. This means sexual contact, skin to skin contact or face to face contact for three hours or longer. In some cases, mpox can be spread through bedding, clothing or other materials that have been in contact with a sick person, although this is a lower risk.

What should be done?

- If a child develops a suspicious rash isolate or remove from contact with others.
- Notify the parents to pick up the child and ask them to contact the child's health care provider. (A child should immediately see their primary care provider or visit the county health department for testing if there are concerns for exposure along with the rash).

When should people be excluded and when can they return?
Anyone who tests positive for mpox should be excluded until all blisters have crusted over, fallen off and new skin has grown underneath. As a general recommendation, a child with a fever should be excluded from the facility until he/she is fever free from 24 hours without the use of fever reducing medications.

What can be done to prevent the spread of MPox?
Limiting contact with anyone who is ill with mpox is key to stopping the spread. Use an EPA registered disinfectant to clean surfaces. Avoid sweeping and dusting virus particles into the air.

Who should be notified?
Mpox is an immediately notifiable disease and should be reported to the Acute Disease Service Epi-on-call at 405-426-8710 if there are suspicions or a positive lab result.

Mumps

What is it?
Mumps is an infection caused by the mumps virus that can result in swelling with tenderness of the salivary glands in the cheek and jaw area.

What are the signs or symptoms?
Symptoms can include:

- Swollen glands in front of and below the ear or under the jaw
- Fever
- Headache
- General aches and muscle pains
- Earache
- Adolescent boys may have painful swelling of the testicles
- Adolescent girls may have painful swelling of the ovaries

Complications include meningitis, deafness (usually permanent), glomerulonephritis (kidney inflammation), and inflammation of joints. Mumps infection during the first three months of pregnancy may be linked to miscarriage.

How long does it take from exposure to development of the disease?
16 to 18 days

When is it contagious?
From six days before symptoms to nine days after the swelling begins.

How is it spread?

- Respiratory route: contact with droplets that form when a person talks, coughs, or sneezes. These droplets can land on or be rubbed into the eyes, nose or mouth.
- Contact with the respiratory fluids from objects contaminated by people who carry the mumps virus.

What should be done?

- Isolate the child.
- Notify parents to pick up the child and consult with their health care provider.
- If symptoms occur in a staff member, they must leave the facility and contact their health care provider. They cannot return until five days after the start of swelling.
- During outbreaks exclude exposed children who have not been immunized until they become immunized, or until the health department determines it is safe for them to return.

When can the child be re-admitted?

- Five days after onset of swelling.
- When the child is feeling well enough to participate in regular daily activities.

What can be done to prevent the spread of mumps?

- **Mumps is vaccine preventable**. Children 12 to 15 months old should receive the MMR vaccine which prevents mumps, followed by a booster at four to six years.
- Ensure up-to-date immunizations of children, staff members, volunteers, and family members according to current recommendations.
- Make sure all children and adults use good hand washing practices.
- Wash and sanitize mouthed toys, bottle nipples, and utensils that have come in contact with saliva or have been touched by children who are drooling.

Who should be notified?

Notify the local health department. They will provide you with further information.

Norovirus

What is it?
Noroviruses are viruses that cause intestinal illnesses.

What are the signs or symptoms?
- Diarrhea
- Vomiting
- Stomach cramps
- Sometimes people with norovirus have a headache, muscle aches, or feel very tired.

People with norovirus usually recover in less than three days.

How long does it take from exposure until the disease develops?
Symptoms usually begin about 24 to 48 hours after exposure but can happen as soon as 12 hours after exposure.

When is it contagious?
- It is most likely to be spread while a person has symptoms, especially diarrhea and vomiting.
- After symptoms are gone, people can still spread the virus for at least three more days.
- Norovirus can also stay on unclean objects and surfaces and still infect people after days or weeks.

How is it spread?
- Norovirus is in the stool (poop) of people who are ill. Norovirus is very easily spread from person to person, and outbreaks are fairly common in group settings.
- It is spread by unclean hands or surfaces.
- Poor hand washing after using the bathroom spreads norovirus.
- Norovirus can stay on unclean objects and surfaces and infect people after days or weeks.

What should be done?
- When a child has vomiting (two or more times in a 24-hour period) or diarrhea (three or more loose stools in a 24-hour period), they should be separated from others until a parent can pick them up.
- Employees with these symptoms should go home.
- If a child or employee has been in the child care center or school while vomiting or having diarrhea, clean and disinfect any surfaces or objects that may have been contaminated.
- **Cleaning up vomit or diarrhea may release the germs into the air**, and they can be inhaled.
- **Wear disposable gloves and face masks** if cleaning large amounts of vomit or diarrhea.

- Clean up vomit and diarrhea promptly and carefully so that the germs are not released into the air. A good way to do this is to **cover the area with paper towels to absorb the body fluids**. Next carefully finish cleaning the area before using disinfectant.
- Immediately remove clothing or other personal items which have vomit or diarrhea on them and seal in a plastic bag to be sent home with the child for appropriate cleaning.
- Ask parents to wash with an approved detergent in hot water ≥ 160° F for ≥ 25 minutes. Dry in a hot dryer if fabric allows.
- For sheets and other non-disposable items that belong to the facility, handle as little as possible, without shaking or spreading the germs. Wash with an approved detergent in hot water ≥ 160° F for ≥ 25 minutes. Dry in a hot dryer if fabric allows.
- If laundry is not done at your facility, immediately place dirty clothes or linens in a plastic bag, then seal or tie the bag.

How is it treated?
People usually recover on their own, but need to drink plenty of fluids, and treat the symptoms with over-the-counter medicines. It is NOT recommended to take an antidiarrheal medicine, which will cause the body to retain the virus instead of flushing it out. Antibiotics will not help with norovirus illness because antibiotics do not work on viruses.

When can the child be re-admitted? Any child or employee with symptoms of norovirus infection should be sent home and must not return until they are no longer symptomatic for 72 hours without taking antidiarrheal medicine.

What can be done to prevent the spread of norovirus?
- Cleaning hands often is important in stopping the spread of norovirus. Hands should be washed vigorously with soap and water for at least 20 seconds:
  - Before eating or feeding children.
  - Before food preparation.
  - Before serving food.
  - After changing diapers, assisting with toileting or using the toilet.
  - After cleaning up vomit or diarrhea.
  - After handling dirty clothes or linen.
- Adults should supervise children washing their hands after using the toilet and before eating.
- Each sink should be supplied with an adequate amount of soap and paper towels.
- Always clean a surface or object well before disinfecting. Leave the disinfecting solution on the cleaned surfaces or objects for 10-20 minutes, and then rinse with water. Use one of these options for disinfection:
  - A commercial disinfectant that says on the label that it kills noroviruses, or
  - A diluted bleach solution, mixed daily, using regular unscented household bleach.

- Areas to focus cleaning and disinfection (besides play areas) are frequently touched places such as doorknobs, faucets, sinks, toilets, bathroom surfaces, phones, counters (especially where food is prepared), chairs, tables and light switches.

Who should be notified? If more than one child or staff member becomes ill with symptoms of norovirus in a short period of time, contact the Acute Disease Service Epi-On-Call at 405- 426-8710. They will assist you in making sure you are doing everything you can to stop the spread of norovirus in your facility.

Pinworms

What are they?
Pinworms are small, white, threadlike worms that live in the large intestine. The female worms (resembling short, white threads less than half an inch long) come out through the anus at night and lay their microscopic eggs around the opening.

What are the signs or symptoms?
- Itchy bottom.
- The child may be irritable and experience restlessness while sleeping.
- Anal irritation due to scratching.
- Sometimes thread-like worms are visible in child's bowel movement, but more often they are seen on the skin at the anus.

How long does it take from exposure to development of the infestation?
It can take one to two months or longer from the time of ingesting the pinworm egg until an adult worm migrates to the anal area.

When are they contagious?
Pinworms are contagious as long as the female worms are discharging eggs to the skin around the anus.

How are they spread?
- Fecal-oral route, which means the germs of one person's bowel movement wind up in another person's mouth, usually by way of unwashed hands.
- By sharing toys, bedding, clothing, toilet seats, or baths. The eggs are light and float in the air. Pinworm eggs remain infective (capable of transmitting infection) for two to three weeks in indoor environments.

How are they treated?
- Several oral prescription medications are available for treatment of pinworms.
- The health care provider will often treat the whole family if one person in the house is infected, and will repeat the treatment two weeks later.

When should people with pinworms be excluded?
Children and adults should be excluded ONLY until treatment has begun (initial dose).

What can be done to limit the spread of pinworms?
- Practice good hand-hygiene technique at all times.
- Keep the child's fingernails short.
- Treatment with oral medication once or repeated in two weeks may be necessary.
- Each child's clothing should be stored separately in plastic bags and send sent home for laundering.

Who should be notified?
- Notify the parents of the infected child.
- Notify other parents and staff to watch for signs and symptoms.

Pneumonia

What is it?
Pneumonia is an inflammation of the lungs, most often caused by a viral infection, less commonly by a bacterial infection. It is often secondary to an infection that starts in the nose and throat area and then spreads to the lungs.

What are the signs or symptoms?
Some signs and symptoms of pneumonia are:
- Fast difficult breathing
- Cough
- Fever
- Muscle aches
- Loss of appetite
- Lethargy

How long does it take from exposure to development of pneumonia?
Pneumonia is caused by a variety of types of germs, so the time it takes to develop will vary.

When is it contagious?
The contagious period depends on the germ that is causing the pneumonia.

How is it spread?
- Pneumonia does not spread, but the germ that is causing the pneumonia can spread.
- Most of the germs that cause pneumonia spread by direct or close contact with mouth and nose secretions and touching contaminated objects.

How do you control it?
- Make sure all children and staff use good hand washing practices.
- Wipe noses with clean tissues, dispose of them properly and wash your hands.
- Don’t share food, cups, bottles, or toothbrushes.
- Teach children to cough into their elbow and away from people.
- Sanitize surfaces that are touched by hands frequently, such as toys, tables, and doorknobs.

Should children with pneumonia be excluded?
No, unless
- The child is unable to participate and staff members determine they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group.
- The child meets other exclusion criteria, such as fever with behavior change, rapid or distressed breathing, or persistent severe cough.

Polio Myelitis

What is it?
Polio is caused by a virus that lives in the throat and intestines. Most infections do not cause serious illness, however, in some cases it can become severe and cause paralysis.

What are the signs or symptoms?
One out of four sick people will have flu-like symptoms such as:

- Fever
- Sore throat
- Tiredness
- Nausea
- Headache
- Stomach pain

These symptoms will last around two to five days and will usually go away on their own. In more serious cases, the virus can infect the brain and spinal cord. This infection can cause serious complications like meningitis (inflammation around the brain) or paralysis (unable to move parts of the body).

How long does it take from exposure to development of disease?
It takes between three to six days for a person to start showing non-severe symptoms. It takes between seven to 21 days for severe symptoms.

When is it contagious?
An infected person can spread the virus to others immediately, before symptoms start and up to two weeks after symptoms appear.

How is it spread?
Poliovirus is very contagious and spreads through person-to-person contact. In some conditions, food and water can be contaminated. It enters the body through the mouth. The most common way it spreads is then contact with the feces (poop) of an infected person. Less common transmission can occur through the droplets from a cough or sneeze

What should be done?

- Isolate the child.
- Notify parents to pick up the child and consult with their health care provider.
- If symptoms occur in a staff member, they must leave the facility and contact their health care provider

When should people be excluded and when can they return?
Anyone ill with polio should stay home until it has been at least two weeks since symptoms first appeared.

What can be done to prevent the spread of Polio?
Vaccination is the best way to protect against the spread of polio virus. Hand hygiene is very important to stop the spread, especially when changing diapers. Alcohol based hand sanitizers do NOT kill polio virus.

Who should be notified?
Polio is an immediately notifiable disease and should be reported to the Acute Disease Service Epi-on-call at 405-426-8710.

Respiratory Syncytial Virus (RSV)

What is it?
Respiratory Syncytial Virus or RSV is a viral infection of the respiratory system. It is the most common cause of acute respiratory diseases (such as bronchiolitis and pneumonia) in infants and young children.

What are the signs or symptoms?

- Runny nose, congestion, and cough for most children.
- Very young infants can also experience:
  - Irritability
  - Poor feeding
  - Lethargy
  - Cyanosis (turn blue with cough or brief periods of no breathing
- Respiratory problems include:
  - Bronchiolitis (wheezing from narrowed airways in lungs)
  - Pneumonia
  - Wheezing and asthma attack in children who already have asthma
- Children with weakened immune systems, prematurity, or heart or lung problems have greater difficulty when ill with this infection.

In the early stages of RSV, symptoms are similar to the common cold: runny nose, sore throat, and low-grade fever. In most cases, the illness will not pass this point and resolve on its own in a few days. If the virus spreads to the lungs, the child develops a cough, chest congestion, and an expiratory (breathing out) wheeze. If infection progresses, a more persistent cough and shortness of breath are possible.

How long does it take from exposure until the disease develops?
Usually from four to six days, but may range from two to eight days.

When is it contagious?
Usually, three to eight days.

How is it spread?

- RSV is highly contagious and spreads easily from person to person by direct contact with nose and mouth secretions.
- The virus can live on surfaces, toys, and hands and infected children shed the virus before symptoms appear.
- Droplets from a cough or sneeze may also spread the infection.

What should be done?

- Isolate the child only if other symptoms such as fever are present.
- Stress careful hand washing and appropriate hygiene with staff and children.
- Notify parents to pick up child immediately if he or she is having difficulty breathing and encourage medical supervision.

What can be done to prevent the spread of RSV?

- Practice frequent hand washing, especially when wiping a child's runny nose.
- Teach children to wash their hands after blowing their nose or coughing.
- Practice proper disposal of tissues.
- Clean and disinfect toys and hard surfaces frequently. Mouthed toys should be cleaned and sanitized after each use, or removed until cleaning takes place.
- Do not allow sharing of mouthed toys, bottles, cups or pacifiers.
- When possible, limit the time that children with high-risk conditions spend in child care centers during the RSV season.
- There is a medicine that can help protect some babies at high risk for severe RSV disease. Healthcare providers usually give this medicine (called palivizumab) to very premature infants and young children with certain heart and lung conditions as a series of monthly shots during RSV season.
- Children with RSV should stay home when having a fever or cough.

Who should be notified?

Other parents may be notified so they can be alert to symptoms in their own children. Very young children, infants, or those who have a compromised health status may be at risk for developing severe infection and complications.

Ringworm

What is it?
Ringworm is a fungal infection that may affect the body, feet, or scalp.

What are the signs or symptoms?
Skin
- Ringworm appears as a flat, growing, ring-shaped rash.
- The edges of the circle are usually reddish and may be raised, scaly and itchy.
- Another type of ringworm fungus can cause the skin to become lighter in flat patches, especially on the trunk and face.

Scalp
- Infection begins as a small bump and spreads outward, leaving scaly patches of temporary hair loss.
- Patchy areas of dandruff-like scaling with or without hair loss.
- Redness and scaling of scalp with broken hairs or patches of hair loss.

Feet
- The skin between the toes, scales and cracks.
- Blisters may be seen.
- On the nails, a chronic infection can cause thickening, discoloration and fragility.

How long does it take from exposure to development of ringworm?
It takes from 10 to 14 days.

When is it contagious?
A person with ringworm of the skin is infectious as long as the fungus remains present in the skin lesion. The fungus is no longer present when the lesion starts to shrink.

How is it spread?
- Ringworm is spread by direct contact with a person or animal infected with the fungus.
- It can also be spread indirectly through contact with articles (such as combs or clothing), or with surfaces which have been contaminated with the fungus.

What should be done?
- Isolate the child and call the child's parents.
- Recommend a visit to the child's health care provider.
- Practice good hygiene to keep ringworm from spreading.

When can the child be re-admitted?
- After prescription treatment and release by a health care provider.
- Once treatment has begun, there is usually no need to exclude the child, although you may need to cover areas infected with light gauze dressing.

Who should be notified? The parents of the infected child.

Rocky Mountain Spotted Fever

What is it?
Rocky Mountain Spotted Fever (RMSF) is a disease that a person gets from a tick bite. If left untreated, RMSF can be life threatening.

What are the signs or symptoms?
Early Symptoms (one to four Days of onset)

- High fever
- Severe headache
- Malaise
- Myalgia
- Edema around eyes and on the back of hands
- Gastrointestinal symptoms (nausea, vomiting, anorexia)

Late (5 Days after onset, if left untreated))

- Altered mental status, coma, cerebral edema
- Respiratory compromise (pulmonary edema, ARDS)
- Necrosis, requiring amputation
- Multiorgan system damage (CNS, renal failure)

How long does it take from exposure to development of disease?
Symptoms will start from three to 12 days after a tick bite.

When is it contagious?
RMSF is not contagious and cannot be spread from person to person.

How is it spread?
RMSF is spread from the bite of a tick. It cannot be spread from one child to another.

What should be done?

- If a child develops these symptoms, notify the parents to pick up the child and consult with the child's health care provider.

When can the child be re-admitted?
Children should be excluded until symptoms have resolved.

What can be done to prevent the spread of Rocky Mountain Spotted Fever?
Because RMSF is caused by tick bites, try to avoid areas that are tick infested and check protective measures to keep ticks from biting is key to reducing the risk of RMSF.

- Wear light-colored clothing to help see ticks more easily.
- Check kids each day for ticks – look in and behind ears, behind knees and under the arms.
- Consider using an insect repellent with 20% to 30% DEET.
- Since RMSF is a bacterial infection, it can be treated with antibiotics, which can substantially reduce the length of illness.

Who should be notified?
Because it is not spread person to person, cases of Rocky Mountain Spotted Fever identified in a child care setting are not required to be reported to your local health department.

Roseola

What is it?
Roseola is a viral infection causing fever or rash in infants and children that primarily occurs between six and twenty-four months.

What are the signs or symptoms?
- High fever (greater than 103 F) that lasts for three to five days
- The high fever can cause febrile seizures
- Runny nose
- Eyelid swelling
- Irritability and tiredness
- When the fever breaks a red, raised rash appears over the neck, chest and body and typically lasts from one to three days
- Some children will have no symptoms at all

How long does it take from exposure until the disease develops?
It can take nine to ten days.

When is it contagious?
After infection, the virus is present in the saliva on and off for the rest of a person's life.

How is it spread?
Through sneezing, coughing, direct contact, such as eating or drinking after an infected child or handling personal items of the child.

What should be done?
- Isolate from other children until parents arrive.
- A child with fever and rash should be excluded from child care until seen by a health care provider.

When can the child be re-admitted?
After the fever breaks, a child may return to care while the rash is still present, provided the child feels well and is able to participate in all activities.

What can be done to prevent Roseola?
Make sure all children and staff use good hand washing practices; especially after wiping or blowing noses, after contact with any nose, throat or eye secretions, and before touching food.

Rotavirus

What is it?

- A virus that causes diarrhea and vomiting.
- The disease occurs more frequently in cooler months.
- Nearly all children have been infected by the time they reach three years of age.
- Children can get infected more than once because the virus has many types.

What are the signs or symptoms?

- Severe watery diarrhea
- Nausea
- Vomiting
- Fever
- Stomach pain
- Dehydration in severe cases

How long does it take from exposure until the disease develops?

Symptoms usually begin about 24 to 72 hours after exposure.

When is it contagious?

It is most likely to be spread while a person has symptoms, especially diarrhea and vomiting. After symptoms are gone, people can still spread the virus for at least three more days.

How is it spread?

- Fecal-oral route: the virus is spread in the stool (poop) of people who are ill.
- It is spread by unclean hands, objects such as toys or surfaces, food and water.
- Rotavirus can stay on uncleaned objects and surfaces and still infect people after several days.
- People can spread the virus both before and after they become sick with diarrhea. They can also pass rotavirus to family members and other people with whom they have close contact.

What should be done?

Exclude from group settings if:

- Stool is not contained in the diaper for diapered children.
- Diarrhea is causing accidents for toilet trained children.
- Stool frequency exceeds two or more above normal for that child.
- Stool is all black, or there is blood or mucus in stool.
- The child meets other exclusion criteria, such as fever with behavior change.

Exclude any child or employee who has diarrhea along with illness, fever, or vomiting.

How is it treated?

- There is no treatment or cure. Antibiotic drugs will NOT help because antibiotics fight against bacteria not viruses.
- It is important to prevent dehydration by drinking plenty of fluids. If a child becomes severely dehydrated, he may need to receive intravenous (IV) fluids in a health care setting.

When can the child be re-admitted?

- Once diapered children have their stool contained by the diaper, and when toilet trained children do not have toileting accidents.
- When the child is well enough to participate in group activities.

What can be done to prevent the spread of Rotavirus?

- ***Rotavirus is a vaccine preventable disease***. Follow the most recent immunization recommendations.
- Practice good hand washing.
- Clean and sanitize objects and surfaces regularly.
- Exclude children from care when symptoms require it.

Roundworm Infection (Toxocariasis)

What is it?
Toxocariasis is an infection transmitted from animals to humans caused by the parasitic roundworms commonly found in the intestine of dogs and cats.

Who is at risk for *toxocariasis* or roundworm infection?
Anyone can become infected with *Toxocara.* However, some people are at higher risk of infection, including:

- Children
- People who accidentally eat dirt
- Dog or cat owners

How serious is infection with *Toxocara*?
- In most cases, *Toxocara* infections are not serious, and many people, especially adults infected by a small number of larvae (immature worms), may not notice any symptoms.
- The most severe cases are rare, but are more likely to occur in young children, who often play in dirt, or eat dirt contaminated by dog or cat feces.

What are the signs or symptoms?
- Many people do not have symptoms and do not ever get sick.
- Some people (usually children) get sick from the infection and may have:
  - Fever along with damage to organs in their body, problems breathing, or stomach pain.
  - Eye disease that causes vision problems, eye pain, or eye redness.

How is the roundworm infection spread?
- Dogs and cats infected with *Toxocara* shed *Toxocara* eggs in their feces.
- People become infected by accidentally swallowing dirt that has been contaminated with dog or cat feces that contain *Toxocara* eggs.
- Although it is rare, people can become infected from eating undercooked meat containing *Toxocara* larvae.
- The disease is not spread by person-to-person contact.

What should be done?
If you think a child may have roundworm infection, notify the parents and encourage them to take the child to their health care provider for an exam.

What can be done to prevent Roundworms?
- Use good hand washing practices – especially after playing outside or with animals.
- Supervise children closely outdoors and teach not to eat dirt.
- Dispose of dog and cat feces promptly and wash your hands after handling pet waste.
- Cover sandboxes and restrict animal access to play areas.
- Take your pets to the veterinarian to prevent infection with Toxocara. Your veterinarian can recommend a testing and treatment plan for de-worming.

Rubella (German Measles)

What is it?
Rubella, also called German measles or three-day measles, is a childhood disease caused by the rubella virus.

What are the signs or symptoms?
- Mild fever
- Swollen lymph glands behind the ears
- Red or pink rash appearing first on the face, then spreading down over the body
- Many experience joint aches or pain

How long does it take from exposure to development of the disease?
Two to three weeks.

When is it contagious?
- From seven days before rash appears through 14 days after rash appears.
- Children are most contagious three to four days before and until seven days after.

How is it spread?
It is spread by saliva and respiratory discharges from the nose and mouth, through the air, or on hands and surfaces.

What should be done?
- Isolate the child.
- Contact the parents to take the child home.

When can the child be re-admitted?
- Seven days after the onset of the rash.
- When the child is able to participate in daily activities.

What can be done to prevent the spread of Rubella?
- ***Rubella is a vaccine preventable disease***. Follow the most recent immunization recommendations.
- Strictly enforce good hand washing practices.
- Clean and sanitize objects and surfaces regularly.
- Make sure procedures for cleaning and disinfecting toys are being followed, and that toys are cleaned and disinfected between uses by children who are likely to put them in their mouths.
- All female staff in the childbearing years should have a blood test for sensitivity to rubella.
- Keep pregnant women, infants and unimmunized individuals away from a person ill with rubella.
- Carefully observe other children, staff, or family members for symptoms.

Who should be notified?
Notify the local health department, they will provide you with further information.

Salmonella

What is it?
It is an intestinal infection caused by *Salmonella* bacteria and is a common cause of diarrheal illness in the United States.

What are the signs and symptoms?
- Diarrhea
- Fever
- Abdominal pain
- Nausea and vomiting
- Sometimes blood or mucus in stool

How long does it take from exposure to development of disease?
It takes about 12 to 36 hours, though the earliest symptoms may start within six hours.

When is it contagious?
A person is able to infect others once they start having diarrhea.

How is it spread?
- Ingestion of contaminated food, water, meats, eggs, and unpasteurized milk.
- Fecal-oral route: contact with feces (poop) of infected children and animals.
- Animals such as birds, turtles and lizards often carry salmonella.

Should the child be excluded from group setting?
The child should be excluded from group care when:
- The diarrhea is not contained in the diaper for diapered children.
- Diarrhea is causing “accidents” for toilet-trained children.
- Stool frequency exceeds two or more stools above normal for that child.
- There is blood or mucus in the stool.
- The stool is all black.
- Dry mouth, no tears, or no urine output in eight hours.
- Child is unable to participate in daily activities.

When can the child be re-admitted?
The child should not return to care until 24 hours after diarrhea has stopped (without anti-diarrhea medication) and the child is able to participate in daily activities.

What can be done to prevent the spread of Salmonella?
- Use good hand hygiene at all times. Make sure children and staff wash their hands after handling animals and cleaning cages or pens.
- No reptiles or amphibians (turtles, snakes, lizards, iguanas, frogs, toads, and newts), in child care facilities or schools.
- Limit the serving of snacks and treats prepared outside the facility and served for special occasions to those from commercial sources.

- Do not serve children raw or undercooked eggs.
- Poultry and meat should be stored in a refrigerator and well-cooked, not pink in the middle.
- Children should not eat or drink raw or unpasteurized fruit juice or dairy products.
- Use proper sanitation methods for food processing, preparation, and service.

Who should be notified?

- Notify all parents and staff there is a case of salmonella.
- Notify the local health department. They will provide you with further information.

Scabies

What is it?
Scabies is a skin infection caused by a tiny bug called a mite. The mite burrows into the skin, causing a rash.

What are the signs or symptoms?
- Rash with severe itching (increased at night).
- Itchy red bumps or blisters found on fingers, toes, wrists, elbows, armpits, waistline, thighs, abdomen, genital area and lower buttocks.
- In infants and young toddlers, the rash may look different and can also occur on the face or scalp.

How long does it take after exposure before symptoms appear?
- Four to six weeks for those who have never been infected.
- One to four days for those who have been previously infected.

When is it contagious?
It is contagious until the mites and eggs are destroyed by treatment. The mites can survive only three days off the body and cannot jump or fly.

How is it spread?
Direct skin-to-skin contact and contact with contaminated clothing, towels, and bed linens is the usual way scabies is spread.

What should be done?
- Isolate the child.
- Notify the parents and request they take their child to a health care provider.
- Check other children for unrecognized cases.
- Notify parents of children who may have had direct contact with the infected person.

When can the child be re-admitted?
The child should not return to group care until diagnosed and treated for 24 hours. Household members should be checked and treated at the same time if necessary.

What can be done to prevent the spread of scabies?
- Proper and frequent hand washing.
- Look for signs of scabies in the morning health check and refer suspected cases.
- Do not share hats and jackets.
- Keep personal clothes and bedding separate.
- Launder bedding and clothes used in the 48 hours prior to treatment. Wash in a machine and dry in a hot dryer.
- Store difficult to wash items (such as stuffed toys and pillows) in tightly closed plastic bags for four days before using again.
- Vacuum carpets, upholstered furniture, and car seats.

Shigella

What is it?
Shigella is a bacterial infection of the large intestine.

What are the signs or symptoms?
- Loose, watery stools with blood or mucus
- Fever
- Headache
- Nausea and vomiting
- Abdominal pain
- Convulsions

How long does it take after exposure before symptoms appear?
Illness generally begins one to four days after exposure.

When is it contagious?
Although symptoms usually disappear without treatment after four to seven days, bacteria may still be passed through the stool for up to four weeks.

How is it spread?
- It is spread through the fecal-oral route: contact with stool (poop) of children who are ill.
- It is spread when diarrheal stools get on hands or objects and then onto other children's hands and mouths.
- It can also be spread through stool-contaminated food, drink, or water.

What should be done?
- Exclude child from group setting if stool is not contained in the diaper for diapered children, or diarrhea is causing "accidents" for toilet-trained children.
- When Shigella is identified, the child should not return to group care until completion of five days of antibiotics or two successive stool cultures are negative.

How is it treated?
- Drink plenty of fluids to prevent dehydration.
- Prescription antibiotics may be used during outbreaks, for severe illnesses or to protect people at high risk of complications.

What can be done to prevent the spread of Shigella?
- Practice proper hand washing techniques.
- Make sure procedures for cleaning and disinfecting toys are being followed, and that toys are cleaned and disinfected between uses by children who are likely to put them in their mouths.
- Eliminate access to shared water play areas during a known outbreak.

Who should be notified?

Notify your local health department if someone in your program has this disease. They will provide you with further information.

Prompt intervention may help prevent the spread of Shigella to others.

Shingles (Herpes Zoster)

What is it?
Shingles is a painful rash illness which looks like groups of small blisters. It is caused by the varicella zoster virus, the same virus that causes chickenpox. After a person has had chickenpox, the virus may reappear later as Shingles.

What are the signs or symptoms?
- Itching, tingling, and pain may occur before the rash starts.
- The rash begins with raised reddish bumps which become blisters.
- It usually appears on one side of the body.
- The blisters crust over and fall off after 7 to 10 days.
- Some people continue to have pain even after the rash is gone.

How long does it take from exposure to development of the disease?
- The virus can remain inactive in the body for many years after the original chickenpox infection.
- Exposure to shingles can cause chickenpox in a person who has not had chickenpox or the varicella vaccine.

When is it contagious?
The blisters of a person with shingles are contagious until they have dried and crusted.

How is it spread?
- A person can only get shingles if they have had chickenpox.
    - If a person has never had chickenpox and comes into contact with the virus, they will develop chickenpox.
    - If a person has had chickenpox before and comes into contact with the virus, they will develop shingles.
- A person with shingles can spread the virus when the rash is in the blister-phase.

What can be done to prevent the spread of the virus?
- Always use good hand washing practices.
- Avoid touching the rash area and cover the rash if participating or teaching in a group setting.
- There is now a ***shingles vaccine*** recommended for people 50 years of age and older.

Skin Infections including Staphylococcus ("Staph"), Impetigo and MRSA (Methicillin-resistant *Staphylococcus aureus)*

What are they?
Skin infections are usually caused by bacteria such as *Staphylococcus* (also known as "staph"). In most cases skin infections are not serious. However, some infections can become more dangerous. It is very important for skin infections that are not improving to be examined by a health care provider.

What are the signs or symptoms?
- Skin infections usually start as a "break" in the skin which becomes red and tender.
- The area may be swollen, and there may be pus.
- A skin infection may also look like a rash.

How are they spread?
Skin infections are spread from person to person by ***direct contact*** with someone's skin infection. Touching objects or surfaces that have had drainage from someone's skin infection can also spread infection. This is known as ***indirect contact***.

What should be done?
- Keep skin infections completely covered with a bandage.
- If the bandage becomes soaked or loose, remove it and throw it away in a trash can, wash your hands, then place a clean bandage over the infection.
- If the infection cannot be covered by a bandage, or if the child or worker will not leave the bandage on, then they need to be excluded from the child care setting until the infection has healed or can be kept covered.

How is it treated?
Most skin infections will heal by keeping the area clean and covered with a bandage. Antibiotics are rarely needed. If a skin infection does not improve, or if it spreads, ask the parent to take the child to see his health care provider.

When can the child be re-admitted?
A child with a skin infection can attend child care if the infected area can be completely covered by a bandage, and if the child is cooperative in leaving the bandage in place.

What can be done to prevent skin infections?
When you first notice a break in your skin, wash it with soap and running water, and then put a clean, dry bandage over it. Change the bandage if it becomes wet, dirty or loose. Keeping your skin clean and free from contamination will help to prevent skin infections.

What can be done to prevent spreading skin infections to others?

You can prevent spreading skin infections to others by following these steps:

1. Keep any skin infections covered with clean, dry bandages, especially if pus or drainage is present. Keep any drainage from getting on others, or on objects or surfaces.
2. Wash your hands often, especially after touching the area of infected skin, and before touching anything else.
3. Advise your family and others to wash their hands more often, especially if they touched the affected area or any items that had contact with it.
4. Wear disposable latex or vinyl gloves if you are caring for a skin infection other than your own. Always remove and dispose of gloves immediately and wash your hands with soap and water.
5. Do not share personal items such as towels, washcloths, razors, clothing, or uniforms that may have had contact with pus or drainage.
6. Wash soiled bed linens and clothes with hot water (at least 160° F), laundry detergent and (when possible) bleach. Using the hottest setting on your clothes dryer (commercial dryers are hottest) instead of air-drying will help kill bacteria.
7. Put all bandages or items with any pus or drainage (including blood and nasal discharge) immediately into the trash.
8. Clean all possible contaminated surfaces with a commercial disinfectant or with a bleach water solution recommended for disinfecting. The bleach water solution must be mixed fresh daily.

Strep Throat and Scarlet Fever

What are they?
A variety of infections, including strep throat, scarlet fever and impetigo are caused by Group A Streptococci bacteria.

What are the signs or symptoms?
***Signs of strep throat*:**

- Very red and painful throat
- Fever
- Tender and swollen lymph nodes in neck
- Headache
- Stomachache
- Decreased appetite

Scarlet fever is a type of streptococcal infection characterized by a skin rash.

- Fine red bumps that feel like sandpaper
- Rash appears on the neck, chest, armpit and groin area and may only last a few hours
- Flushed cheeks
- Paleness around the mouth
- A red tongue that resembles the surface of a strawberry

How long does it take from exposure before symptoms appear?
Two to five days.

When is it contagious?
Strep throat is probably contagious before symptoms appear and continues to be infectious until treated for 24 hours.

How is it spread?

- The Group A Streptococci are transmitted from one person to another through direct contact with the respiratory discharges of infected persons.
- Contact with the respiratory secretions from or objects contaminated by people who carry strep bacteria.
- Close contact helps the spread of the infection.

What should be done?

- Isolate the child from the other children.
- Contact the parents to pick up the child and consult with the child's health care provider.

When can the child be readmitted?
If the health care provider diagnoses strep throat, the child may return 24 hours after antibiotics have been started.

What can be done to prevent the spread of Strep?

- Make sure all children and adults use careful hand washing practices.
- Teach children to cough and sneeze into their elbow, wipe noses with clean tissues, throw the tissue into the wastebasket, and wash hands.
- Do not allow food to be shared.
- Do not kiss children on the mouth.
- Open windows indoors and maximize outdoor play.
- Parents who become aware that their child has strep throat or scarlet fever should inform caregivers.

Styes and Eyelid Conditions

What is it?
A stye is a mild infection in the eyelid at the base of the eyelashes or near the edge of the eyelid.

What are the signs or symptoms?
- A red bump on or near the edge of the eyelid that is similar to a pimple
- Eyelid pain
- Eyelid swelling
- Tearing

Styes typically don't cause vision problems.

When is it contagious and how is it spread?
- Styes may drain pus that contains bacteria. This could be contagious to others, but the drainage period is usually brief.
- Styes are contagious, but everyone has the stye causing bacteria in their body. At any age we have the potential to develop a stye without outside contamination.

What should be done?
- Never "pop" a stye.
- Most styes heal on their own within a few days.
- To encourage healing and provide comfort apply warm compresses to eye for 10 minutes three or four time a day.

Other eyelid conditions:
- **Chalazia**: often mistaken for a stye, a chalazion (kah-LAY-zee-on) is an enlarged, blocked oil gland in the eyelid. A chalazion mimics a stye for the first few days, then turns into a painless hard, round bump later on.
  - Most chalazia develop farther from the eyelid edge than styes. The same treatment used for a stye speeds the healing of a chalazion, though the bump may linger for one to several months.
  - If the chalazion remains after several months, an eye doctor may drain it or inject a steroid to facilitate healing.

- **Milia:** also called "milk spots" or "oil seeds," milia are tiny white cysts, usually appearing on the outer skin layer (epidermis) of the eyelid and around the eyes and nose.
  - They occur when dead skin cells don't slough off normally and are trapped at the base of a sweat gland or hair follicle, forming a raised "pinhead" bump that looks similar to a whitehead.
  - Milia are most common in newborns, but adults also can be affected. In babies, milia tend to clear up on their own over a week or two, but most adults will require medical treatment.

  - The preferred method of removing a bothersome milial cyst is by a simple surgical excision (no stitch is needed) by your dermatologist.
- **Xanthelasma:** A subtype of xanthoma (zan-THOE-mah), this skin condition is characterized by yellowish bumps (plaques) under the skin, occurring on or around the eyelids.
  - Xanthelasma (zan-thah-LAZ-mah) generally appear as disc-like lesions with a flat surface and well-defined borders, ranging in size from several millimeters up to three inches in severe cases.
  - They are usually non-symptomatic, but can be surgically removed by your doctor for cosmetic purposes.
  - They are caused by a build-up of certain fats, namely cholesterol, under the surface of the skin and often are attributed to elevated lipid levels in the blood stream such as high cholesterol.
  - The growth is non-cancerous, but elevated blood lipids could increase your risk of cardiovascular disease and should be investigated further by your doctor.

See the ***All About Vision*** website for further information. http://www.allaboutvision.com

Thrush

What is it?
Thrush is a yeast-like fungus infection.

What are the signs or symptoms?
- White lesions on inner cheeks and tongue, and sometimes on the roof of the mouth, gums and tonsils.
- Slightly raised lesions with a cottage cheese-like appearance.
- Redness or soreness that may be severe enough to cause difficulty eating or swallowing.
- Slight bleeding if the lesions are rubbed or scraped.
- Cracking and redness at the corners of the mouth.

Infants and breastfeeding mothers
- In addition, the distinctive white mouth lesions, infants may have trouble feeding or be fussy and irritable.
- The infants can pass the infection to their mothers during breast feeding.
- The infection may then pass back and forth between the mother's breasts and the baby's mouth.

When is it contagious?
As long as the white lesions are present.

How is it spread?
- Person to person contact.
- Babies sharing the same bottles, cups, and eating utensils.
- From breastfeeding mothers to their babies and back to the mothers.

What should be done?
- Notify the child's parent about possible thrush.
- Ask parent to seek medical attention for the child.

When can the child be re-admitted?
The infected child does not need to be excluded.

What can be done to prevent the spread of Thrush?
- Closely supervise the use of pacifiers and bottles.
- Use good hand washing practices at all times.
- Use disposable eating utensils for the infected child.
- Wash and sanitize all toys mouthed by children.

Tuberculosis (TB)

What is it?
Tuberculosis (TB) is an infectious disease caused by bacteria, which usually affects the lungs. However, other parts of the body can also be affected.

What are the signs or symptoms?
General symptoms may include:

- Feeling week or sick
- Weight loss
- Fever
- Night sweats
- Cough
- Chest pain

Most children initially infected with the bacteria do not have signs or symptoms.

- Two to ten weeks after initial infection, they will react to a tuberculin skin test.
- If an infected child does develop signs or symptoms of TB, it most often occurs one to six months after the initial infection and may include:
    - Chronic cough
    - Weight loss
    - Fever
    - Growth delay
    - Night sweats
    - Chills

How long does it take from exposure to development of the disease?
The risk of disease after infection is highest in the first two years, but the bacteria can be carried in the body for many years before active disease develops.

When is it contagious?

- Individuals with infection but without active disease are not contagious – they are referred to as latent TB infection.
- Adults and some adolescents who have active TB spread the bacteria by coughing and contaminating the environment.
- The disease will remain active in someone who has developed symptoms of TB until the person is treated.

How is it spread?

- Airborne route: breathing small particles containing these bacteria in the air, as a result of someone with active TB coughing or sneezing.
- Infection of children is nearly always the result of close contact with an adult who has active TB.
- Generally, infants and children with active TB disease are not contagious because when they cough, they do not create enough force to expel large numbers of TB germs into the air.

What should be done and how do you prevent the spread of TB?

- Make sure all children and adults use good hand washing practices.
- Teach children and staff to cough and sneeze into their elbow, wipe noses with clean tissues, throw the tissue into the wastebasket, and wash hands.
- Provide adequate ventilation.
- Tuberculin skin testing of children and staff may be necessary if there has been an exposure to TB.
- Exclude children and adults with active TB infection and ensure they receive prescribed medication from their health care provider.

When can the child with active TB be re-admitted?

- After prescribe medication has been started.
- When the child is approved to return by local health officials and is considered noninfectious to others.
- When the child is able to participate in daily activities.

Who should be notified?

Notify the local health department. They will provide you with further information.

Urinary Tract Infection

What is it?
A urinary tract infection is an infection of one or more parts of the urinary system – the kidneys, the tubes that join the kidneys to the bladder (ureters), the bladder, and the tube that leads from the bladder to the outside (the urethra).

What are the signs or symptoms?
- Pain, burning, stinging sensation when urinating.
- Increased urge to urinate or frequent urination.
- Fever.
- Wetting problems in children that are toilet trained.
- Low back pain or abdominal pain in the area of the bladder (below the navel).
- Foul-smelling urine that may look cloudy or contain blood.

Signs and symptoms in infants and toddlers (children still in diapers) may be very general – they may seem irritable and have a poor appetite. Sometimes the only symptom is a fever that doesn't go away.

When is it contagious?
Urinary tract infections are not contagious.

How is it spread?
- Infection usually occurs from bacteria from feces on the skin that enter the urethra, particularly in girls.
- Urinary infection is more common in children with constipation and who do not fully empty their bladders when voiding.
- Less commonly, it is caused by bacteria from the bloodstream entering the kidneys.
- Urinary tract infection is not passed from one person to another.

What should be done?
- Keep track of the child's trips to the bathroom and symptoms.
- Notify the parents if the symptoms are a concern, and recommend they contact the child's health care provider.
- Urinary tract infections are treated with antibiotics.
- There is no reason to exclude a child with a urinary tract infection unless the child meets other exclusion criteria or is unable to participate in daily activities.

What can be done to prevent the spread of urinary tract infections?
- For infants and toddlers – change diapers frequently and clean up correctly.
- Teach children good hygiene, and to wipe from front to back.
- Children should be taught not to "hold it in" when they have to go because urine that remains in the bladder gives bacteria a good place to grow.
- Encourage children to drink plenty of fluids (water).
- Girls should avoid bubble baths and strong soaps that might cause irritation.

Vomiting

What is it?
Vomiting is the forcible emptying of the stomach contents through the mouth.

What are the signs or symptoms?
- Children with vomiting from an infection often have diarrhea and sometimes fever.
- Prolonged or severe vomiting can result in children becoming dehydrated, which means their bodies lose nutrients and water, leading to further illnesses.

When is it contagious?
If the vomiting is associated with an infection, the contagious period depends on the type of germ causing the infection.

How is it spread?
Direct contact with vomit can result in the spread of certain infections.

What should be done?
- Use good hand washing practices at all times.
- Clean and disinfect surfaces that have been contaminated with body fluids.
- Exclude children if:
  - Vomited more than two times in 24 hours.
  - There is vomiting and fever.
  - Vomit appears green or bloody.
  - There is no urine output in eight hours.
  - There is a history of a recent head injury.
  - The child looks or acts very ill.

When can the child be re-admitted?
- When the vomiting has stopped for at least 24 hours.
- When the child is able to participate in daily activities.

Warts

What are warts? Warts are skin growths caused by a virus called human papilloma virus. There are many different types of human papilloma viruses. Some cause warts on the hands, some on the feet and some in the genital areas.

What are the signs or symptoms?

- Warts may appear as a single bump or a series of bumps on the skin.
- They may have a “cauliflower” appearance.
- Warts are generally painless unless they are irritated.

Who is at risk for warts? People of all ages can get warts.

How long does it take from exposure until warts develops? It can take weeks or months before a wart appears after the skin is infected.

When is it contagious? This is not known. It might be as long as a person has warts.

How are warts spread?

- Warts are spread by direct contact with someone who has warts.
- Some warts, such as warts on the bottoms of the feet (called plantar warts), can be caused by contact with contaminated surfaces such as public shower floors.

How is a person diagnosed? It depends on the type of warts a person has. Refer the parent to their health care provider if needed.

What is the treatment? Warts may not always need to be treated, but if so, the treatments can vary. Warts can by removed by freezing, chemical, or surgical means if needed.

Should children or others be excluded from child care, school, work or other activities if they have warts?
Exclusion is not necessary since warts are not likely to cause serious health problems.

What can be done to prevent the spread of warts?
Good and frequent hand washing, along with keeping surfaces and objects cleaned and disinfected are important to prevent the spread of warts.

West Nile Virus

What is it?
West Nile Virus is a disease found in the U.S. and is the most common mosquito borne illness.

What are the signs or symptoms?
Common symptoms of WNV disease include:

- Fever
- Headache
- Body aches
- Rash
- Joint pain
- Vomiting
- Diarrhea
- Fatigue
- More rare but serious symptoms are encephalitis (inflammation of the brain) or meningitis (inflammation around the brain and spinal cord).

How long does it take from exposure to development of disease?
A person who is exposed to West Nile Virus will start to have symptoms between five and 15 days later.

When is it contagious?
West Nile Virus disease cannot be spread from person to person. It is commonly spread through a mosquito bite. In rare cases it can be spread through blood transfusion, organ donation, laboratory exposure and mother to baby.

How is it spread?
It is commonly spread through a mosquito bite. It cannot be spread from one child to another.

What should be done?
If a child or staff member develops these symptoms, remove him/her from contact with others and contact guardians to take the child home. A child or staff member should immediately see their primary care provider.

When should people be excluded and when can they return?
Children or staff should be excluded until symptoms have resolved.

What can be done to prevent the spread of West Nile Virus?
WNV is not spread person to person so there is low risk for transmission between children. Because WNV is spread through mosquito bites, protection from mosquito bites is key to reducing the risk of becoming ill.

Who should be notified?
Because it is not spread person to person, cases of West Nile Virus identified in a child care setting are not required to be reported to the health department.

Whooping Cough (Pertussis)

What is it?
Whooping cough is a serious respiratory infection caused by bacteria that is highly contagious. It gets its name from the whooping sound the child makes when trying to inhale after a coughing spell. Pertussis is a severe infection that would require a public health investigation. However, a similar virus called parapertussis is less severe and does not require a public health investigation.

What are the signs or symptoms?
- Begins with cold-like symptoms – runny nose and cough.
- Coughing may progress to severe coughing, which may cause:
  - Vomiting
  - Loss of breath, difficulty catching breath
  - Cyanosis (blueness)
- Whooping sound when inhaling after a period of coughing.
- Coughing persists for weeks to months.
- Usually, no fever or very minimal.
- Symptoms are more severe in infants younger than one year.
- Infants may develop complications that require hospitalization, such as:
  - Pneumonia
  - Ear infections
  - Swelling of the brain

How long does it take from exposure to development of the disease?
Five to 21 days.

When is it contagious?
From the beginning of symptoms until two weeks after the cough begins, depending on age, immunization status, previous episodes of infection, and antibiotic treatment.

How is it spread?
It is spread through the air after an infected person coughs or sneezes, and other people breathe in infected droplets (Respiratory route).

What should be done?
- Isolate the child with symptoms from other children until parents arrive. Recommend parents take the child to the health care provider and ask them to let you know what they find out.
- Watch for symptoms in other children and exclude infected persons from the program.

When can infected children and staff return to the program?
- After five days of appropriate antibiotic treatment, or after three weeks from the beginning of the cough if antibiotics are not used.
- And when the child is well enough to participate in group activities.

What can be done to prevent the spread of Whooping Cough?

- **Whooping Cough is a vaccine-preventable disease**. Require up-to-date immunizations for all children in your care.
- Always use good hand washing practices.
- Teach children and staff to “Cover Your Cough” using a tissue (followed immediately by hand hygiene) or by covering their coughs or sneezes with their sleeves.
- Monitor all children and staff for coughs. Anyone developing a persistent cough should be referred to their health care provider.

Who should be notified?

Notify your local health department if someone in your program has this disease. They will provide you with further information.

Zika

What is it?
Zika is a disease caused by the Zika virus. It is rare in the United States and is usually associated with travel.

What are the signs or symptoms?
Symptoms include:

- fever
- rash
- joint pain
- red eyes
- muscle pain

Symptoms usually last from a few days to a week.

How long does it take from exposure to development of disease?
After someone is exposed to Zika symptoms usually begin three to 14 days later.

When is it contagious?
A person cannot get Zika from close contact with another person. A person can become infected by an ill person through sexual contact.

How is it spread?
Zika is spread through the bite of an infected mosquito, from a pregnant person to baby, and through sex.

What should be done?
If a child develops these symptoms, notify the parents to pick up the child and consult with the child's health care provider.

When should people be excluded and when can they return?
Children should be excluded until symptoms have resolved.

What can be done to prevent the spread of Zika?
For those in areas where Zika is common or those who have traveled to an area where Zika is common, prevention of mosquito bites is key to reducing the risk of getting Zika. Pregnant women should avoid traveling to areas where Zika is common because of the severe risks for the baby. Men who are ill with Zika should use condoms or consider not having sex for 3 months after symptoms start.

Who should be notified?
Because it is not spread person to person in most instances, cases of Zika virus identified in a child care setting are not required to be reported to your local health department.

Chapter 6: Managing Chronic Medical Conditions and Special Health Care Needs

Alphabetical listing of medical conditions and special health care needs

Managing Chronic Medical Conditions and Special Health Care Needs

Definition
Children and Youth with Special Health Care Needs (CYSHCN) are children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions. They also require health and related services of a type or amount beyond that required by children generally.

Inclusion in All Activities
All children should be included in all activities possible unless a specific medical contraindication exists. Federal and state laws do not permit discrimination on the basis of the disability (Americans with Disabilities Act [ADA] and Section 504 of the Rehabilitation Act).

The ADA requires that child care providers not discriminate against persons with disabilities on the basis of disability, that is, that they provide children and parents with disabilities with an equal opportunity to participate in the child care center or family child care home's activities and services. Specifically:

- Child care programs cannot exclude children with disabilities unless their presence would pose a *direct threat* to the health or safety of others or require a *fundamental alteration* of the program.
- Child care programs have to make *reasonable modifications* to their policies and practices to integrate children, parents, and guardians with disabilities into their programs unless doing so would constitute a *fundamental alteration*.
- Child care programs must provide appropriate auxiliary aids and services needed for *effective communication* with children or adults with disabilities, when doing so would not constitute an *undue burden*.
- Child care programs must generally make their facilities accessible to persons with disabilities. Existing facilities are subject to the *readily achievable* standard for barrier removal, while newly constructed facilities and any altered portions of existing facilities must be *fully accessible*.

All children benefit from inclusion. Inclusion allows a child with a disability to see and learn from their peers. If a child needs to learn new words, a room full of their peers talking and playing is the best place for modeling and learning. For the typical child, an inclusive environment helps them learn about differences and helping others.

Studies have found many benefits to inclusive child care:

- Children with special needs develop increased social skills and self-esteem.
- Families of children with special needs gain social support and develop more positive attitudes about their child.
- Children and families without special needs become more understanding and accepting of differences and disabilities.
- Child care providers and teachers learn from working with the children and families, and service providers and develop skills in individualizing care for all children.

Inclusion and participation of children with special health care needs requires proactive planning:

- The facility must plan for the resources, support, and education necessary to increase the understanding and knowledge of staff, as well as the parents and the children without disabilities within the program.
- Remember safety considerations throughout the program.
- Develop a service plan.

Developing a service plan

To serve children with disabilities or special health care needs, caregivers should take a flexible approach to combine and deliver services. Parents must be involved to assure that the plan is compatible with their expectations and meets their child's needs.

In facilities that are not designed primarily to serve a population with disabilities or special health care needs, the additional therapeutic services may be obtained through consultants or arrangements with outside programs serving children with disabilities or children with special health care needs.

An ***Individualized Family Service Plan (IFSP)*** is a document intended to help families and professionals within a community to support the special needs of a child under three years of age. The IFSP is developed based on in-depth assessments of the child by a variety of professionals. In addition to learning goals and supports, the IFSP documents the child's current developmental level, describes outcomes for the child and family, and specifies community services for the child and family that will support the development of the whole child. IFSP teams must include the parent or guardian and other team members may include medical professionals, physical and occupational therapists, speech therapists, child development specialists, child care providers, early intervention specialists, social workers, and others.

An ***Individualized Education Program (IEP)*** is a plan that is developed to guide the education of a child with special needs between ages three and 21 in the early childhood or school setting. The federal *Individuals with Disabilities Education Act (IDEA)* requires that all children with an identified special need have an IEP to help educators meet their unique educational needs. The IEP is a team-based effort that includes the child's parents, child care providers, school staff, doctors, therapists, and even the child when appropriate. At every step, the family is involved to ensure that the decisions made are best for them and their child.

An IEP is a written document that describes the ways that an individual child learns best, the measures and assessments that are most appropriate to document that child's learning, and the supports and special educational services that the child needs in order to learn most successfully. An IEP must be reviewed and updated regularly to ensure that it continues to be appropriate for the child's learning progress and special needs.

The IEP and IFSP can be effective tools to help educators make decisions about the most effective care and education practices for a young child with special needs. **Child care providers may be members of a team that creates, reviews, and revises the IEP or IFSP for a child in their child care program**. If you are asked to be a team member, here are some of the things you may contribute:

- **Observations of the child's development**. IEPs and IFSPs are based on observations of the child with special needs. Child care providers may be able to add valuable information from the day-in, day-out interactions with the child.
- **Documentation**. The IEP or IFSP team may ask to see any documentation kept about the child with special needs, including notes, goals, information learned from the family, photographs of the child engaged in learning activities, and samples of the child's artwork, writing, and other materials.
- **Information about the early childhood curriculum**. Child care providers may be asked to share information about curriculum goals, activities, and plans, as well as information about the physical layout of the classroom or family child care home.

From the U.S. Department of Justice Civil Rights Division, *Disability Rights Section* https://ada.gov and the Extension Alliance for Better Child Care https://childcare.extension.org

The **Oklahoma Family Network** provides support for Oklahoma families. Oklahoma Family Network (OFN) focuses on supporting families of children and youth with special needs via emotional support, resource navigation, and ensuring quality healthcare for all children and families through strong and effective family/professional partnerships.

OFN promotes family-centered care and provides tools so families and individuals can make informed decisions, advocate for improved services, build partnerships among professionals and families, and serve as a trusted resource. www.oklahomafamilynetwork.org

Allergies

What are allergies?

Allergy is the term used to describe the body's over-reaction to something it views as foreign or different. An allergic reaction is a response in various parts of the body to a substance that has been inhaled, eaten, injected (from stings or medicine), or that came into contact with the skin. The body reacts by releasing histamine and other substances that cause allergy symptoms.

Allergy symptoms can be as minor as sneezing and itching. For some children, however, allergy symptoms can become very serious or even life-threatening.

What are the signs or symptoms?

Allergies produce many different symptoms, including:

- Stuffy nose
- Runny nose
- Itchy, watery eyes
- Hives
- Eczema
- Wheezing
- Itching of roof of mouth
- Swelling of throat or mouth
- Swelling of the skin
- Stomach cramps

How long does it take after the child is exposed to an allergenic substance before a reaction occurs?

Anywhere from seconds to weeks: it varies with the child, the substance, and many other factors.

When is an allergy contagious?

Never.

What causes allergies?

There are many things that can cause allergic reactions:

- Lotions, oils, perfumes, soaps
- Cigarette smoke
- Wool, polyesters, and other fabrics
- Foods (chocolate, nuts, cow's milk, wheat, soy, shellfish, strawberries, eggs, and others)
- Pollen from grass, flowering plants, trees, and shrubs
- Prescription and over-the counter medications
- Animal dander
- Dust mites
- Saliva and venom from insect stings

What should be done?
Find out about a child's allergies at the time of enrollment. If a child has asthma, this information should be on file, along with the recommended treatment, and the name and phone number of the health care provider.

Try to be sure the child avoids the offending substance if possible. Do not give medication of any kind to an allergic or asthmatic child, unless it is recommended by the child's health care provider and you have written permission from the child's parent.

Managing Food Allergies in Child Care

All food allergies occur when the immune system mistakes a protein in a food as a dangerous invader and produces chemicals to protect the body. This triggers an allergic reaction.

Symptoms of an allergic reaction vary, but can include:

- Difficulty breathing
- Swelling of the tongue and throat
- Itching inside the mouth
- Vomiting
- Abdominal cramps and diarrhea
- Hives
- Eczema

In severe cases, a whole-body allergic reaction can occur, also known as anaphylaxis. Anaphylaxis is an extremely serious reaction and can result in loss of consciousness and even death, but it can be treated with a drug called epinephrine.

The primary way to prevent the possibility of an allergic reaction is strict avoidance of the allergy causing food. Allergic reactions can be triggered by eating the food, contact with the food, or, in some cases, by just being near the food.

Young children have the highest incidence of food allergies of any age group. The most common food allergens in young children are:

- Cows' milk
- Eggs
- Soybeans
- Wheat
- Peanuts
- Tree nuts (almonds, cashews, pecans, walnuts)
- Fish
- Shellfish

When a child has an allergic reaction, he or she tends to describe it in very different terms than adults use. Children may say things like: "My tongue/mouth itches", "It (my tongue) feels like there is hair on it", or "My tongue (or mouth) is tingling (or burning)".

Child care providers should discuss allergic reaction symptoms and how the child talks about the reaction with the child's parent. Child care providers need to be alert for the verbal cues and body language the child uses in the event of an allergic reaction.

A child could have a first allergic reaction while in your care, so staff training should be conducted by a child care health consultant or other health care provider. The training should include information on how to:

- Recognize the symptoms of an allergic reaction.
- Treat an allergic reaction.
- Prevent exposure to the food causing the allergic reaction for the child with a known food allergy.
- Develop policies and procedures and communicate the policies to parents so they are understood.
- Maintain required documentation about the child's food allergies, and the appropriate steps taken to keep the allergy causing foods away from the child.

A treatment plan should be developed by the child care provider and the parent with information from the child's health care provider that includes:

- What foods may trigger an allergic reaction.
- Steps for avoiding the food.
- Treatment in the event of an allergic reaction.
- When to contact emergency services.

The specifics of a child's food allergies, along with up-to-date documentation, should be maintained in the child's records. Any forms and correspondence between the child care provider, the child's family, and the child's health care provider should be included along with any other relevant information.

Child care programs should have a written policy for food allergies that specifically defines the responsibilities of the child's family and the child care program in managing the food allergy. The family's responsibilities include providing documentation of the food allergy from the child's health care provider, providing instructions that need to be taken for avoiding the allergic food, and supplying the medical provider's order for medication administration.

Management of a food allergy requires careful menu planning. Everyone involved in preparing and serving food should be vigilant about accommodating food allergies. Train staff to carefully read food labels and recognize allergens in the ingredient lists. Organize kitchen space to keep food for a food allergic child separate from other foods. Prepare foods for the child with food allergies first in order to prevent cross-contamination. Closely supervise children during meals and snacks to discourage food sharing between a child without a food allergy and one with a food allergy.

Field Trips and Special Events

Young children enjoy field trips, celebrations, and parties. Planning is the key for children with food allergies. You may provide a safe food alternative or you may ask the family to bring one on those special days.

Resources:

Centers for Disease Control and Prevention, *Voluntary Guidelines for Managing Food Allergies in Schools and Early Care and Education Programs*. Washington, DC: U.S. Department of Health and Human Services; 2013.

Food Allergies in Early Childhood
https://foodallergy.org/resources/food-allergies-early-childhood

Anemia

What is it?
Anemia is a condition in which blood has a lower than normal number of red blood cells. Anemia can also occur if red blood cells don't contain enough hemoglobin. Hemoglobin is an iron-rich protein that gives blood its red color. This protein helps red blood cells carry oxygen from the lungs to the rest of the body.

If you have anemia, your body doesn't get enough oxygen-rich blood. As a result, you may feel tired or weak. Other symptoms include:

- Pale skin
- A fast or irregular heartbeat
- Shortness of breath
- Dizziness
- Cold hands and feet
- Headache

Anemia can be caused by many things, but the three main bodily mechanisms that produce it are:

1. **Excessive destruction of red blood cells**: sickle cell disease, toxins from liver or kidney disease
2. **Blood loss**: gastrointestinal conditions, menstruation and childbirth
3. **Inadequate production of red blood cells**: kidney disease, diabetes, rheumatoid arthritis

Lead poisoning can lead to anemia.

- Anemia makes it easier for lead to get into the blood.
- Lead poisoning and anemia are both detected by a blood test.
- Lead poisoning and iron deficiency anemia are both preventable.
- Practice good nutrition and proper handwashing to help prevent lead poisoning and iron deficiency anemia.

Iron-deficiency anemia, and other nutritional anemias can be prevented and mild cases can be reversed by eating diets high in iron. Vitamin C helps the body use iron, so ***combine foods high in iron and vitamin C*** in meals and snacks.

Some foods high in iron

Beef
Pork
Liver
Tofu
Cooked beans
Dried fruit
Iron-fortified cereals
Enriched tortillas and breads
Leafy greens

Some foods high in vitamin C

Broccoli
Cabbage
Cauliflower
Tomatoes
Potatoes
Bell peppers
Oranges
Melon
Strawberries

Asthma

Asthma is the most common chronic disease among children who use child care. It occurs in seven. to 10 percent of all preschool and school-aged children. With appropriate care at the health care provider's office, home and child care, most children with asthma do extremely well in child care settings and can participate in all activities.

Asthma is a condition in which the air passages of the lungs become temporarily narrowed and swollen and produce a thick clear mucous, causing the child to have difficulty breathing. The symptoms can disappear temporarily with treatment and/or removal from whatever is causing the asthma. Asthma can be controlled, but it never truly goes away. Inflammation from uncontrolled asthma can cause scarring of the lungs and airways.

Signs and symptoms of asthma

Each child may have different asthma symptoms. The parents and health care provider should tell you what to watch for.

- Coughing (children often have a cough as an early or only symptom of asthma)
- Complaint of tightness in the chest
- Wheezing
- Rapid breathing or difficulty breathing
- Decrease in peak flow meter reading
- Unusual tiredness
- Difficulty playing, eating, or talking

Indications of severe asthma episode:

- Flaring nostrils or mouth open
- Bluish color to the lips or nails (late sign: call 911)
- Sucking in chest or neck muscles (retractions)

Asthma triggers

Asthma episodes are usually started by "triggers," events that begin an asthma attack. Each child will have different triggers. Not every child has identified triggers.

- Allergies to substances such as pollen, mold, cockroaches, animal dander, or dust mites.
- Allergies to a particular food.
- Infections such as colds or other viruses.
- Cold air or sudden temperature or weather changes.
- Exercise or overexertion.
- Very strong emotions such as laughing, crying and stress.

Discuss a child's asthma history with the parent at enrollment. Have parent document information regarding medications, a description of the child's triggers, symptoms, and a plan of what to do during an attack. This information should be entered on the child's Asthma Action Plan (see a sample in the Appendix).

Procedure When Child Has an Asthma Episode

- Remove the child from the trigger, if known.
- Remove the child from strenuous play activities (running, jumping, etc.).
- Have the child sit upright and try to keep the child calm and relaxed.
- Encourage the child to drink fluids (but nothing ice cold).
- Administer medications as indicated by the parent and health care provider.
- Notify all staff of signs that may signal an impending attack.
- If you are unsure, it is better to call the parents to take the child to the health care provider, than wait until the child is in severe distress. Every child is different and will need an individualized treatment plan.

It is a good idea to provide staff training on asthma, including signs and symptoms of asthma, administration of medications, and the asthma emergency plan.

Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder (ADHD) is a condition that causes a person to be overactive and impulsive or have a hard time paying attention, or both. These behaviors may begin in early childhood or not detected until a child is older.

Diagnosis

ADHD affects approximately three to five percent of all school-age children and is three times more common in boys than girls. Many children continue to have behaviors of ADHD as adults. ADHD affects all socioeconomic, cultural, and racial backgrounds. More than 20 percent of children with ADHD also have learning disabilities. However, having a diagnosis of ADHD or a learning disability is not related to intelligence.

Diagnosis of ADHD is made by a physician, psychiatrist, psychologist, or licensed social worker, with close collaboration and input from the parents, teachers, and child care providers. Children with ADHD demonstrate behaviors that generally fall into **three categories**: inattention, hyperactivity, and impulsivity.

Examples of inattention (trouble paying attention) include a child who:

- Makes careless mistakes.
- Has difficulty paying attention in tasks or play activities.
- Does not seem to listen to what is being said.
- Does not follow through or finish activities or tasks.
- Avoids or strongly dislikes routine tasks or activities.
- Is easily distracted and forgetful.

Examples of hyperactivity (being very active) include a child who:

- Fidgets with hands and feet, or squirms in seat.
- Has difficulty playing quietly.
- Is “on the go” or acts as if “driven by a motor”.
- Talks excessively.
- Has difficulty waiting in line or for a turn.

Examples of impulsivity (acting before thinking) include a child who:

- Blurts out answers to questions before they have been completed.
- Has difficulty waiting in lines or waiting for a turn.
- Interrupts or intrudes on others.

All of these behaviors are common for children at different ages and stages of development. Many two-year-olds are “on the go” and many three and four-year-olds fidget when seated. For a child to be diagnosed with ADHD, some of these behaviors must have appeared before the child was seven years of age, have lasted for at least six months, and be happening enough to cause concern at home and school, and possibly the child care setting.

Causes
Scientists have not been able to determine the exact cause of ADHD, though research suggests it may be caused by a chemical imbalance or a lack of certain chemicals in the brain responsible for attention and activity. There is evidence that if one or both parents have ADHD, their children are more likely to show symptoms as well. Exposure to toxins (including drugs and alcohol during pregnancy), brain injury, and childhood illnesses may also contribute. ADHD is not caused by too much TV or poor parenting.

Treatment
All interventions for children with ADHD should help build the child's sense of self-esteem. A team approach using educational, psychological, behavioral, and medical techniques is recommended and requires an effort by parents, teachers, child care and health care providers to find the right combination of responses.

Children with ADHD are typically "hands-on" learners and often respond to:

- Lower adult-child ratios.
- Predictable environments.
- Individualized programming.
- Structure, routine, and consistency.
- Motivating and interesting curricula.
- Shorter activity periods.
- Use of positive reinforcement.
- Supplementing verbal instructions with visual aids.

Counseling is an important part of the treatment plan and it may help to have the family involved in the counseling.

Physical activities can help the child with ADHD to improve coordination and self-esteem and provide an outlet for extra energy.

Tips for Child Care Providers:

- Learn what you can about ADHD.
- Ask the child's parents for suggestions and tips that they have found useful at home.
- Try to be consistent with the ways the child's parents guide and manage behavior.
- Let the child take regular breaks and have access to a quiet place to regroup.
- Have clear rules and consistent schedules for the child.
- Don't forget to look for and praise appropriate behavior.

This information is from the California Childcare Health Program, https://cchp.ucsf.edu.

Autism Spectrum Disorders (ASDs)

What are Autism Spectrum Disorders?

Autism spectrum disorders (ASDs) are a group of developmental disabilities caused by a problem with the brain. Children with ASDs have trouble in three core areas of their development:

- Language difficulties – especially no apparent desire to communicate.
- Social interactions.
- Restricted interests or behaviors that are repeated over and over again.

How common are they?

- According to the Centers for Disease Control and Prevention (CDC), two to six out of 1,000 children has an ASD diagnosis.
- These disorders affect children of all ethnicities.
- Boys are four times more likely to be diagnosed than girls.
- The CDC estimates that in the United States up to 500,000 individuals between the ages of zero and 21 have an ASD.
- The number of children diagnosed with autism has increased since 1990.

What causes Autism Spectrum Disorder?

No one knows exactly what causes ASD. However, it is clear that autism is a biological brain disorder.

- Scientists believe genes play an important role in the development of autism.
- Environmental factors may also play a role.
- Studies show that **immunizations DO NOT cause ASD**.

Early Warning Signs of ASD in infants and toddlers:

- Has limited eye contact and diminished responsiveness to others.
- Does not babble, point, or make meaningful gestures by one year of age.
- Has loss of language and /or social skills during the second year.
- Does not play “pretend” games.
- Does not respond to his or her name at one year.
- Does not smile.
- Becomes attached to unusual objects.
- Seems to be hearing impaired at times.
- Exhibits unusual repetitive behaviors like hand flapping, humming, or rocking.
- Does not use eye contact and finger pointing for the social purpose of sharing experiences with others.

Warning Signs of ASD in pre-school aged children:

- Has difficulty with change.
- Is unable to imitate the behaviors of others.
- Has difficulty expressing emotion and responding to the emotion of others.
- Repeats or echoes words or phrases.
- Has difficulty initiating and maintaining a conversation with another child.

- Laughs, cries, or shows distress for no apparent reason.
- Has uncontrollable tantrums.
- May not want to cuddle or be cuddled.
- Has uneven gross and fine motor skills.
- Plays oddly with toys or objects.
- Has unusual reaction to sensory stimuli (sounds, smells, tastes, touches, pain).
- Has no real fear of danger.

If you notice any of these warning signs in a child in your care, **talk with the parents** about your concerns and suggest that a health care provider who is familiar with evaluating developmental delay evaluate the child.

Early diagnosis of ASDs can lead to early intervention services. The time to intervene is when that child is a toddler, when her young brain is still more "plastic" and can be taught new skills. The child who is unable to have social relationships or communicate his needs and feelings is at risk for becoming an adult with severe disabilities.

Treatment
There is no cure for autism or ASDs. The best hope is for children to receive early and intensive intervention that focuses on teaching the child communication and social skills that allow him to connect to the world. Developmental and behavioral interventions form the core of treatment for children with ASD. Some children have special dietary requirements and some are on medication. It is important to have the parents fill out a Special Care Plan (see the Appendix) and learn about how you can provide the best care for the child.

The treatment team for children with ASDs can include:
- Developmental pediatrician.
- Pediatric neurologist.
- Child psychiatrist and /or child psychologist.
- Occupational therapist.
- Speech therapist.

How can you assist and support the child with ASD in a child care setting?
- Communicate with the family regularly and follow the Special Care Plan.
- Keep messages simple and direct.
- Use objects and actions along with words when communicating.
- Focus on improving the child's communication skills and emphasize spoken language by having the child ask for something by name when possible.
- Establish a predictable environment including teachers' language, behaviors, daily routines and classroom furnishing and materials.
- Do not rush the child.
- Whispering may be a useful communication tool that can be used for both talking with and calming down a child with ASD.
- Do not require eye contact when talking with the child.

Diabetes

Diabetes is a serious illness in which the body is unable to properly change sugar from food into energy. A simple sugar called glucose is the main source of energy for our body. Insulin, a hormone produced by the pancreas – a large gland behind the stomach – helps the body use the glucose for energy.

Diabetes happens when the body does not produce enough insulin (Type 1 or insulin-dependent), or use it properly (Type 2 or non-insulin dependent). As a result, glucose begins to build up in the blood, creating high sugar levels in the body.

Type 1 Diabetes occurs when the pancreas does not produce insulin.

- It requires multiple doses of insulin every day through shots or an insulin pump.
- It accounts for 5 to 10 % of all cases of diabetes and is the most prevalent type of diabetes among children and adolescents.
- Type 1 diabetes cannot be prevented.

The three big **symptoms of Type 1 Diabetes** are:

1. Constant thirst
2. Frequent urination
3. Rapid weight loss

Anyone experiencing these symptoms should see their health care provider.

Type 2 Diabetes

- Occurs when the pancreas does not produce enough insulin or body cells do not use insulin properly (*Insulin Resistance*).
- Is managed with diet and exercise, oral medication, and sometimes insulin.
- Increase in diagnosis of type 2 diabetes among children and adolescents in the U.S.

Symptoms of Type 2 Diabetes:

- Increased thirst and urination
- Blurry vision
- Feeling tired or ill
- Dark skin around the neck or armpits
- Frequent infections (usually yeast infections)
- Slow healing cuts and bruises
- Numbness and tingling of the hands and feet

These symptoms usually occur gradually and may go unnoticed.

Two kinds of problems occur when the body does not make insulin:

1. ***Hyperglycemia***, or high blood sugar, occurs with both types of diabetes. It occurs when the body gets too little insulin, too much food, too little exercise, or with illnesses. Stress from a cold, sore throat, or other illness may increase the level of blood glucose. Symptoms include:
    - Frequent urination
    - Excessive thirst
    - Extreme hunger
    - Unusual weight loss
    - Irritability
    - Poor sleep
    - Nausea and vomiting
    - Weakness
    - Blurred vision

2. ***Hypoglycemia***, or low blood sugar, is more common in people with Type 1 diabetes. It is the most common immediate health problem and is also called "insulin reaction" or "insulin shock". It occurs when the body gets too much insulin, too little food, a delayed meal or more that the usual amount of exercise. Symptoms may include:
    - Hunger
    - Pale skin
    - Weakness
    - Dizziness
    - Headache
    - Shakiness
    - Changes in mood or behavior
    - Sweating
    - Rapid pulse

Every child with diabetes will be different.

- Diabetes requires a constant juggling of insulin/medication with physical activity and food.
- It is important to recognize the signs of "high" and "low" blood sugar levels.
- Children with diabetes can do the same every day activities as students without diabetes.
- A child with a diabetes emergency will need help from child care staff.

Diabetes Management in Child Care:

- Designate personnel trained in diabetes.
- Have access to the tools that monitor and maintain blood glucose levels.
- Assist the child with performing diabetes care tasks as needed.
- Plan for disposal of sharps and materials that come in contact with blood.
- Be prepared to recognize and treat hypo and hyperglycemia.

- Be prepared to administer insulin or glucagon as needed.
- Develop a plan for disasters and emergencies.
- Follow individualized meal plans.
- Develop plans for field trips, class parties, and extracurricular activities.
- Have an individual care plan in place for each child with a chronic condition or special health care need.

Diabetes Medical Management Plan (DMMP)
The DMMP must be in place for the child's diabetes care to be implemented in the child care program. It should be:

- Individualized.
- Developed by the child's health care team, parents, and child (if applicable), and signed by the physician.
- Implemented collaboratively by the program diabetes team including:
  - Program director
  - Teacher or caregiver
  - Parent or guardian
  - Student (if developmentally appropriate)
  - Other designated personnel

DMMP Required Information Includes:

- Emergency contact information
- Level of self-care
- Blood glucose monitoring
- Insulin/medication administration
- Glucagon administration
- Meal and snack schedule
- Physical activity and sports
- Recognition and treatment of hypo and hyperglycemia

Other Recommended areas to include:

- Date of diagnosis
- Current health status
- Specific medical orders
- Nutrition requirements – including provisions for meals and snacks
- List of diabetes equipment and supplies needed for child care
- Location for and timing of blood sugar monitoring and treatment
- Maintenance of confidentiality and child's right to privacy

Refer to the Appendix to find:

- Diabetes Medical Management Plan
- Special Health Care Plan

Developmental Issues, Diabetes Care Tasks and Educational Considerations

The child care provider can play an important role in guiding children to participate in their care to the extent appropriate for their age and developmental level. The degree of independence the child is able to participate in their care should be agreed upon by the medical provider, parent/guardian, child (if appropriate), and child care team.

In general, child care and after school care staff can anticipate:

1. The infant, toddler, and pre-school age child is unable to perform diabetes care tasks independently. Assistance and close supervision by the staff in diabetes care is necessary.
2. The elementary school student is able to cooperate in all diabetes care tasks, and perform independently with varying degrees of competence at school. Staff supervision in diabetes care is recommended.
3. The middle school student should be able to perform most diabetes care tasks independently under circumstances when not experiencing hypoglycemia. Periodic staff supervision is recommended.
4. The high school student most probably will perform all diabetes care tasks independently, when not experiencing hypoglycemia. Staff surveillance is recommended.

Age (years)	Developmental Issues	Diabetes Care Tasks	Educational Considerations
Below age 3 years	Developing trusting relationship or bond with caregivers Developing the desire for greater autonomy	Preventing and treating hypoglycemia Avoid extreme fluctuations in blood glucose levels due to irregular food intake Toddlers may refuse to cooperate with his/her diabetes care	The diabetes regime is adjusted quickly to the child's dynamic growth and development Staff must learn the skills to provide diabetes management and perform associated diabetes tasks while meeting the developmental needs of the child Staff – establish a schedule Manage the picky eater

			Limit setting and coping with toddler's lack of cooperation
4 to 5 years	Knows likes and dislikes Identifies with "good" and "bad" Fear of intrusive procedures Magical thinking	Child can: Pinch own skin Collect urine for ketones Turn on glucose meter Help with recording data May begin to identify symptoms of hypoglycemia and alert adults	Can use guided play, play therapy, artwork to express concerns and to learn
6 to 7 years	Physically coordinated Concrete reasoning Able to share and cooperate	Can begin to identify carbohydrates in foods Can help with injections Can help with blood testing – able to prick own finger Able to activate bolus on pump with supervision Able to connect and disconnect insulin pump with assistance	May need reminders and supervision

8 to 10 years	Increased need for independence Does not want to be different Developing "scientific mind" Intrigued by tests Feelings of sadness, anxiety, isolation, and friendlessness	Able to participate in meal planning Correctly able to identify foods that fit into meal plan Increased independence with injections, blood and urine testing Able to keep records	Understands only immediate consequences of diabetes control, not long term Finds support groups, camps, individual counseling useful Learns best when information is presented in a fun and interesting way
11 to 13 years	Puberty: hormonal and physical changes may occur more for females Dependent versus independent struggles between parent and child, care giver and child Aware of body image; concerned with not being different More involved with peers than family	Can help plan meals and snacks along with starting carbohydrate counting Able to recognize and treat hypoglycemia Able to measure and inject own insulin Able to recognize patterns in blood glucose levels May need help assessing urine tests Able to connect and disconnect insulin pump Hormones of puberty can affect glucose control during this time.	Peer pressure begins to influence decisions May want to hide their disease from their peers

14+	Hormonal and physical changes continue Increased physical and social activities Experimentation and risk-taking behaviors At risk for eating disorders Strong peer pressure Values independence and self-image Finds assuming responsibility for self-management the most difficult task	Able to identify appropriate portion sizes Able to alter food intake in relation to blood glucose level Able to anticipate and prevent hypoglycemia Able to calculate insulin dose based on blood glucose level Can independently administer insulin Able to understand role of exercise in calculating insulin needs	Still needs some supervision and review regarding insulin dosing Knows consequences of poor diabetes control Learns best when educational content is pertinent to adolescent issues Able to learn problem solving with adults and negotiate treatment Likes discussion and support groups among peers

Eczema

What is it?
Eczema is a chronic skin problem that causes dry, red, itchy skin. It is also called *atopic dermatitis*.

Who gets eczema?
Eczema is the most common skin problem treated by pediatric dermatologists. About 65% of patients develop symptoms before age one, and about 90% before age five. Many babies outgrow eczema by age four, and some children outgrow eczema by the time they are young adults. Eczema often runs in families with a history of eczema or other allergic conditions, but it is not contagious.

Common signs and symptoms:
- Dry, red, itchy skin and rashes. The rashes can be oozing or very dry.
- **In babies**, a rash often appears on the face and scalp.
- **In younger children**, a rash often appears in the folds of the elbows and knees.
- **In teens and young adults**, a rash often appears on the hands and feet.

There are times when the symptoms are worse (flare-ups) followed by times when the skin gets better or clears up completely (remissions).

How to prevent flare-ups:
- Keep the child's skin moisturized.
  - Use fragrance-free moisturizers.
  - Cream or ointment is more moisturizing that lotion.
- Avoid irritants.
  - Children should wear soft fabrics such as 100% cotton clothing.
  - Use mild, unscented soap for bathing and handwashing.
  - The child's parent should be careful to use mild laundry detergent with no dyes or perfumes and no fabric softener sheet in the dryer.
- Remind child not to scratch. Scratching can make the rash worse and lead to infection.
- Parent should consult with child's health care provider about what might trigger a flare-up.

Treatment
The child's health care provider will recommend medication to help the child feel better and to keep the symptoms of eczema under control. Eczema medication can be given two ways:
- Topical – applied to the skin (available as creams or ointments)
- Oral – taken by mouth (available in pill or liquid form)

Consider developing a Special Health Care Plan with the parents and the child's health care provider so you can provide the best care possible.

Hearing Loss

A hearing loss, hard of hearing, hearing impairment, or deafness is a partial or total inability to hear. In children it may affect the development of language. Good hearing is necessary for a child to learn to talk. Newborn infants can hear a full range of sounds from the moment they are born (and even before)! Infants demonstrate that they hear as they quickly learn to recognize and respond to familiar voices. Hearing children turn to new sounds and their language development continually progresses.

Hearing impairment occurs when there is a problem with or damage to one or more parts of the ear. ***Types of hearing loss***:

- **Conductive** results from a problem with the outer or middle ear, including the ear canal, eardrum, or ossicles. A blockage or other structural problem interferes with how sound get conducted through the ear, making sound levels seem lower. In many cases, conductive hearing loss can be corrected with medications or surgery.
- **Sensorineural** results from damage to the inner ear (cochlea) or the auditory nerve. The most common type is caused by the outer hair cells not functioning correctly. The person has trouble hearing clearly, understanding speech, and interpreting various sounds. This type of hearing loss is permanent. It may be treated with hearing aids. In most severe cases, both outer and inner hair cells aren't working correctly. This is also a type of permanent hearing loss and can be treated with a cochlear implant.
- In some other cases, the outer hair cells work correctly, but the inner hair cells or the nerve are damaged. This type of hearing loss is called **auditory neuropathy spectrum disorder**. The transmission of sound from the inner ear to the brain is then disorganized. Children with auditory neuropathy spectrum disorder can develop strong language and communication skills with the help of medical devices, therapy, and visual communication techniques.
- **Mixed** occurs when someone has both conductive and sensorineural hearing problems.
- **Central** happens when the cochlea is working properly, but other parts of the brain are not. This is a less frequent type of hearing loss and is more difficult to treat.
- **Auditory processing disorders (APD)** – not exactly a type of hearing loss because someone with APD can usually hear well in a quiet environment. Most people with APD have difficulty hearing in a noisy environment. In most cases APD can be treated with proper therapy.

Common Causes of Hearing Loss:

- Otitis media – the medical term for an ear infection that affects the middle ear which can cause a buildup of fluid behind the eardrum. Even after the infection gets better, fluid might stay in the middle ear for weeks.
- Blockages in the ear, such as a foreign object, impacted ear wax, or dirt.
- Damage to parts of the ear – for example a hole in the eardrum from a cotton swab inserted too far or a sudden change in air pressure.

- Genetic disorders – some genetic disorders may interfere with the proper development of the inner ear and the auditory nerve.
- Injuries to the ear or head, such as a skull fracture.
- Complications during pregnancy or birth.
- Infections or illnesses.
- Medications – certain medications, such as antibiotics and chemotherapy drugs can cause hearing loss.
- Loud noise – a sudden loud noise or exposure to high noise levels over time can cause permanent damage to the tiny hair cells in the cochlea.

Congenital hearing loss is present at birth. **Acquired** hearing loss happens later in life and it can be sudden or progressive. About 1 in 300 children are born with hearing loss, making hearing loss one of the most common birth defects in the United States.

Hearing Screening and Evaluation
In Oklahoma all babies are screened for hearing loss before they leave the hospital.
Oklahoma State Law §63-1-543. Screening for detection of congenital or acquired hearing loss.
A. This act shall be known and may be cited as the "**Newborn Infant Hearing Screening Act**".
B. Every infant born in this state shall be screened for the detection of congenital or acquired hearing loss prior to discharge from the facility where the infant was born. A physician, audiologist or other qualified person shall administer such screening procedure in accordance with accepted medical practices and in the manner prescribed by the State Board of Health.

If a baby does not pass the hearing screening at birth, more testing needs to be done. The results are sent to the infant's health care provider and to the parents. Information about where hearing can be checked is also sent to the family.

If you suspect an infant or child in your care has a hearing loss, ask the parents to have the child evaluated by a trained professional. Parents can contact their child's health care provider or local health department.

Indicators of Potential Hearing Loss
- Frequent mouth breathing
- Failure to turn toward the direction of a sound
- Delay in acquiring language
- Development of poor speech patterns
- Using gestures rather than words
- Unusual voice quality – one that is extremely high, low, hoarse, or monotone
- Difficulty understanding and following directions
- Mispronouncing many words
- Failing to respond to normal sounds and voices
- Responding to questions inappropriately

Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome (HIV/AIDS)

What is it?

HIV/AIDS is an infection caused by a virus called human immunodeficiency virus (HIV) that over time damages the body's immune system and other organs, and can lead to severe life-threatening illness.

What are the symptoms?

When a person is first infected with HIV, he or she may have no symptoms or may become ill with a fever, night sweats, sore throat, general tiredness, swollen lymph glands, and a skin rash lasting for a few days to a few weeks. These early symptoms go away by themselves. However, the virus stays in the body and causes increasing loss of immune function. This results in the body becoming unable to fight off infections. The late stage of this infection is called acquired immunodeficiency syndrome (AIDS). A person who is infected becomes potentially infectious to others for life.

Early symptoms of HIV infection in children include:

- Failure to grow and gain weight
- Chronic diarrhea without a specific cause
- Enlarged liver and spleen
- Swollen lymph glands
- Chronic thrush (yeast infections)
- Skin infections
- Pneumonia
- Bacterial, viral, fungal, and parasitic infections uncommon in healthy children

Many children are infected with HIV for years before developing any symptoms.

Who gets it and how?

HIV is not easily transmitted. For HIV to spread, the virus, present in blood and other body fluids, must enter the uninfected person's blood stream through a break in the skin or through mucous membranes. In a child care setting this can only happen through blood-to-blood exchange. It cannot be transmitted through urine, stool, vomit, saliva, mucous, or sweat.

HIV is most commonly spread:

- By sharing contaminated needles
- Through sexual intercourse
- By infected pregnant women to the fetus

Less commonly, HIV may be spread:

- By infected mothers who breastfeed their infants.
- To health care workers, primarily after being stuck with a needle containing HIV infected blood.
- By exposure of open skin or mucous membranes to HIV contaminated body fluids.

Recommendations for child care providers who care for children with HIV/AIDS:

- Protect all children and staff by strictly following special procedures for cleaning and handling blood and body fluids containing blood (standard precautions).
- Provide education to all staff members on standard precautions, including information on blood-borne pathogens and diseases and methods to control exposure, as well as accurate information about HIV/AIDS.
- Protect people with HIV from infection by communicable diseases by excluding them when there is an outbreak (upon the advice of their health care provider).
- Notify parents of all children if there is a case of chicken pox, tuberculosis, fifth disease, diarrheal disease, or measles in another child attending the program.
- Immediately refer children with HIV to their health care providers to receive appropriate preventive measures and advice about readmission to child care if they are exposed to measles or chicken pox.
- Protect the right to privacy by maintaining confidential records and by giving medical information only to persons who need to know, and with the consent of the parent.
- Help children with HIV/AIDS lead as normal a life as possible.

To reduce the risk of spreading HIV (or any other blood-borne infection), all child care providers should routinely follow these precautions:

- Make sure everyone uses good hand washing procedures.
- Make sure all adults use good diapering practices.
- Wear gloves when changing a diaper soiled with bloody stools.
- Wash skin on which breast milk has spilled with soap and water immediately.
- Do not allow children to share toothbrushes.
- Wear gloves when cleaning up blood and bodily fluid spills.
- Immediately clean and disinfect surfaces on which blood or bodily fluids have spilled.
- Cover open wounds on children and adults.
- Develop policies and procedures to follow in the event of an exposure to blood.

Who should be notified?

- Notify your local health department if someone in your program has this disease. They will provide you with further information.
- Parents and children attending group programs **do not have the "right" to know** the HIV status of other children in the program.
- Caregivers and teachers need to know when a child has an immunodeficiency, so that precautions can be taken to protect the child from infections. However, this does not require knowledge of HIV status.

Juvenile Rheumatoid Arthritis

What is it?

Juvenile rheumatoid arthritis, also known as juvenile idiopathic arthritis occurs when the body's immune system attacks its own cells and tissues. It's unknown why this happens, but both heredity and environment seem to play a role.

Common signs and symptoms:

- Joints that are warm to the touch
- Swelling and tenderness to the joints
- Fever
- Rash
- Favoring one limb over another or limping
- Pain (often worse following sleep or inactivity)
- Stiffness, especially upon waking
- Inability to bend or straighten joints completely
- Decreased physical activity
- Fatigue
- Sleep problems
- Swollen lymph nodes
- Reduced appetite and weight loss

Diagnosis

An early diagnosis and aggressive treatment are vital to preventing or slowing joint damage and preserving mobility. If you have concerns about a child, be sure to discuss this with the parent and suggest they visit with the child's health care provider.

Treatment

- There is no cure, but with prompt diagnosis and early treatment, remission is possible.
- The goal of treatment is to relieve inflammation, control pain, and improve quality of life.
- The treatment plan may include medication, exercise, eye care, dental care and proper nutrition.

Self-care

Getting plenty of physical activity, eating well and learning how to cope with the challenges of the disease will be beneficial for children with arthritis.

- ***Remember to develop a Special Health Care Plan with the parents and the child's health care provider so you can provide the best care possible.***

Seizure Disorders

A seizure disorder is a neurological condition usually diagnosed after a person has had at least two seizures that were not caused by some known medical condition. Brain cells communicate by using electricity. A seizure is a sudden surge of too much electrical activity in the brain.

Seizures can be caused by low blood sugar, accidental poisoning, drug overdose, an infection, a head injury, or abnormality of the brain. Some children under five years old have ***febrile seizures***, which can develop when they have a fever – usually above 100.4 degrees. Seizures that happen more than once or over and over might indicate a seizure disorder. The cause of a seizure disorder is usually not known.

Children with seizure disorders usually have normal intelligence, however;

- Some children may have difficulties thinking and remembering.
- Some children may have behavioral and emotional problems that include:
    - Difficulties with concentration
    - Problems with temper control
    - Hyperactivity
    - Impulsiveness

What does a seizure look like?
Some seizures are difficult to notice, while others are very dramatic. Seizures can be:

- *Generalized*, which affect all of the brain and cause the child to lose consciousness, and his or her body to stiffen and the limbs to shake.
- *Partial*, which affect just parts of the brain. It can take many different forms and may partly affect consciousness.

How to help during seizures

- Stay calm!
- Keep the child from getting hurt during the seizure; help ease her to the floor.
- Remove hazards such as hard or sharp objects that can cause injury if the child falls or knocks against them.
- Loosen clothing around the child's head and neck and remove glasses.
- Gently turn the child on his side so any fluid in the mouth can drain safely.
- Talk softly to reassure the child.
- Explain to the other children what is happening – the child is having a seizure, it will be over soon, and she is not in pain.
- Keep track of when the seizure started and how long it lasted.
- Stay with the child as he comes out of the seizure to reassure him.

What *NOT* to do during a seizure

- **DO NOT** put anything in the child's mouth.
- **DO NOT** try and restrain the child's movements.
- **DO NOT** try to bring the child out of the seizure by using cold water or shaking – it won't work and could be harmful.
- **DO NOT** give the child anything to eat or drink before fully awake.

When to call 911 for emergency help

- If the child has never had a seizure before.
- If the seizure lasts longer than five minutes in a child with a known seizure disorder.
- If the child has more than one seizure without fully regaining consciousness.

When a seizure ends, the brain begins to recover and the child returns to awareness. Be calm and reassuring because the child may be confused and frightened, and may not remember the seizure. Let the child rest or sleep as needed.

Most children with seizures take medication to control their seizures. Some medications may cause changes in the child's behavior or learning, and some can occasionally cause side effects. If you notice a change in behavior or any physical side effects such as rash, stomach pain, frequent nosebleeds, or excessive sleepiness, discuss this with the child's parent. It is also a good idea to document what you observe and when, and keep the notes on file.

How to prepare your program. See Appendix B for sample forms.

- Train staff on how to identify and respond to a child having a seizure.
- Consider enrolling in a course through the Epilepsy Foundation: https://www.epilepsy.com
  Access the 30-minute online training ***Seizure First Aid Ready*** that educates the public on the Epilepsy Foundation's basic procedures for responding to someone having a seizure. The on-demand course is presented in an interactive format with animations, videos, and activities to help everyone become Seizure First Aid ready.
  Or, take the 90-minute ***Seizure Recognition and First Aid Certification Training*** which provides information to increase the knowledge, skills and confidence in recognizing seizures and safely administering seizure first aid. The first aid procedures in the course reflect the standard of knowledge and current best practices. Participants who successfully complete the course will receive a two-year certification.
- Develop a Seizure Care Plan with the child's parent.
- Have parent fill out the Medication Administration Form.
- Provide written documentation, including who is responsible to care for the child, how they have been trained, and how to store and administer any prescribed medication.
- Document every seizure.
- Keep a copy of the child's Seizure Care Plan and any medication given, in the child's file.

Sickle Cell Disease

What is it?

- Sickle cell is an inherited condition in which red blood cells change shape. Instead of being round and smooth, they form a “c” shape like a crescent moon.
- The red blood cells can get stuck in blood vessels and block blood flow, which can cause pain or swelling and keep the body from fighting infection.
- The abnormally shaped red blood cells do not live as long as regular cells, so children with sickle cell disease have a low blood count and must make new red blood cells more quickly.
- Children are born with the condition and have it for life. Some children are more severely affected; some have a milder form.

What are some characteristics of children with sickle cell disease?

- Hand-foot syndrome – swollen hands and feet may be the first signs of sickle cell in babies. The swelling is caused by the sickle-shaped red blood cells blocking blood flow out of their hands and feet.
- Pale skin or nail beds.
- Yellow tint to the skin or whites of the eyes.
- Child is small and slender for his or her age.

Children with sickle cell may have increased absences because of complications and may need to be hospitalized for treatment.

Some complications include:

- **Pain**. Pain can happen in any part of the body but often occurs in the hands, feet and joints. Chest pain can be especially serious.
- **Fever**. Children with sickle cell disease have a hard time fighting infection. Fevers must be evaluated by the child’s health care provider.
- **Pneumonia** can be very serious in children with sickle cell disease.
- **Splenic sequestration** is an emergency. Sickled cells can clog up the spleen and keep it from working properly (straining the blood and removing damaged cells and infection). The sickled cells can cause the spleen to back up. The spleen can get very big if that happens and sometimes break open – which is a life-threatening emergency.
- **Aplastic crisis**. Abnormal blood cells have a shorter life span, so the body needs to make new blood cells very quickly. If something like an infection prevents the body from keeping up with making new blood cells, the child can get a dangerously low blood count very quickly.
- **Strokes**. If sickled cells block the blood flow to the brain, a stroke can occur.

What adaptations may be needed?

1. Medications. Children with sickle cell may take:
    - Penicillin from two months until five years of age (to help prevent infection).
    - Acetaminophen or ibuprofen (for pain control).
    - Extra Folic Acid (because of the red blood cells needed).
    - Special vaccinations (in addition to required).

2. Dietary considerations. Children with sickle cell disease should have at least 8 cups of water or fluid daily.

3. Physical environment
    - Hydration helps prevent sickling, so allowing the child to have a water bottle is a good idea.
    - Children with sickle cell disease may need increased bathroom breaks.

4. Be aware of what is considered an emergency
   Inform parents immediately of:
    - Fever
    - Pain that does not improve with medication and rest
    - Cough or mild chest pain
    - Abdominal pain or swelling
    - Paleness or increased tiredness
    - Painful erection

Call emergency medical services – 911 if:
- Difficulty breathing
- Seizure or loss of consciousness
- Headache or dizziness
- Change in vision
- Numbness or inability to move a body part
- Severe pain
- The spleen gets enlarged
- Prolonged erection

Remember to develop a Special Health Care Plan with the parents and the child's health care provider so you can provide the best care possible.

Resources for further information
- The Sickle Cell Information Center, https://scinfo.org
- National Heart, Lung and Blood Institute, www.nhlbi.nih.gov

Visual Impairment

Visual impairment is a term experts use to describe any kind of vision loss, whether it's someone who cannot see at all or someone who has partial vision loss. Some people are completely blind, but many others have what's called **legal blindness**. They haven't lost their sight completely but have lost enough vision that they'd have to stand 20 feet from an object to see it as well as someone with perfect vision could from 200 feet away.

Some babies have **congenital blindness**, which means they are visually impaired at birth. Congenital blindness can be caused by a number of things — it can be inherited, or caused by an infection (like German measles) that's transmitted from the mother to the developing fetus during pregnancy.

The American Foundation for the Blind estimates that 10 million people in the United States are visually impaired. **Visual impairments include**:

- **Myopia** or nearsightedness. A child who is nearsighted can see objects that are near, but has poor distance vision.
- **Amblyopia** or "lazy eye" is a decrease in the child's vision that can happen even when there is no problem with the structure of the eye. The decrease in vision results when one or both eyes send a blurry image to the brain. The brain then "learns" to only see blurry with that eye, even when glasses are used.
- **Strabismus**, where the eyes look in different directions and do not focus simultaneously on a single point. It is commonly referred to as crossed eyes.
- **Hyperopia** or farsightedness is thought to be a normal occurrence in children under the age of five and is caused by a shortness of the eyeball. This condition often corrects itself as children mature and their eyeballs change shape. Children who are farsighted can see objects clearly at a distance, but have trouble focusing on near objects.
- **Congenital Cataracts**, where the lens of the eye is cloudy.
- **Retinopathy of Prematurity**, which may occur in premature babies when the light-sensitive retina hasn't developed sufficiently before birth.
- **Retinitis Pigmentosa**, a rare inherited disease that slowly destroys the retina.
- **Coloboma**, where a portion of the structure of the eye is missing.
- **Optic Nerve Hypoplasia**, which is caused by underdeveloped fibers in the optic nerve and which affects depth perception, sensitivity to light, and acuity of vision.
- **Cortical Visual Impairment** (CVI), which is caused by damage to the part of the brain related to vision, not to the eyes themselves.
- **Glaucoma** is an increase in pressure inside the eye. The increased pressure impairs vision by damaging the optic nerve. It is mostly seen in older adults, but babies may be born with the condition.

There are also numerous other eye conditions that can cause visual impairment.

It's important to diagnose and address visual impairment in children as soon as possible. Some vision screening may occur at birth, especially if the baby is born prematurely or there's a family history of vision problems, but baby wellness visits as early as six months should also include basic vision screening to ensure the baby's eyes are developing and functioning as expected.

Early signs of vision problems in infants and toddlers:

- Jerky or fluttering eye movements.
- Eyes that wander in opposite directions or are crossed (after three months).
- Inability to focus or follow a moving object (after three months).
- Pupil of one eye larger than the other.
- Absence of a blink reflex.
- Drooping of one or both lids.
- Cloudiness on the eyeball.
- Chronic tearing.

Signs of vision problems in older children:

- Eyes that don't move together when following an object or a face.
- Strains to see distant objects; squints or screws up face.
- Crossed eyes, eyes that turn out or in, eyes that flutter from side to side or up and down, or eyes that do not seem to focus.
- Eyes that bulge, dance, or bounce in rapid rhythmic movements.
- Pupils that are unequal in size or that appear white instead of black.
- Repeated shutting or covering of one eye.
- Tilts head to one side.
- Unusual degree of clumsiness, such as frequent bumping into things or knocking things over.
- Frequent squinting, blinking, eye-rubbing, or face crunching, especially when there's no bright light present.
- Sitting too close to the TV or holding toys and books too close to the face.

If any of these symptoms are present, parents will want to have their child's eyes professionally examined. Early detection and treatment are very important to the child's development.

Appendices: Resources and Sample Forms

Appendix A: Resources

Appendix B: Sample Forms

Appendix A
Developmental and Behavioral Resources

Centers for Disease Control and Prevention (CDC) Learn the Signs Act Early

CDC's **"Learn the Signs. Act Early."** program aims to improve early identification of children with autism and other developmental disabilities so children and families can get the services and support needed. The program is made up of three components:

- Health education campaign
- Act Early Initiative
- Research and Evaluation

Milestones matter! CDC's "Learn the Signs. Act Early." program encourages parents and providers to learn the signs of healthy development, monitor every child's early development, and take action when there is a concern. The program offers free checklists and other tools to make developmental monitoring practical and easy.

Free Materials for Families and Providers

- ***Developmental milestone checklists*** (for ages two months to five years), booklet, brochure, and growth chart
- ***Milestone Tracker mobile app*** (iOS and Android) with interactive, illustrated checklists, tips for supporting development, sharable summary and more
- Children's books that teach parents about milestones
- Milestones in Action: a collection of free photos and videos of developmental milestones
- How to Help Your Child and How to Talk with the Doctor: tip sheets to support parents when there is a developmental concern
- ***Watch Me! Celebrating Milestones and Sharing Concerns***: http://www.cdc.gov/ncbddd/watchmetraining/index.html
  A 1-hour online training for early care and education providers to learn how to monitor each child's development. This FREE, online training course, offered through the Center for Disease Control and Prevention (CDC) helps early childhood professionals by providing tools and best practices for monitoring the development of children in care and talking about it with their parents.

Grief Support

Compassionate Friends – an organization for bereaved parents, assisting families following the death of a child.

- https://www.compassionatefriends.org

First Candle provides 24/7 bereavement support, offering compassion, expertise, professional guidance, and a network of people who understand because they too know the pain of losing a baby.

- **Call 1-800-221-7437**

- **Visit https://firstcandle.org** to find resources as well as connect with First Candle's peer-to-peer online support groups – a safe and supportive place for individuals and their families to share information and experiences surrounding pregnancy and infant loss.

Maternal Mental Health Hotline

Call or text the National Maternal Mental Health Hotline at 1-833-9-HELPMOMS (1-833-943-5746). Free confidential, 24/7 mental health support for moms and their families before, during, and after pregnancy. English and Spanish speaking counselors are available. TTY Users can use a preferred relay service or dial 711 and then 1-833-943-5746.

Professional counselors will provide referrals to local or telehealth providers if you need longer-term care and support. Counselors are licensed or certified, and also have training in how to provide culturally appropriate and trauma-informed support. They will take into consideration your preferences for age, gender, ethnicity, and language-specific resources when providing referrals for you.
Learn more at https://mchb.hrsa.gov/national-maternal-mental-health-hotline

Oklahoma's Comprehensive Crisis Response

Urgent Care and Crisis Centers are places of stabilization and offer the community a no wrong door access to mental health and substance use care, working with persons of varying ages. These facilities provide assessment and support, and are staffed 24/7/365 with a multidisciplinary team. This team includes but is not limited to psychiatrists, nurses, licensed behavioral health practitioners and peers with lived experience similar to the population served. It all starts with an easy to remember helpline number (988) staffed by mental health professionals to answer calls around the clock.

- **Call the Helpline: 988**
- https://oklahoma.gov/odmhsas/treatment/comprehensive-crisis-response.html

Oklahoma Warmline

The Oklahoma Warmline is a program for families, child care providers, and other caregivers where callers can receive consultation and support around the difficult job of caring for and nurturing infants, toddlers, and school-aged children **birth to 13** as they grow and develop.

Trained Consultants are available to help you by phone **Monday through Friday from 8am to 6pm**. A team of consultants trained in child health, child development, and behavioral health are available to take your calls, help to generate ideas and solutions for the challenges you face daily as you care for kids, to offer support, and to help you find additional resources and referrals if you are needing them.

- **Call the Warmline: 888-574-KIDS (5437)**
- **Email the Warmline with questions to warmline@health.ok.gov**
- **Explore resources and the health topic library at https://okwarmline.org**

Postpartum Depression – Perinatal Mood and Anxiety Disorders (PMADs)

PMADs is the umbrella term for mood and anxiety disorders that occur during pregnancy or up to one year postpartum. These terms include women (and men) who experience postpartum post-traumatic stress disorder, depression, postpartum anxiety, postpartum OCD, postpartum blues, and postpartum psychosis.

- **Postpartum Support International (PSI) Helpline 1-800-944-4773** (does not handle emergencies).
- **The National Suicide Prevention Lifeline** is a national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week in the United States. **Call 1-800-273-8255.**
- Go to the Postpartum Support International website to connect with a PSI Support Coordinator near you, and/or join a weekly online support group. https://www.postpartum.net.

SoonerStart

SoonerStart is Oklahoma's early intervention program. It is designed to meet the needs of families with infants or toddlers with developmental delays and/or disabilities in accordance with the Individuals with Disabilities Education Act (IDEA). The program builds upon and provides supports and resources to assist family members to enhance infants or toddler's learning and development through every day learning opportunities.

Eligibility Guidelines

Infants and toddlers in Oklahoma who meet the criteria of developmentally delayed are eligible for SoonerStart services. As used in the Oklahoma Early Intervention Act, [Oklahoma State Statutes Title 70, Section 13-123] "developmentally delayed" means children who:

- Exhibit a delay in their developmental age compared to their chronological age of fifty percent or score two standard deviations below the mean in one or more of the following areas or in a sub-domain of one of the areas: cognitive, physical, communication, social or emotional, or adaptive development; or
- Have a diagnosed physical or mental condition that has been identified as having a high probability for a developmental delay.

A referral to the SoonerStart, early intervention program can be made by any concerned individual by visiting the SoonerStart website and making an on-line referral, or by contacting the SoonerStart county site. The referral source would need to provide the program with contact information of the child and family and the intake process begins.

- http://sde.ok.gov/sde/soonerstart
- SoonerStart Referral By County

ZERO TO THREE
http://www.zerotothree.org/
A national, nonprofit organization that provides parents, professionals, and policymakers the knowledge and know-how to nurture early development.

ZERO TO THREE plays a key role in ensuring that babies and toddlers get a strong start in life by supporting:

- Parents with practical resources that help them connect more positively, deeply and continuously with their babies.
- Professionals with knowledge and tools that help them support healthy early development.
- Policymakers in advancing comprehensive and coherent policies which support and strengthen families, caregivers and infant toddler professionals.

Appendix A
Health and Safety Resources

California Childcare Health Program produces quality materials on health and safety in early care and education settings for professionals and families.

- https://cchp.ucsf.edu

Center for Disease Control and Prevention (CDC)
CDC is one of the major operating components of the Department of Health and Human Services. CDC works to protect America from health, safety and security threats, both foreign and in the U.S. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same.

- Safety in the Home and Community
  http://www.cdc.gov/parents/children/safety.html

Children's Oral Health - Cavities (also known as caries or tooth decay) are one of the most common chronic diseases of childhood in the United States. Untreated cavities can cause pain and infections that may lead to problems with eating, speaking, playing, and learning. A healthy mouth and teeth are an important part of a child's wellness. Adding a dental professional as a resource to your support system can provide ongoing peace of mind for your entire family.

- http://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html
- http://www.healthychildren.org/English/healthy-living/oral-health

Consumer Product Safety Commission (CPSC) http://www.cpsc.gov
CPSC is charged with protecting the public from unreasonable risks of injury or death associated with the use of the thousands of types of consumer products under the agency's jurisdiction. CPSC's work to ensure the safety of consumer products – such as toys, cribs, power tools, cigarette lighters, and household chemicals – contributed to a decline in the rate of deaths and injuries associated with consumer products over the past 40 years.

- Current Safety News & Infant Crib Safety http://www.cpsc.gov/SafeSleep
- Recalled products http://www.cpsc.gov/en/Recalls/
- Safety education http://www.cpsc.gov/en/Safety-Education/

Environmental Protection Agency (EPA) www.epa.gov
The United States EPA was established on Dec. 2, 1970, to consolidate into one agency a variety of federal environmental responsibilities including research, monitoring, standard setting, and enforcement activities to ensure environmental protection while simultaneously safeguarding human health.

- Lead – www.epa.gov/lead
- Air quality – www.epa.gov/environmental-topics/air
- Mold – www.epa.gov/mold
- Radon – www.epa.gov/radon

Food Allergy Research & Education (FARE)
FARE enhances the lives of individuals with food allergies empowering them to lead safe, productive lives with the respect of others through education and advocacy initiatives and improved awareness around healthcare options and treatment.

- https://www.foodallergy.org

HealthyChildren.org, from the American Academy of Pediatrics (AAP), is the only parenting website backed by 64,000 pediatricians committed to the attainment of optimal physical, mental, and social health and well-being for all infants, children and adolescents.

- http://www.healthychildren.org

National Resource Center for Health and Safety in Child Care and Early Education

- Information for caregivers and teachers, parents, regulators, child care health consultants, and home visitors: http://nrckids.org/.
- *Caring for Our Children, National Health and Safety Performance Standards* (CFOC) http://nrckids.org/CFOC.
- Healthy Weight Resources http://nrckids.org/HealthyWeight.

Occupational Safety and Health Administration (OSHA) helps to ensure safe and healthful working conditions for workers by setting and enforcing standards and by providing training, outreach, education and assistance. OSHA covers most private sector employers and their workers, in addition to some public sector employers and workers in the 50 states and certain territories and jurisdictions under federal authority. http://www.osha.gov

Oklahoma 2-1-1 Heartline
2-1-1 is a free, 24-hour phone service that provides Oklahomans access to information about health and human services. Highly trained 2-1-1 call specialists offer compassionate engagement and can make in-depth assessments and referral plans based on eligibility requirements for each program. They work with callers to make a

plan using the 2-1-1 database – the most comprehensive entity of its kind in the state, with more than 13,000 services available – that improves the quality of families' lives. They offer help in more than 200 languages and provide the public with a place to turn for nonemergency needs during times of disaster.

- **Call 2-1-1**
- **Text 8989211**
- https://heartlineoklahoma.org

Oklahoma Breastfeeding Resources
Oklahoma Breastfeeding Hotline: Call 1-877-271-MILK (1-877-271-6455)
Text OK2BF to 61222
24-hour toll-free breastfeeding support line for nursing mothers, their families, partners, expecting parents, and health care providers; All calls returned by an International Board Certified Lactation Consultant (IBCLC).

- **Oklahoma Breastfeeding Resource Center –** https://obrc.ouhsc.edu

Oklahoma Caring Van Program
The Oklahoma Caring Van Program delivers immunizations to protect children and adolescents from dangerous illnesses at no cost to their families. The Caring Vans travel to licensed child care centers, schools and community locations statewide.

- http://www.oklahomacaringfoundation.org

Oklahoma Center for Poison & Drug Information
The Oklahoma Center for Poison & Drug Information (OCPDI) provides information about the prevention and management of potential toxic exposures. The OCPDI is a free, confidential resource that is open 24 hours a day, 7 days a week, 365 days a year, and is staffed by pharmacists, doctors and nurses who are nationally certified as Specialists in Poison Information.

- **Poison Helpline: 1 (800) 222-1222**
- http://www.oklahomapoison.org

Oklahoma Domestic Violence Hotline: provides assistance with safety planning, crisis intervention, emergency shelter and advocacy to victims of domestic violence, sexual assault, stalking.

- **24-hour Safeline: 1-800-522-SAFE (7233)**
- **National Domestic Violence Hotline: 1-800-799-7233**
- https://okdrs.gov/guide/domestic-violence-hotline

Oklahoma Tobacco Helpline
The Oklahoma Tobacco Helpline is FREE and available 24/7. They provide tools and support to help you quit tobacco your own way.

- **Tobacco Helpline: 1-800-QUIT.NOW (1-800-784-8669)**
- https://okhelpline.com

Oklahoma State Department of Health (OSDH) protects and improves public health through its system of local health services and strategies focused on preventing disease and injury. **Mission**: *To protect and promote health, to prevent disease and injury, and to cultivate conditions by which Oklahomans can thrive.*

- http://www.oklahoma.gov/health
- OSDH has many helpful resources for working with children, including the online version of the ***Good Health Handbook***. https://oklahoma.gov/health/health-education/children---family-health/maternal-and-child-health-service/child-and-adolescent-health/early-childhood-.html

Oklahoma Warmline
The Oklahoma Warmline is a program for families, child care providers, and other caregivers where callers can receive consultation and support around the difficult job of caring for and nurturing infants, toddlers, and school-aged children **birth to 13** as they grow and develop.

Trained Consultants are available to help you by phone **Monday through Friday from 8am to 6pm**. A team of consultants trained in child health, child development, and behavioral health are available to take your calls, help to generate ideas and solutions for the challenges you face daily as you care for kids, to offer support, and to help you find additional resources and referrals if you are needing them.

- **Call the Warmline: 888-574-KIDS (5437)**
- **Email the Warmline with questions to warmline@health.ok.gov**
- **Explore resources and the health topic library at https://okwarmline.org**

ParentPRO – a free service that promotes Oklahoma families with young children by linking them with programs that best fit them.

- **For free parenting support, call 1-800-271-7611**
- www.parentpro.org

The Period of Purple Crying program is an evidence-based shaken baby syndrome/abusive head trauma (SBS/AHT) prevention program that helps parents and caregivers understand the frustrating features of crying in normal, healthy infants that can lead to shaking or abuse and what they can do. Now available as an App.

- http://www.dontshake.org/purple-crying

Safe Kids Oklahoma provides dedicated and caring staff, operation support, and other resources to assist in achieving the goal of keeping kids safe. They can be reached at (405) 470-2304.

- http://www.safekids.org/coalition/safe-kids-oklahoma

Safe Kids Worldwide is a global organization dedicated to protecting kids from unintentional injuries through research, education and awareness programs.

- http://www.safekids.org

Safe to Sleep® Public Action Campaign: the Safe to Sleep® campaign, formerly known as the Back to Sleep campaign, focuses on actions you and others can take to help your baby sleep safely and to reduce your baby's risk of Sudden Infant Death Syndrome (SIDS) and other sleep-related causes of infant death.

- http://www.nichd.nih.gov/sts/

SoonerCare (Oklahoma Medicaid) is a health coverage program jointly funded by the federal and state government. SoonerCare helps pay some or all medical bills for many people who can't afford them. The Oklahoma Health Care Authority (OHCA) is the state agency that administers the program and determines financial eligibility for the program.

- http://www.okhca.org/

SoonerStart is Oklahoma's early intervention program. It is designed to meet the needs of families with infants or toddlers with developmental delays. In accordance with the Individuals with Disabilities Education Act (IDEA) the program builds upon and provides supports and resources to assist family members to enhance their infant's or toddler's learning and development through everyday learning opportunities.
Mission: *To help Oklahoma children develop to their fullest potential while providing individualized, family-centered early intervention services to empower families to support and advocate for their children with developmental needs.*

- http://www.sde.ok.gov/soonerstart

Stop Bullying – a website to help you understand bullying, the many types, who is at risk, how to respond, and prevention efforts.

- http://www.stopbullying.gov/

Text4Baby – Women who **text BABY (or BEBE for Spanish) to 511411** receive free text messages three times per week, timed to their due date or their baby's birth date, through pregnancy and up until the baby's first birthday. Text4baby sends personalized messages directly to you, and the texts have information you can trust because they are developed by experts from all over the country. There is also an app that provides additional information about baby's development, pregnancy, childcare tips, and more.

- https://www.text4baby.org

United States Department of Agriculture (USDA) Food and Nutrition Service: a resource for the **Child and Adult Care Food Program (CACFP)** guidelines and resources for healthy meals and menu planning. The CACFP is a federal program that provides reimbursements for nutritious meals and snacks to eligible children and adults who are enrolled for care at participating child care centers and homes, and adult day care centers.

- http://www.fns.usda.gov/cacfp

USDA MyPlate – The benefits of healthy eating add up over time, bite by bite. Small changes matter. *Start Simple with MyPlate*.

A healthy eating routine is important at every stage of life and can have positive effects that add up over time. It's important to eat a variety of fruits, vegetables, grains, protein foods, and dairy and fortified soy alternatives. When deciding what to eat or drink, choose options that are full of nutrients. Make every bite count.

- http://www.myplate.gov

WIC – The USDA Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.

- **Phone:** (405) 426-8500 or **Toll Free:** (888) 655-2942
- **Find Online Nutrition Education at** http://www.WICHealth.org

American Academy of Allergy Asthma & Immunology
www.aaaai.org

Anaphylaxis Emergency Action Plan

Patient Name: _____ **Age:** _____

Allergies: _____

Asthma ☐ **Yes** ***(high risk for severe reaction)*** ☐ **No**

Additional health problems besides anaphylaxis: _____

_____

Concurrent medications: _____

_____

Symptoms of Anaphylaxis

MOUTH	itching, swelling of lips and/or tongue
THROAT*	itching, tightness/closure, hoarseness
SKIN	itching, hives, redness, swelling
GUT	vomiting, diarrhea, cramps
LUNGS*	shortness of breath, cough, wheeze
HEART*	weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly.
****Some symptoms can be life-threatening. ACT FAST!***

Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

1. **Inject epinephrine in thigh using (check one):**

☐ **0.1 mg (16.5 lbs to less than 33 lbs) Specify brand:** _____

☐ **0.15 mg (33 lbs to less than 66 lbs) Specify brand:** _____

☐ **0.3 mg (66 lbs or more) Specify brand:** _____

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.

2. **Call 911 or emergency medical services (before calling contact)**

3. **Emergency contact #1: home** _____ **work** _____ **cell** _____

Emergency contact #2: home _____ **work** _____ **cell** _____

Emergency contact #3: home _____ **work** _____ **cell** _____

Comments: _____

_____

_____

Doctor's Signature/Date/Phone Number

_____

Parent's Signature (for individuals under age 18 yrs)/Date

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

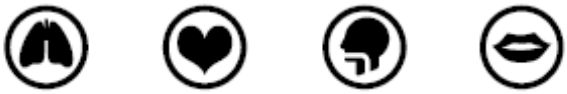
THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG Shortness of breath, wheezing, repetitive cough

HEART Pale or bluish skin, faintness, weak pulse, dizziness

THROAT Tight or hoarse throat, trouble breathing or swallowing

MOUTH Significant swelling of the tongue or lips

SKIN Many hives over body, widespread redness

GUT Repetitive vomiting, severe diarrhea

OTHER Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE Itchy or runny nose, sneezing

MOUTH Itchy mouth

SKIN A few hives, mild itch

GUT Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____ _____ _____ _____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

continued

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

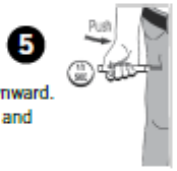
1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

American Academy of Allergy Asthma & Immunology
www.aaaai.org

ASTHMA ACTION PLAN

Name: _____ Date: _____
Emergency Contact: _____ Relationship: _____
Cell phone: _____ Work phone: _____
Health Care Provider: _____ Phone number: _____
Personal Best Peak Flow: _____

GREEN ZONE:
Doing Well
- ✓ No coughing, wheezing, chest tightness, or difficulty breathing
- ✓ Can work, play, exercise, perform usual activities without symptoms
  OR
- ✓ Peak flow ____ to ____
  (80% to 100% of personal best)

Take these medicines every day for control and maintenance:

Medicine	How much to take	When and how often

YELLOW ZONE:
Caution/Getting Worse
- ✓ Coughing, wheezing, chest tightness, or difficulty breathing
- ✓ Symptoms with daily activities, work, play, and exercise
- ✓ Nighttime awakenings with symptoms
  OR
- ✓ Peak flow ____ to ____
  (50% to 80% of personal best)

CONTINUE your Green Zone medicines PLUS take these quick-relief medicines:

Medicine	How much to take	When and how often

Call your doctor if you have been in the Yellow Zone for more than 24 hours.

Also call your doctor if: _____

RED ZONE:
Alert!
- ✓ Difficulty breathing, coughing, wheezing not helped with medications
- ✓ Trouble walking or talking due to asthma symptoms
- ✓ Not responding to quick relief medication
  OR
- ✓ Peak flow is less than ____
  (50% of personal best)

FOR EXTREME TROUBLE BREATHING/SHORTNESS OF BREATH GET IMMEDIATE HELP!

Take these quick-relief medicines:

Medicine	How much to take	When and how often

CALL your doctor NOW.
GO to the hospital/emergency department or CALL for an ambulance NOW!

AAAAIA11380

Child Care Diabetes Medical Management Plan

American Diabetes Association.
YOUR RIGHTS. ONE VOICE.™

Name of Child: _____ DOB: _____ Dates Plan in Effect: _____

Parent or guardian Name(s)/Number(s): _____

Diabetes Care Provider Name/Number: _____

Diabetes Care Provider Signature: _____ Date: _____

Location of diabetes supplies at child care facility: _____

Blood Glucose Monitoring

Target range for blood glucose is: ☐ 80-180 ☐ Other _____

When to check blood glucose: ☐ before breakfast ☐ before lunch ☐ before dinner ☐ before snacks

When to do extra blood glucose checks: ☐ before exercise ☐ after exercise ☐ when showing signs of low blood glucose ☐ when showing signs of high blood glucose ☐ other _____

Insulin Plan: Please indicate which type of insulin regimen this child uses (check one):

☐ Insulin Pump ☐ Multiple Daily Injections ☐ Fixed Insulin Doses

Specific information related to each insulin regimen/plan is included below for this child.

Type of insulin used at child care (check all that apply): ☐ Regular ☐ Apidra ☐ Humalog ☐ Novolog ☐ NPH ☐ Lantus ☐ Levemir ☐ Mix ☐ Other _____

Plan A: Insulin Pump*

1. Always use the insulin pump bolus wizard: ☐ Yes ☐ No
   If no, use Insulin:Carbohydrate Ratio and Correction Factor dosage on Plan B.
2. Blood glucose must be checked before the child eats and will (check one):
   ☐ Be sent to the pump by the meter
   ☐ Need to be entered into the pump
3. The insulin pump will calculate the correction dose to be delivered **before** the meal/snack.
4. **After the meal/snack**, enter the total number of carbohydrates eaten at that meal/snack. The insulin pump will calculate the insulin dose for the meal.
5. Contact parent/guardian with any concerns.

For a list of definitions of terms used in this document, please see the *Diabetes Dictionary*.

***Providers should complete Insulin:Carbohydrate ratio and Correction dosage under Plan B section for ALL pump users.**

Plan B: Multiple Daily Injections

1. Child will receive a fixed dose of _____ long-acting insulin at _____ ☐ **Yes** ☐ **No**
2. Follow blood glucose monitoring plan above.
3. **Use _____ insulin for meals and snacks. Insulin dose for food is** _____ unit(s) for meals **OR** _____ unit(s) for every _____ grams carbohydrate.

Give injection after the child eats.

4. If blood glucose is above target, add correction dose to:
   ☐ **Breakfast** ☐ **Snack**
   ☐ **Lunch** ☐ **Snack**
   ☐ **Other:** _____

Use the following correction factor _____ or this scale:

_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____

Only add correction dose if it has been 3 hours since the last insulin administration.

C: Fixed Insulin Doses

1. Child will receive a fixed dose of long acting insulin? ☐ **Yes** ☐ **No**
   If yes, give child _____ units of _____ insulin at _____.
2. Insulin correction dose at child care (_____ insulin)?
   ☐ Yes ☐ No
3. If blood glucose is above target, add correction dose to:
   ☐ **Breakfast** ☐ **Snack**
   ☐ **Lunch** ☐ **Snack**
   ☐ **Other:** _____

Use the following correction factor _____ or the following scale:

_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____

Only add correction dose if it has been 3 hours since the last insulin administration.

continued

Managing Very Low Blood Glucose

Hypoglycemia Plan for Blood Glucose less than _____ mg/dL

1. Give 15 grams of fast acting carbohydrate.
2. Recheck blood glucose in 15 minutes.
3. If still below 70 mg/dL, offer 15 grams of fast acting carbohydrate, check again in 15 minutes.
4. When the child's blood glucose is over 70, provide 15g of carbohydrate as snack. Do not give insulin with this snack.
5. **Contact the parent/guardian** any time blood glucose is less than _____ mg/dL at child care.

Usual symptoms of hypoglycemia for this child include:

☐ Shaky ☐ Fast heartbeat ☐ Sweating
☐ Anxious ☐ Hungry ☐ Weakness/Fatigue
☐ Headache ☐ Blurry vision ☐ Irritable/Grouchy
☐ Dizzy ☐ Other _____

1. If you suspect low blood glucose, check blood glucose!
2. If blood glucose is below _____, follow the plan above.
3. If the child is unconscious, having a seizure (convulsion) or unable to swallow:
   - Give glucagon. Mix liquid and powder and draw up to the first hash mark on the syringe. Then inject into the thigh. Turn child on side as vomiting may occur.
   - If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance). After calling 911, contact the parents/guardian. If unable to reach parent, contact diabetes care provider.

Managing Very High Blood Glucose

Hyperglycemia Plan for Blood Glucose higher than _____ mg/dL

Usual symptoms of hyperglycemia for this child include:

☐ Extreme thirst ☐ Very wet diapers, accidents
☐ Hungry ☐ Warm, dry, flushed skin ☐ Tired or drowsy
☐ Headache ☐ Blurry vision ☐ Vomiting**
☐ Fruity breath ☐ Rapid, shallow breathing
☐ Abdominal pain ☐ Unsteady walk (more than typical)
**If child is vomiting, contact parents immediately

Treatment of hyperglycemia/very high blood glucose:

1. Check for ketones in the:
   ☐ urine ☐ blood (parent will provide training)
2. **If ketones are moderate or large**, contact parent. If unable to reach parent, contact diabetes care provider for additional instructions.
   Contact parent if ketones are trace or small: ☐ Yes ☐ No
3. Children with high blood glucose will require additional insulin **if the last dose of insulin was given 3 or more hours earlier**. Consult the insulin plan above for instructions. If still uncertain how to manage high blood glucose, contact the parent.
4. Provide sugar free fluids as tolerated.
5. You may also:
   ☐ Provide carbohydrate free snacks if hungry
   ☐ Delay exercise
   ☐ Change diapers frequently/give frequent access to the bathroom
   ☐ Stay with the child

Diabetes Dictionary

Blood glucose - The main sugar found in the blood and the body's main source of energy. Also called blood sugar. The **blood glucose level** is the amount of glucose in a given amount of blood. It is noted in milligrams in a deciliter, or mg/dL.

Bolus - An extra amount of insulin taken to lower the blood glucose or cover a meal or snack.

Bolus calculator – A feature of the insulin pump that uses input from a pump user to calculate the insulin dose. The user inputs the blood glucose and amount of carbohydrate to be consumed, and the pump calculates the dose that can be approved by the user.

Correction Factor – The drop in blood glucose level, measured in milligrams per deciliter (mg/dl), caused by each unit of insulin taken. Also called **insulin sensitivity factor**.

Diabetic Ketoacidosis (DKA) – An emergency condition caused by a severe lack of insulin, that results in the breakdown of body fat for energy and an accumulation of ketones in the blood and urine. Signs of DKA are nausea and vomiting, stomach pain, fruity breath odor and rapid breathing. Untreated DKA can lead to coma and death.

Fixed dose regimen – Children with diabetes who use a fixed dose regimen take the same "fixed" doses of insulin at specific times each day. They may also take additional insulin to correct **hyperglycemia**.

Glucagon – A hormone produced in the pancreas that raises blood glucose. An injectable form of glucagon, available by prescription, is used to treat severe hypoglycemia or severely low blood glucose.

Hyperglycemia - Excessive blood glucose, greater than 240 mg/dL for children using and insulin pump and greater than 300 mg/dL for children on insulin injections. If untreated, the patient is at risk for **diabetic ketoacidosis (DKA)**.

Hypoglycemia - A condition that occurs when the blood glucose is lower than normal, usually less than 70 mg/dL. Signs include hunger, nervousness, shakiness, perspiration, dizziness or light-headedness, sleepiness, and confusion. If left untreated, hypoglycemia may lead to unconsciousness.

Insulin - A hormone that helps the body use glucose for energy. The beta cells of the pancreas make insulin. When the body cannot make enough insulin, it is taken by injection or through use of an insulin pump.

Insulin Pump - An insulin-delivering device about the size of a deck of cards that can be worn on a belt or kept in a pocket. An insulin pump connects to narrow, flexible plastic tubing that ends with a needle inserted just under the skin. Pump users program the pump to give a steady trickle or constant (basal) amount of insulin continuously throughout the day. Then, users set the pump to release bolus doses of insulin at meals and at times when blood glucose is expected to be higher. This is based on programming done by the user.

Ketones - A chemical produced when there is a shortage of insulin in the blood and the body breaks down body fat for energy. High levels of ketones can lead to **diabetic ketoacidosis** and coma.

Multiple Daily Injection Regimen - Multiple daily insulin regimens typically include a basal, or long acting, insulin given once per day. A short acting insulin is given by injection with meals and to correct hyperglycemia, or elevated blood glucose, multiple times each day.

Type 1 Diabetes - Occurs when the body's immune system attacks the insulin-producing beta cells in the pancreas and destroys them. The pancreas then produces little or no insulin. Type 1 diabetes develops most often in young people but can appear in adults. It is one of the most common chronic diseases diagnosed in childhood.

_____
Physician Signature

Safe at School

Emergency Information Form for Children With Special Needs

American College of Emergency Physicians*

American Academy of Pediatrics

Date form completed	Revised	Initials
By Whom	Revised	Initials

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

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

*Consent for release of this form to health care providers

continued

Diagnoses/Past Procedures/Physical Exam continued:

Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1.	
2.	
3.	
4.	Prostheses/Appliances/Advanced Technology Devices:
5.	
6.	

Management Data:

Allergies: Medications/Foods to be avoided	**and why:**
1.	
2.	
3.	
Procedures to be avoided	**and why:**
1.	
2.	
3.	

Immunizations

Dates						**Dates**					
DPT						Hep B					
OPV						Varicella					
MMR						TB status					
HIB						Other					

Antibiotic prophylaxis: Indication: Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: **Print Name:**

Medication Administration Packet

Authorization to Give Medicine

PAGE 1—TO BE COMPLETED BY PARENT/GUARDIAN

CHILD'S INFORMATION

_____ ___/___/___

Name of Facility/School Today's Date

_____ ___/___/___

Name of Child (First and Last) Date of Birth

Name of Medicine _____

Reason medicine is needed during school hours _____

Dose _____ Route _____

Time to give medicine _____

Additional instructions _____

Date to start medicine ____/____/____ Stop date ____/____/____

Known side effects of medicine _____

Plan of management of side effects _____

Child allergies _____

PRESCRIBER'S INFORMATION

_____

Prescribing Health Professional's Name

_____

Phone Number

PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

_____

Parent or Guardian Name (Print)

_____

Parent or Guardian Signature

_____

Address

_____

Home Phone Number Work Phone Number Cell Phone Number

continued

Receiving Medication

PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child _____

Name of medicine _____

Date medicine was received _____/_____/_____

Safety Check

- ☐ 1. Child-resistant container.
- ☐ 2. Original prescription or manufacturer's label with the name and strength of the medicine.
- ☐ 3. Name of child on container is correct (first and last names).
- ☐ 4. Current date on prescription/expiration label covers period when medicine is to be given.
- ☐ 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.
- ☐ 6. Copy of Child Health Record is on file.
- ☐ 7. Instructions are clear for dose, route, and time to give medicine.
- ☐ 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.
- ☐ 9. Child has had a previous trial dose.

Y ☐ N ☐ 10. Is this a controlled substance? If yes, special storage and log may be needed.

_____

Caregiver/Teacher Name (Print)

_____

Caregiver/Teacher Signature

Guide to Medication Administration in the School Setting

SAMPLE Request for Administration of Medication at School

This form must be filled out **completely** in order for school health staff to administer medication to a student. A new medication authorization form must be completed at the beginning of each school year, for each medication, and each time there is a change in the medication's administration instructions.

- Prescription and non-prescription medication must be delivered to school in its original container.
- The container must be properly labeled by a pharmacist or the prescribing physician.

Student's Name_____ Sex_____

Date of Birth ____ /____ /_____ Teacher/Homeroom_____

Condition for which medication is being administered_____

Medication Name_____ Dose_____ Route _____

Times(s) of day to administer_____

Medication shall be administered from: ____/____/_____ to: ____/____/_____

Possible side effects_____

Special requirements for administration/storage_____

Known Food or Drug Allergies YES NO If Yes, please explain_____

Prescriber's Name_____ Telephone____ - ____ - _____

Address_____

Prescriber's Signature_____ Date_____

continued

Parent /Guardian Authorization

I request that school health staff administer the medication as described above by my child's primary prescriber. I consent to medication administration for my child named above and agree to review and provide any special instructions for the administration of child's medication, and share that information with my child's school health staff.

Parent/Guardian Signature_____ Date_____

Cell Phone____ - ____ - _____ Home Phone ____ - ____ - _____ Work Phone ____ - ____ - _____

Faculty Review

Medication was received from_____ Date_____

Medication was received by_____ Date_____

Initial Count (pills or tablets) or Measurement (liquids) _____

Witness Signature_____ Date_____

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

continued

Seizure Action Plan *continued*

Care after seizure

What type of help is needed? (describe) _____

When is student able to resume usual activity? _____

Special instructions

First Responders: _____

Emergency Department: _____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

Epilepsy.com

Revised 01/2020 130SRP/PAB1216

EPILEPSY FOUNDATION | END EPILEPSY

Seizure First Aid

How to help someone having a seizure

1

STAY with the person until they are awake and alert after the seizure.

✓**Time** the seizure ✓Remain **calm**
✓Check for **medical ID**

2

Keep the person **SAFE**.

✓Move or guide away from **harm**

3

Turn the person onto their **SIDE** if they are not awake and aware.

✓Keep **airway clear**
✓**Loosen tight clothes** around neck
✓Put **something small and soft** under the head

Call 911 if...

- Seizure lasts longer than 5 minutes
- Person does not return to their usual state
- Person is injured, pregnant, or sick
- Repeated seizures
- First time seizure
- Difficulty breathing
- Seizure occurs in water

Do NOT

✗ Do **NOT** restrain.

✗ Do **NOT** put any objects in their mouth.

✓**Rescue medicines can be given** if prescribed by a health care professional

Learn more: **epilepsy.com/firstaid**

EPILEPSY FOUNDATION | epilepsy.com

24/7 Helpline: 1-800-332-1000

This publication was created by the Epilepsy Foundation, a nationwide network organization, and is part of our END EPILEPSY® awareness campaign. This publication is made possible with funding from the Centers for Disease Control and Prevention (CDC) under cooperative grant agreement number 1NUS8DP006256-04-00. Its contents are solely the responsibility of the Epilepsy Foundation and do not necessarily represent the views of the CDC. EFA440/PA80220 Rev. 02/2020

Special Health Care Plan

To be completed by the Child Care Health Consultant or Health Advocate. The Special Health Care Plan provides information on how to accommodate the special health concerns and needs of this child while attending an early care and education program.

Name of Child:_____ Date:___/___/_____

Name of Child Care Program:_____

Description of Health Condition(s)

List description each health condition:

_____

_____

Team Member Names and Titles (include parents)

Parent/Guardian_____

Health Care Provider (MD, NP)_____

On-site Care Coordinator_____

_____

Team Members; Other Support Programs Outside of Child Care (name, program, contact information, frequency)

☐ Physical Therapist (PT)_____

☐ Occupational Therapist (OT)_____

☐ Speech & Language Therapist:_____

☐ Social Worker:_____

☐ Mental Health Professional/Consultant:_____

☐ Family-Child Advocate:_____

Other:_____

Communication

The team will communicate: ☐ Daily ☐ Weekly ☐ Monthly Other_____

The team will communicate by: ☐ Notes, ☐ Communication log, ☐ Phone, ☐ E mail, ☐ In Person Meetings,

☐ Other_____ Dates and times_____

Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) is attached. ☐ Yes ☐ No

Staff Training Needs

Type of training:_____

Training will be provided by:_____

Training will be monitored by:_____

Staff who will receive training:_____

Dates for training:_____

Plan for absences of trained personnel responsible for health-related procedure(s):

_____

_____

UCSF School of Nursing, California Childcare Health Program cchp.ucsf.edu Revised 06/2016

continued

Special Health Care Plan

Medical Information

Medical information from the Health Care Provider is attached: □ Yes □ No

Information Exchange Form cchp.ucsf.edu/InfoExchangeForm has been completed by Health Care Provider: □ Yes □ No

Medication to be given: □ Yes □ No

Medication Administration Form has been completed by health care provider and parents: □ Yes □ No

Allergies: □ Yes □ No if yes, list:_____

Safety

Strategies to support the child's needs and safety issues while in child care: (e.g., diapering/toileting, outdoor play, circle time, field trips, transportation, nap/sleeping)_____

Special equipment:_____

Positioning requirements:_____

Equipment care/maintenance:_____

Nutrition and Feeding Needs

A Nutrition and Feeding Care Plan has been completed □ Yes □ No

Allergies to food: □ Yes □ No if yes, list:_____

Other feeding concerns:_____

Behavior Concerns

List specific changes in behavior that arise as a result of the health-related condition/concerns _____

Emergencies

Emergency contact:_____ Telephone: _____

Health Care Provider:_____ Telephone:_____

Emergency Information Form Completed □ Yes □ No

Follow-up, Updates, and Revisions

This Special Health Care Plan is to be updated/revised whenever child's health status changes or at least every _____ months as a result of the collective input from team members.

Due date for revision and team meeting:_____/_____/_____.

Attach additional information if needed. Include unusual episodes that might arise while the child is in care, how the situation should be handled, and special emergency or medical procedures that may be required.

INDEX

This publication was supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, CDC/HHS or the U.S. Government. 4,500 copies were printed by OMES Central Printing at a cost of $105,106.37. A digital file has been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries in compliance with section 3-114 of Title 65 of the Oklahoma Statutes and is available for download at www.documents.ok.gov. | Issued July 2023