# Good Health Handbook

## A Guide For Those Caring for Children

Oklahoma State
Department of Health
Creating a State of Health

**Maternal and Child Health Service**

# Good Health Handbook

## INTRODUCTION

As child care providers, we know that one of your most important roles is to do all that you can to keep every child in your care healthy and safe. This handbook will help you by providing up-to-date information on health and safety issues.

The *Good Health Handbook* includes much of the information you will need about health policies, infection control, injury prevention, and childhood conditions and illnesses. It has been revised and expanded to include new chapters on Child Wellness, Child Abuse and the Successful Caregiver; as well as updated information throughout.

Though Choking and CPR are included in the topics covered in Chapter 5, it is very important for every child care provider to take a class with a certified instructor to learn the correct procedures. The skills needed cannot be learned from a book. It requires repeated hands-on learning. Contact your Licensing Specialist for a list of DHS approved courses in your area.

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 to follow and is in no way intended to replace the recommendations of your medical advisors.

We encourage you to contact your local health department and ask for the child care health consultant. Your child care health consultant can help you with many health and safety issues such as answering questions, assisting you in the development of health policies, teaching infection control, and proper handwashing.

The 2007 revised edition of the *Good Health Handbook for the Child Care Provider* was developed by a dedicated group of individuals and health professionals with funding provided by the Oklahoma State Department of Health Maternal and Child Health Service, and the Oklahoma Department of Human Services Oklahoma Child Care Services.

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# Good Health Handbook

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# Chapter 1

# Child Wellness


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# KEEPING CHILDREN HEALTHY

## Implement Good Health Care Policies

- Accept children only if they have been immunized or are in the process of being immunized according to state law or have a state filed exemption form.
- Exclude ill children from a child care facility that does not provide care for ill children.
- Have an emergency consent form on file for medical treatment in case of an emergency.
- Notify parents of children's exposure to a contagious illness or infestation so parents can discuss the situation with their child's doctor.

## Provide a Safe Environment

- Inspect indoor and outdoor play space daily for hazards. (Refer to the Health and Safety Checklist, Appendix H).
- Repair or discard broken equipment. Ask parents to keep toys with small parts at home.
- Supervise children at all times.
- Store medications safely out of the reach of all children.
- Arrange an environment where all hazardous items such as cleaning items, beauty products, and poisonous plants are safely out of children's reach.

## Meet Children's Physical and Emotional Needs

- Feed children nutritious meals and snacks. Good nutrition contributes to a child's good health.
- Give children enough time for rest. A tired child has more trouble learning and concentrating, as well as more behavior problems.
- Be positive, playful, warm and nurturing with the children. Talk with the children about everything you do in your day, and take time for listening to each of them.

- Be alert to early signs of illness. Inform parents when their child seems to be too quiet, has a change in eating habits, or takes an unusually long or short nap.

**Stress Cleanliness**

- Staff and children must wash their hands prior to food preparation, before eating or feeding someone else, after diapering or toileting, after touching or cleaning up body fluids, including wiping noses, and after handling or feeding pets.

- Teach children proper handwashing techniques. Decide on a fun "*handwashing song*" and make scrubbing a fun activity.

- Toys and other items that are in contact with children's mouths are washed and sanitized after each child's use.

- Follow proper diaper changing procedures.

- Mop and vacuum floors daily or more often if necessary.

**Provide Opportunities to Educate Yourself, Parents and Staff**

- Copy pages from this book to use as handouts for parents about a current disease or a safety issue.

- Contact the county health department for assistance or information on specific diseases.

- Invite health professionals to present units on injury prevention, nutrition, the importance of physical activity and preventing the spread of disease.

# OKLAHOMA IMMUNIZATION LAW

**Child care facilities in Oklahoma are required by law to:**

- Enroll Children only if they have been immunized, are in the process of being immunized according to state law, or have a state filed exemption form.
- Have a record of all children's immunizations.
- Accept only records signed by a "licensed physician or authorized representative of any state or local department of public health" (refer to the Child Care Guide to Immunizations in Oklahoma – Immunization Service, Oklahoma State Department of Health).

**In order to meet this requirement you will need to:**

- Be familiar with immunization schedule.
- Set up a file or system for monthly review.
- Communicate with parents when overdue immunizations might require a child to be excluded from your child care.

# GUIDE TO IMMUNIZATIONS REQUIRED TO ATTEND CHILD CARE IN OKLAHOMA

As a general rule, healthy children between the ages of 18 months and 5 years require at least three doses of polio vaccine; at least four doses of DTP/DTaP vaccine; one to four doses of Hib, depending on the age of the child at first dose of Hib; one dose of measles, mumps and rubella vaccine (MMR), one dose of varicella (chickenpox) vaccine, 3 doses of Hepatitis B vaccine, 1 to 4 doses of pneumococcal conjugate vaccine (PCV) and 2 doses of Hepatitis A vaccine.

This chart shows the recommended ages for the required immunizations:

| | 2 months | 4 months | 6 months | 12-15 months | | 4-6 years |
|---|---|---|---|---|---|---|
| DTaP | 1 | 2 | 3 | 4 | | 5 |
| Polio | 1 | 2 | 3 | | | 4 |
| Hib | 1 | 2 | 3 | 4 | | |
| MMR | | | | 1 | | |
| Hep B | 1 (or earlier) | 2 | 3 | | | |
| PCV | 1 | 2 | 3 | 4 | | |
| Hep A | | | | 1 | 2 (6 to 18 mos. later) | |
| Varicella | | | | 1 | | |

- The 4th dose of DTP/DTaP can be given as early as 12 months provided the interval between the 3rd and 4th doses is at least 6 months.
- Measles, mumps and rubella must be given on or after the child's first birthday to be acceptable.
- The second dose of Hepatitis A vaccine is due 6 to 18 months after the first dose.

DTaP Diphtheria-tetanus-acellular pertussis
Polio IPV or OPV
Hib *Haemophilus influenzae* type b
MMR Measles-mumps-rubella
HepB Hepatitis B
HepA Hepatitis A
Varicella Chicken Pox
PCV Pneumococcal conjugate vaccine

**The schedule and required number of doses for Hib vaccine varies depending on the age of the child when the first dose is received and the brand of the vaccine. The required number of doses for PCV varies depending on the age of the child when the first dose is received. See tables on page 8.**

| **Hib Vaccine** | Age at first vaccination (mos) | Primary Series | Booster |
|---|---|---|---|
| HibTITER (HbOC) | 2-6 | 3 doses, 2 mos apart | 12-15 mos |
| ActHIB (PRP-T) | 7-11 | 2 doses, 2 mos apart | 12-18 mos |
| | 12-14 | 1 dose | 2 mos later |
| | 15-59 | 1 dose | - |
| PedvaxHib (PRP-OMP) | 2-6 | 2 doses, 2 mos apart | 12-15 mos |
| | 7-11 | 2 doses, 2 mos apart | 12-18 mos |
| | 12-14 | 1 dose | 2 mos later |
| | 15-59 | 1 dose | - |
| ProHIBIT (PRP-D) | 15-59 | 1 dose - | |

**PCV7 or PCV (7-valent pneumococcal conjugate vaccine – Prevnar)**
Vaccination Schedules for Children Less Than 5 Years, by PCV7 Vaccination History

| Child's Current Age in Months | Number of Prior Doses of PCV7 - Vaccination History | Recommended Schedule |
|---|---|---|
| 2-6 | 0 doses | 3 doses, 2 mos. apart; fourth dose at age 12-15 mos. |
| | 1 dose | 2 doses, 2 mos. apart; fourth dose at age 12-15 mos. |
| | 2 doses | 1 dose, 2 mos. after the most recent dose; fourth dose at age 12-15 mos. |
| 7-11 | 0 doses | 2 doses, 2 mos. apart; third dose at 12-15 mos. |
| | 1 or 2 doses before age 7 mos. | 1 dose at age 7-11 mos., with another dose at 12-15 mos. ($\geq$2 mos. later) |
| 12-23 | 0 doses | 2 doses $\geq$2 mos. Apart |
| | 1 dose before age 12 mos. | 2 doses $\geq$2 mos. Apart |
| | 1 dose at $\geq$12 mos. | 1 dose, $\geq$2 mos. after the most recent dose |
| | 2 or 3 doses before age 12 mos. | 1 dose, $\geq$2 mos. after the most recent dose |
| 24-59 | 0 doses or any incomplete schedule | 1 dose, $\geq$2 mos. after the most recent dose |

For further information, please call the Immunization Service, State Health Department, 405-271-4073.

# Guide to Immunization Requirements in Oklahoma
# 2007-2008

| CHILD CARE | PRE-SCHOOL/PRE-KG | KDG thru 9th | 10th and 11th | 12th |
|---|---|---|---|---|
| 4 DTP/DTaP/Td | 4 DTP/DTaP/Td | 5 DTP/DTaP/Td/Tdap | 5 DTP/DTaP/Td/Tdap | 3 DTP/Td/Tdap |
| 1-4 PCV | | | | |
| 3 Polio | 3 Polio | 4 Polio | 4 Polio | 3 Polio |
| 1 MMR | 1 MMR | 2 MMR | 2 MMR | 2 MMR |
| 1-4 Hib | | | | |
| 3 Hep B | 3 Hep B | 3 Hep B | 2 or 3 Hep B | 2 or 3 Hep B |
| 2 Hep A | 2 Hep A | 2 Hep A | 2 Hep A | 2 HEP A |
| Varicella | Varicella | Varicella | | |

- This table lists the vaccines that are required for children to attend childcare and school. Not all recommended vaccines are required.
- Children in childcare must be up-to-date for their age for the vaccines listed.
  - All measles, mumps and rubella (MMR) and varicella vaccine doses must be administered on or after the child's first birthday or up to 4 days before the birthday to be counted as valid doses.
  - **If the 4th dose of DTP/DTaP is administered on or after the child's 4th birthday then the 5th dose of DTP/DTaP is not required.**
  - Beginning Jan.1, 2003, if a 5th dose of DTaP is required it must be given on or after the 4th birthday or within 4 days before the birthday.
  - **If the 3rd dose of Polio is administered on or after the child's 4th birthday then the 4th dose of Polio is not required.**
  - Hepatitis A vaccine must be administered on or after the child's first birthday or within 4 days before the birthday.
  - **Hepatitis B may be administered in a two (2) dose series to children 11 through 15 years of age.** All other age groups will receive the three (3) dose Hepatitis B series.
  - **A parental history of a child having varicella (chickenpox) disease is acceptable in lieu of varicella vaccine.**
  - Hib vaccine is not required for students in pre-school, pre-kindergarten or kindergarten through grade twelve, but is required for children in childcare.
  - Longer than recommended time periods between doses of multi-dose vaccines do not diminish the effectiveness of these vaccines. **It is not necessary to restart the series of any vaccine due to longer than recommended time periods between doses.**
  - Children may be allowed to attend school if they have received the first dose in the series of any multi-dose vaccine but must complete the series on schedule. These children are "in the process of receiving " immunizations.
  - Doses administered 4 days or less, before the minimum intervals or ages, will be counted as valid doses; applies to all children including those already enrolled.

For further immunization information please call the Immunization Service, Oklahoma State Department of Health, at 1-800- 234-6196.

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# IMMUNIZATION INFORMATION

**Who is responsible?**

- Parents are responsible for having their children immunized.
- Child care directors and staff are responsible for following the law by refusing entry to children who do not have immunizations; refer them to their private provider or the county health department.
- Child care licensing staff and health inspectors are responsible for auditing the immunization records to assure compliance with the law.

Children are not in compliance with State law unless they have a certificate of immunization or exemption on file. New enrollees should present evidence of immunization ***before*** the child is allowed to attend.

**Immunization records are lost or cannot be found**

If records are not available the child will need to receive immunizations again.

**The child is sick.**

If a physician or public health agency determines a child cannot receive an immunization on time due to illness, a note from that authority must be kept on file at the child care facility. Children should be immunized as soon as they are medically able.

**Parents who are concerned about side effects**

Always refer these parents to a medical professional who can give them accurate information. They can call any public health agency that gives immunizations.

**When is a child fully immunized?**

A child who has received the complete "series" of each immunization is fully immunized. For most immunizations, the final dose of the "series" should last for many years.

**What is "acceptable evidence" of immunization?**

Any record provided by a licensed physician or public health agency that contains the following:

- Which immunization was received.
- The date the immunization was given.
- The signature or stamp of the person or agency giving the vaccination.
- Name and date of birth of the child.

**What about children that are behind on their immunizations?**

These Children may be allowed to attend as long as they are in the process of receiving the immunizations. The parents ***are required*** to present a schedule, note, or letter signed by a physician or public health agency that outlines a medically approved timetable for completion of the remaining immunizations. The schedule must be followed or the child should be excluded from the center.

**Immunization of children over two years of age, who are not up to date**

Refer to the schedules provided by the Oklahoma State Department of Health (OSDH) in the Child Care Operator's guide to Oklahoma's Immunization Requirements. If you are having trouble call the OSDH Immunization Service information at 1-800-234-6191; your local county health department; or your private physician.

**What about "drop-ins"?**

Drop-ins must also have immunization records before attending.

**Can adults get sick with "childhood illnesses"?**

Yes. Adults who work with children should evaluate their own immunizations with their physician or through a public health agency.

Everyone should receive one dose of Tetanus, Diphtheria, and Pertussis (Tdap) vaccine and a Tetanus and Diphtheria (Td) vaccine every ten years. Some adults may need a Varicella, and Measles, Mumps and Rubella immunization (MMR). An annual flu immunization may be recommended.

# VACCINE-PREVENTABLE DISEASES: THE BASICS

- **Chickenpox (Varicella)** is an illness caused by a virus. Chickenpox is usually a mild febrile illness with a rash. In adolescents and adults however, this virus may produce more serious disease with complications such as pneumonia. Pregnant women who become infected with the varicella virus are at even greater risk for serious complications than other adults, especially late in pregnancy. In addition, infection early in gestation can occasionally produce serious birth defects in the fetus.\

- **Diphtheria** is a serious bacterial disease and is spread person to person by infected secretions. Diphtheria can cause blockage of the airway, making it impossible to breathe. It can also cause heart problems.

- **Haemophilus influenza type b (Hib)** is a very serious bacterial disease, which causes about 12,000 cases of meningitis (inflammation of the covering of the brain) in the United States each year. For the most part, this disease affects children under the age of five (children between six months of age and one year of age are affected by the most serious Hib disease). One in four children with the disease suffers permanent brain damage and about one in twenty dies. Other problems caused by "Hib" are pneumonia and infections of the blood, joints, bones, soft tissues, throat, and the covering of the heart. Please do not be confused with the name. "Hib" ***does not*** have anything to do with the flu (influenza).

- **Hepatitis** is a disease characterized by inflammation of the liver. The symptoms of hepatitis are mild fever, loss of appetite, nausea, vomiting, fatigue, stomach pain, dark urine, and sometimes yellow discoloration of the eyes and/or skin. It should be noted that young children (those under five years of age) may not seem sick or may appear to have a mild illness like "stomach flu" but can still spread the illness to adults. Several viruses can cause hepatitis, but the most common are A and B.

    - **Hepatitis A virus** is spread from person to person by eating food or drinking water that has been contaminated with human feces. It is estimated that 150,000 people in the United States are infected each year by hepatitis A. The Centers for Disease Control list household or sexual contact, child care attendance or employment, and recent international travel as the major risk factors for Hepatitis A.

    - **Hepatitis B virus** can cause a serious form of Hepatitis. The infection may occur in two phases. The acute phase occurs just after a person becomes infected, and can last from a few weeks to several months. Some people recover after the acute phase, but others remain infected for the rest of their lives. Over half the people who become infected with hepatitis B never become sick, but some later develop long-term liver disease. Hepatitis B is passed from one person to another in blood or certain body fluids. A baby can get Hepatitis B from its mother during birth.

- **Influenza (flu)** is a highly contagious viral infection of the nose, throat, and lungs. It is one of the most severe illnesses of the winter season, and spreads easily when an infected person coughs or sneezes. Influenza may lead to hospitalization or even death, especially among the elderly. Typical symptoms include an abrupt onset of high fever, chills, a dry cough, headache, runny nose, sore throat, and muscle and joint pain. Because the virus changes, persons can contract influenza each year.

- **Measles** is a highly contagious disease caused by a virus. Symptoms are rash, high fever, cough, runny nose, and watery eyes. Measles can cause serious problems. Nearly one out of ten children with measles will get an ear infection or pneumonia. One child out of 1,000 will develop an inflammation of the brain, which can lead to convulsions, deafness, or mental retardation. One or two children out of 1,000 will die from it. A pregnant woman can experience a miscarriage or give birth too early due to measles.

    - Immunization for measles has greatly reduced the number of cases occurring in the United States. Ten years prior to the vaccine, an average of 530,000 cases were reported each year in the United States and over 450 people died each year from measles. Today, the number of measles cases is less than five percent of what it was before the vaccine was available.

    - However, cases continue to occur due to inadequate immunization. Any child who has not been immunized for measles is at risk for getting the disease.

- **Mumps** is another disease caused by a virus. Symptoms of mumps are fever, headache, and inflammation of the salivary glands (this causes swelling of the cheeks at the angle of the jaw). More serious effects from mumps are meningitis (inflammation of the coverings of the brain and spinal cord) which occurs in one out of ten children. Other problems which can occur are encephalitis (inflammation of the brain), deafness, and painful inflammation and swelling of the testicles (one out of every four males).

    - Before the vaccine, nearly every child got mumps. Because of the vaccine, the number of cases is much lower.

- **Pertussis (Whooping Cough)** is a highly contagious disease. It is caused by bacteria living in the mouth, nose, and throat of the infected person.

    - Pertussis causes severe spells of coughing which can interfere with eating, drinking, and breathing. Pertussis is most serious in infants less than one year of age, and more than half of the infants reported with Pertussis are hospitalized.

    - Complications are fairly common. One out of every ten children with Pertussis will develop pneumonia. Convulsions (seizures) occur in 20 out of 1,000 children. An average of nine deaths a year has been caused by Pertussis.

**Pneumococcal disease** is the leading bacterial cause of meningitis, pneumonia, ear infections and sinus infections. Pneumonia symptoms include high fever, cough with chest pain and

mucus, shaking, chills, breathlessness, and chest pain that increases with breathing. Older adults often experience changes in level of consciousness or confusion.

- **Polio** is a very dangerous disease caused by a virus which lives in the throat and intestines of the individual infected with it. Many people can spread the infection to others even though they may not have symptoms of the illness.

  - Milder forms of polio usually come on suddenly and last only a few days. Although some individuals do not have any symptoms, others may experience fever, sore throat, nausea, headache, stomach ache, pain and stiffness (neck, back, and legs).

  - "Paralytic Polio" is the serious form of polio and can cause paralysis (inability to move parts of the body). The symptoms are the same as in the milder form, however, they are usually accompanied by severe muscle pain. If paralysis occurs, it does so within the first week. The person may not be able to move his/her arms or legs, and may have difficulty breathing without the help of a respirator, or assisted breathing. There is not a specific treatment for polio and the amount of recovery varies with the individual.

  - In 1952, the number of cases of paralytic polio in the United States was more than 20,000. Polio has been irradicated from the Western Hemisphere.

- **Rubella (German Measles)** Rubella is usually considered a mild disease of childhood. It is caused by a virus which is spread through coughing, sneezing, or talking.

  - The usual symptoms are mild discomfort, a slight fever for about 24 hours, and a rash on the face and neck that lasts for two or three days. Young adults may experience swollen glands in the back of the neck and temporary pain, swelling, or stiffness of body joints. Recovery is usually quick and complete.

  - The biggest concern about Rubella is its affect on unborn children; they are in the greatest amount of danger from rubella if their mothers get the disease early in the pregnancy. The chances of such babies being born with birth defects may be as high as 80%. The most common birth defects are blindness, deafness, heart and major artery damage, abnormally small brains and developmental delays.

  - Immunization for Rubella not only protects the immunized child but also protects those not able to be immunized.

**Tetanus (Lockjaw)** is caused by a toxin (poison) produced by a bacteria that enters the body through a cut or wound. Tetanus causes serious, painful spasms of all muscles and can lead to ”locking” of the jaw so a person cannot open his or her mouth, swallow, or breathe. Three of ten people who get tetanus die from the disease. Everyone should receive a “Td” vaccine (Tetanus and Diphtheria) every ten years after their last childhood DTP/DTaP or TD.

# NUTRITION - HEALTHY EATING TIPS

Encourage food choices for a healthy diet. When children are offered a balanced diet, over time they will develop good eating habits.

**Be patient**

Young children may not be interested in trying new foods. Offer a new food more than once. Show your child how the rest of the family enjoys it. The food may be accepted when it becomes more familiar to your child.

**Be a planner**

- Most young children need a snack or two in addition to three regular daily meals.
- Offer foods from three or more of the major food groups for breakfast.
- Offer foods from four or more of the major food groups for the "main meal."
- Plan snacks so they are not served too close to mealtime, and offer foods from two or more of the major food groups

**Be a good role model**

What you do can mean more than what you say. Your child learns from you about how and what to eat.

- Eat meals at the table with your children whenever possible. Turn off the TV and all other electronic equipment and have a conversation with your family.
- Try new foods and new ways of preparing them with your children. Both you and your children can be healthier by eating more dark-green leafy vegetables, deep-yellow vegetables, fruits, and whole grain products.
- Walk, run, and play with your children. Don't just sit on the sidelines. A family that is physically active together has lots of fun!

**MyPyramid For Kids**

**MyPyramid for Kids** reminds children to be active every day and to make healthy food choices. Every part of the new symbol has a message.

**Be Physically Active Every Day**

The person climbing the stairs is a reminder to do something active every day, like running, walking the dog, playing, swimming, biking, or climbing lots of stairs.

**Eat More From Some Food Groups Than Others**

Some of the color stripes are wider than others. This is a reminder to children to choose more foods from the food groups with the widest stripes.

**Choose Healthier Foods From Each Group**

Every food group has foods that people should eat more often than others; these foods are at the bottom of the pyramid.

**Every Color Every Day**

The colors orange, green, red, yellow, blue and purple represent five different food groups plus oils. Children should remember to eat foods from all food groups every day.

**Take One Step at a Time**

You do not need to change what you eat and how you exercise overnight. Just start with one new good thing, and add a new one every day.

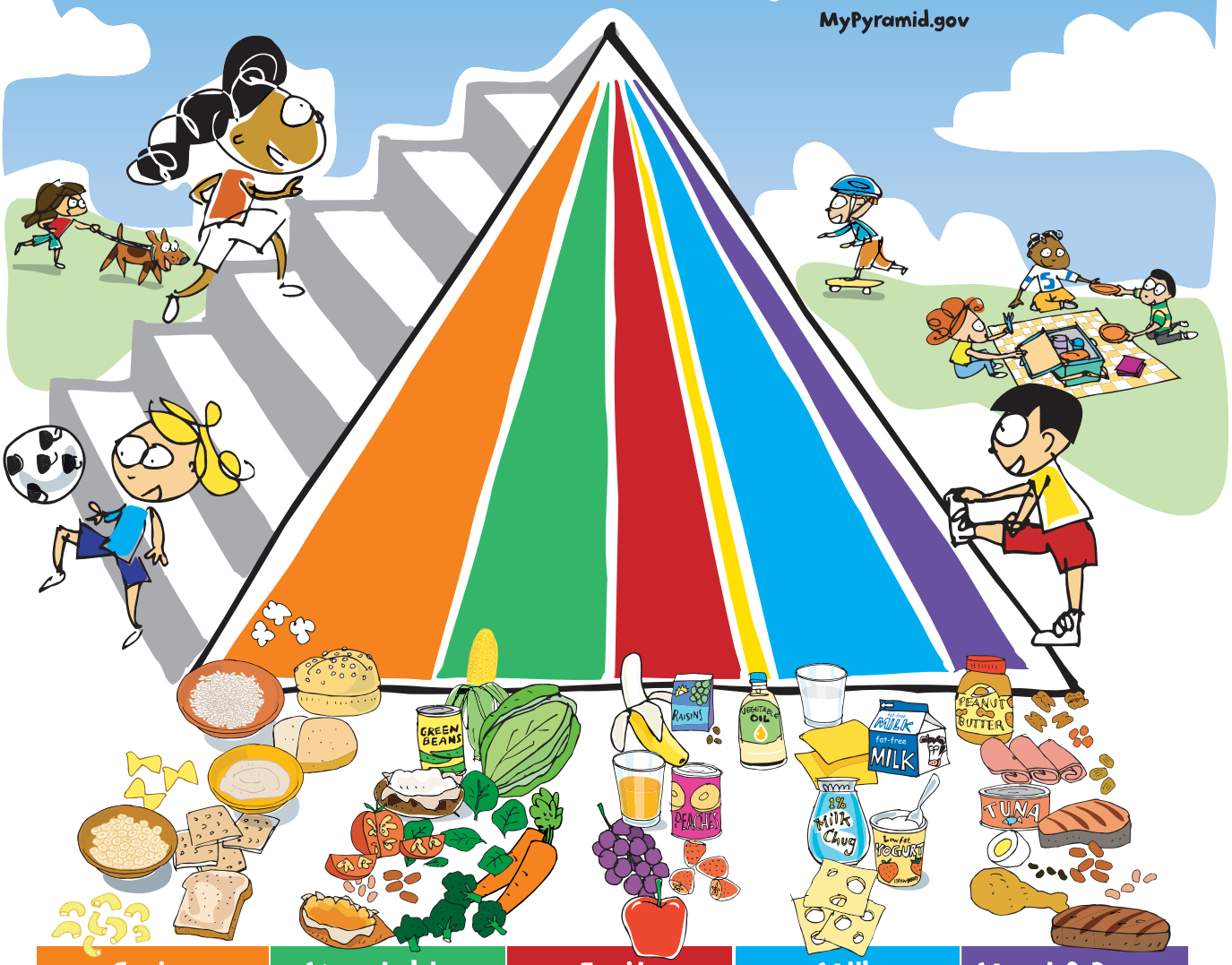
**Make Choices That Are Right for You**

MyPyramid.gov is a Web Site that will give everyone in the family personal ideas on how to eat better and exercise more.

# MyPyramid For Kids

**Eat Right. Exercise. Have Fun.**

MyPyramid.gov




## Grains
**Make half your grains whole**

Start smart with breakfast. Look for whole-grain cereals.

Just because bread is brown doesn't mean it's whole-grain. Search the ingredients list to make sure the first word is "whole" (like "whole wheat").

## Vegetables
**Vary your veggies**

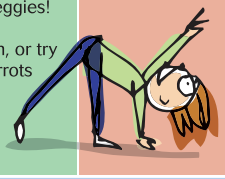
Color your plate with all kinds of great-tasting veggies.

What's green and orange and tastes good? Veggies! Go dark green with broccoli and spinach, or try orange ones like carrots and sweet potatoes.

## Fruits
**Focus on fruits**

Fruits are nature's treats – sweet and delicious.

Go easy on juice and make sure it's 100%.



## Milk
**Get your calcium-rich foods**

Move to the milk group to get your calcium. Calcium builds strong bones.

Look at the carton or container to make sure your milk, yogurt, or cheese is lowfat or fat-free.

## Meat & Beans
**Go lean with protein**

Eat lean or lowfat meat, chicken, turkey, and fish. Ask for it baked, broiled, or grilled – not fried.

It's nutty, but true. Nuts, seeds, peas, and beans are all great sources of protein, too.

**For an 1,800-calorie diet, you need the amounts below from each food group. To find the amounts that are right for you, go to MyPyramid.gov.**

| Grains | Vegetables | Fruits | Milk | Meat & Beans |
|---|---|---|---|---|
| Eat 6 oz. every day; at least half should be whole | Eat 2 1/2 cups every day | Eat 1 1/2 cups every day | Get 3 cups every day; for kids ages 2 to 8, it's 2 cups | Eat 5 oz. every day |

**Oils** Oils are not a food group, but you need some for good health. Get your oils from fish, nuts, and liquid oils such as corn oil, soybean oil, and canola oil.

### Find your balance between food and fun

- Move more. Aim for at least 60 minutes everyday, or most days.
- Walk, dance, bike, rollerblade – it all counts. How great is that!

### Fats and sugars – know your limits

- Get your fat facts and sugar smarts from the Nutrition Facts label.
- Limit solid fats as well as foods that contain them.
- Choose food and beverages low in added sugars and other caloric sweeteners.

MyPyramid.gov
STEPS TO A HEALTHIER YOU

U.S. Department of Agriculture
Food and Nutrition Service
September 2005
FNS-381

USDA

TEAM NUTRITION
teamnutrition.usda.gov

# CARING FOR BREASTFED BABIES

## Helping Breastfed Babies Adjust to the Child Care Setting

Many mothers want to continue breastfeeding after they return to work or school. They feel good knowing their milk helps keep their babies healthy, and they treasure the special closeness they feel with their babies, especially when they must be away all day.

Being separated from "Mommy" can be a difficult adjustment for any child or infant. You can help breastfeeding mothers make an easy transition back to work or school. When babies are healthy, everyone benefits, including your child care facility.

**Breastfeeding is good for babies because it:**

- Has just the right amounts of nutrients needed for a healthy start;
- Helps baby and mother develop a special closeness;
- Helps protect babies from infections and delays allergies; and
- Is easy to digest.

**Breastfeeding is good for mothers because it:**

- Helps them lose their pregnancy weight faster;
- Decreases their risk of breast cancer and ovarian cancer;
- Helps them feel good about themselves; and
- Saves money.

## What does human milk look like?

Human milk looks different from formula or whole milk. It is thinner and sometimes has a slightly bluish tint. The fatty part of the milk separates and rises to the top. To blend together again, simply gently rotate the bottle back and forth. Babies who are breastfed usually have soft and/or runny stools. This is normal!

**Handling human milk**

Discuss your facility's policy for storing breastmilk with the mother, as the guidelines you follow may not be the same as what she is following at home. If the mother has questions about storing and handling breastmilk at home, refer her to her health care provider for guidance.

**Always wash your hands before handling human milk!**

**Breastmilk should be:**

- Stored in small containers;
- Labeled with the baby's name;
- Dated when milk was collected; and
- Dated when milk was thawed.

**Storing and Serving Breastmilk**

- **Always** store breastmilk in the refrigerator or freezer.
- Dispose of human milk that has been in the **refrigerator for more than 5 days**.
- Store frozen breastmilk in the back of the freezer until it is needed for a feeding. Use the first in first out method when serving breastmilk.
- Thawed breastmilk may be kept in the refrigerator for up to 24 hours and should **not** be refrozen.
- Dispose of breastmilk that has been in the refrigerator **freezer for 3 months or longer.**
- Thaw breastmilk in the refrigerator or under running water. Warm breastmilk under warm running water or in a pan of warm (not hot) water. Bottles of breastmilk may also be warmed with a bottle warmer.
- **Never microwave breastmilk or heat it directly on the stove!** Microwaving destroys antibodies in breastmilk and can create hot spots that could scald the baby's mouth.
- Gently rotate the bottle back and forth to blend the milk if it becomes separated.

**Feeding the breastfed baby**

- Breastmilk is digested more easily than formula, so breastfed babies usually get hungry every 1 ½ to 3 hours.
- Do not warm more breastmilk than is used for that feeding.
- Start by feeding the baby a small amount of breastmilk and add more as needed.
- Feed the baby slowly.
- Dispose of any unused breastmilk left in the bottle after the feeding.

**The following are guidelines for feeding breastfed babies in child care. Remember each infant is an individual and will have different needs.**

**Tips for getting baby to accept a bottle**

Some breastfed babies need more time to get used to an artificial nipple. Bottle-feeding is a challenge that caregiver and baby will have to work on together. Experiment with different positions for bottle-feeding.

- Try offering the bottle before the baby is likely to be too hungry.
- Hold the baby lovingly while offering the bottle.
- Wrap the baby in some of the mother's clothing that has her smell on it while offering the bottle.
- Instead of pushing the bottle nipple into the baby's mouth, put it near his lips. This helps encourage him to open his mouth wide, as he does with the breast, and to take the nipple on his own.
- When all else fails, keep trying. Always remember that the baby can be fed the mother's milk using other feeding methods, such as cup or a spoon, if the baby continues to refuse the bottle.

**Caring for breastfed babies has many advantages for you as a child care provider such as:**

- Babies with less colic and spitting up;
- Diapers that do not smell bad;
- Babies who are sick less often;

- Breastmilk does not stain clothes; and

- Mothers who feel good about child care because they can continue to breastfeed their babies.

**Breastfeeding helps everyone because it:**

- Leads to healthier people;

- Lowers food costs for families compared to buying infant formula; and

- Creates less waste and pollution since there are fewer cans, bottles, and nipples to throw away.

**Ways to support the breastfeeding mother**

Breastfeeding is natural, but not always easy. Working moms have many competing demands that can affect their milk supply. Your support can make the difference.

- **Ask the mother what to feed her baby.** Many mothers want their babies to be fed only breastmilk; others may choose to provide both breastmilk and formula.

- **Offer mothers a quiet, comfortable, and private place to nurse.** Some mothers travel a long way from home to child care. They may want to nurse their baby before they leave for work or at the end of the day before driving home. Some mothers have the opportunity to breastfeed their babies during a break or lunch hour.

- **Talk with the mother about her special requests** if difficulties arise. For instance, if baby gets hungry in the last hour or so before mother arrives at the end of the day, does she want you to provide a pacifier or a small amount of breastmilk?

- **Tell her you are supportive** of her efforts to breastfeed her baby.

- **Communicate with parents.** All parents like to know how their babies are doing. Keeping notes and sharing with the parents how much the baby ate and when, number of bowel movements and wet diapers, and the baby's mood, helps parents know how their baby is doing. It also helps you to know when there are changes in the baby's daily routine.

- **Provide names of resources** in your community that can help with breastfeeding.

  Visit the state health department website page on breastfeeding: http://bis.health.ok.gov.

# FITNESS
## The Power of Movement in Children's Lives

Physical activity of all kinds stimulates children's development in the following ways:

- Physical Development – children learn about their bodies and grow strong through movement.
- Intellectual Development – physical activities stimulate the connection between mind and body.
- Communication – movement is a means of communication and one of the earliest ways children express their thoughts and feelings.
- Building Strong Relationships – movement is an important way we connect with others.
- Self-confidence – as children use their bodies to discover their world, they gain knowledge, strength and skills.

Children need lots of free time to move, play and discover on their own, but they also benefit from some teacher/caregiver directed games and activities. Provide a safe play space inside and outside and be a good role model and get moving too.

### Motivation

- Provide support with the involvement and encouragement of teachers, peers, and parents.
- Use physical fitness as a positive tool for self-improvement and learning.
- Make the activities fun and interesting to specific age groups.
- Be a model and interact with the children in the activities.

### Age Specific Activities

**Infant** (newborn – one year)

- Help develop skills to roll over, sit, stand, and walk.
- Time on their bellies helps develop coordination between upper and lower body.
- Dance and move to different types of music.

**Toddler** (1-3 years)

- Developing skills to follow directions and learning limitations.
- Activity suggestions: Finger play: “Itsy Bitsy Spider”, “Ring-Around-The-Rosie”, “London Bridges”, follow the leader, dance, jump and/or chase bubbles.
- At least 30 minutes daily of physically active, structured play, plus 60 minutes of free play.

**Preschooler** (3-5 years)

- Developing skills for balance and coordination.
- Activity Suggestions: Make up silly movements to songs, dance, skip, obstacle courses, balance on one foot, walk a low balance beam and jumping jacks.
- At least 30-60 minutes daily of physically active, structured play, plus 60 minutes of free play.

**School-age** (6-12 years)

- Developing skills of complex movements and understanding rules to games.
- Activity suggestions: Hopscotch, jump rope, shoot baskets, play catch or kickball, free-style dance, go on a hike with a goal in mind.
- At least 30-60 minutes daily of physically active structured play, plus 60 minutes of free play.

**Adolescent** (13-older)

- Developing a sense of individuality and self-worth.
- Let them choose activities of interest in both team and individual fitness activities such as swimming, yoga, basketball, baseball, dance, karate, volleyball, or track events.
- At least 30 minutes of physical activity daily. In addition adolescents should have three to five 20-minute sessions of vigorous exercise weekly.

**Benefits of Physical Activity**

- Strengthens muscles and bones;
- Increases classroom participation and attention;
- Reduces anxiety;
- Increases endurance and flexibility; and
- Prevents obesity.

# ORAL HEALTH CARE

**Did you know that…**

- Cavities (dental caries) are the most common childhood disease?
- Left untreated, dental disease can interfere with language development, eating, sleeping, and the ability to learn, as well as predispose children to infection and some systemic diseases?
- Cavities are entirely preventable through education, fluoride and similar treatments, and proper nutrition?

**Infants 0-6 months**

Clean babies' gums daily with a clean, damp washcloth, finger cot, or gauze pad. Hold babies while feeding them and never put babies in bed with a bottle. Milk and juice left to pool in babies' mouths leads to early childhood cavities. Use only a clean pacifier, and never dip it in honey or anything sweet or alcoholic. Fluoride makes babies' teeth stronger and more resistant to cavities. Starting at about 6 months, baby needs fluoride through drinking water or a fluoride supplement prescribed by their physician.

**Infants 6-12 months**

At this age, the primary teeth begin to appear. These teeth are important to the development of permanent teeth and need to be kept clean and healthy. Babies' teeth, mouths, and gums can show signs of early oral health problems at this age. White or brown spots or lesions behind the front teeth are an early sign of dental caries. Clean babies' teeth and gums with a soft bristle toothbrush.

**Toddlers 12-24 months**

Children should be involved at this age to help care for their teeth in order to build good oral hygiene habits. Encourage children to brush as early as 18 months, with assistance. Use songs, games and favorite toys to make brushing a positive experience. Use a pea-sized portion of toothpaste on the child's brush. The tongue needs to be brushed and all surfaces of the teeth. When finished, children should rinse with water and spit if possible. The children's toothbrushes should be identified with their names and air dried without touching each other. Brushes should be replaced every 3 months and after an illness.

**Preschool 3-5 years**

Practice brushing with preschoolers, making sure the surfaces of all teeth to the gum line are brushed. Young children cannot get their teeth clean by themselves. Until they are 7 or 8 years old, you will need to help them. Try brushing their teeth first and then letting them finish.

# IDEAS AND ACTIVITIES TO TEACH ORAL CARE

Toothbrushing should be a part of every child's daily routine from an early age. Make this time fun and reinforce with learning activities.

**Supplies**

- Personal, permanently marked, soft bristle toothbrush is available for each child in the activity
- Wax paper with pea sized amounts of fluoride toothpaste for each child over 2 years old. (Less than 2 years use plain water for brushing – also known as "brushing like the astronauts")
- Paper cups with water on a tray nearby
- Paper towels
- An area to store toothbrushes is needed that allows for space to air out the brushes without touching and with minimal exposure to splatter or contaminants
- Model teeth or supplies to make some (empty clean egg carton, card stock, glue gun)
- Toothbrush to demonstrate brushing
- Yarn to demonstrate flossing
- Dental Floss
- Milk Jug
- Yarn for Hair
- Children's books about teeth and dental care

**Make a Teeth Model**

- Wash and dry an egg carton (white Styrofoam type works best)
- Cut the egg carton in half
- Glue the egg carton to the cardstock paper with a glue gun in the shape of a "U" with the bumps up

**Read Books about Caring for Teeth**

- Does A Hippo Say Ahh? By Fred Ehrlich,MD
- Clarabella's Teeth by An Vrombaut
- Cousin Ruth's Tooth by Amy MacDonald
- Little Rabbit's Loose Tooth by Lucy Bate
- Little Bill: A Visit to the Dentist by Eleanor Fremont
- Loose Tooth by Lola M. Schaefer
- Maisy, Charley, and the Wobbly Tooth by Lucy Cousins

**Practice Brushing**

- Use the model teeth to introduce brushing and flossing
- Use a toothbrush to demonstrate brushing the teeth
- Emphasize brushing the sides, tops and back of teeth
- Read stories about losing a tooth, caring for teeth or going to visit the dentist
- Sing a tooth brushing song

*This is the way we brush our teeth, brush our teeth, brush our teeth,*
*This is the way we brush our teeth, after every meal.*
*(To the tune of Wheels on the Bus)*

- Provide each child with a Styrofoam egg carton (turn it upside down so that the "bumps" are the teeth). Give each child a toothbrush. Squirt some shaving cream onto the egg carton, and encourage the children to "brush the teeth!"

**Practice Flossing**

- Use a piece of cut white yarn
- Show the children how to wrap the yarn around their fingers and floss
- Talk about the importance of flossing areas the toothbrush can't reach
- Instruct step by step

- Make a flossing puppet out of a plastic milk jug: Cut a hole for the mouth and make slits to create teeth. The children then use real floss to practice flossing the puppet's teeth. Add silly yarn hair and big funny eyes so the children really like the puppet itself and are eager to help him learn to "take care of his teeth!"

**Drilling Cavities – an activity for school-age children**

Place large Styrofoam chunks in your water table as "sets of teeth" (no water). Provide small battery-operated drills for children to drill out cavities. Close supervision is required for this activity.

**Make a Sand Timer**

Children are supposed to brush their teeth for 2 minutes. Using homemade sand timers is one way to accomplish this task. Remove the lids from two baby food jars and glue them together (top to top) using very strong glue. After they dry, pound holes through the lids (a couple through each side) using a hammer and nail. Fill one jar with sand (or salt) and screw the double lid onto it. Screw the empty jar to the top. Children now have their own sand timers! (Or, you could make one large classroom timer.) Play with the amount of sand in advance and time it as it flows through, then add more sand or remove sand accordingly to make your full 2 minutes.

**Science Experiments with Oral Care**

- Hard-boil an egg for each child to represent "teeth."
    - The children place their eggs (in the shell) in clear plastic cups (remember to print their names on their cups). Have the children fill the cups about half-full with a soda product. Discuss and predict what might happen to the eggs (teacher should print their words on paper – one sentence per child). Leave the eggs in the cups overnight. This demonstrates what lots of sweets can do to our teeth, especially if we don't brush.
    - The next day have the class check the eggs and compares the findings to the predictions from the day before. The children then taste test three cleaning agents (baking soda, toothpaste, and salt) and try to guess which one will clean their eggs the best. Next, the children clean the eggs with toothbrushes. They try each cleaning agent to discover which one is the correct cleaning solution. (Then tartar is discussed.)
    - Refill the cups with vinegar and leave the eggs in them overnight, after again sharing thoughts on what might happen. Check the eggs the next day. By this time they are so slimy that many of the children don't like the feel. This simulates tartar build up.

During this week of experiments, teach the children how to chart which students brushed their teeth, flossed, lost teeth and who has new teeth coming in. Display the chart for all to see.

**Time to Brush!**

- Have small groups of children (3 or 4 at a time) gather around the bathroom sinks
- Wash hands
- Give children their toothbrush and a tiny smear of toothpaste applied to the wax paper
- Use model teeth and toothbrush to demonstrate angling the toothbrush toward the gum line and brush with gentle strokes – first the front, tops, and then backs of teeth
- Instruct on brushing the tongue
- Let children begin brushing on their own, then provide assistance
- Use the nearby water cups to rinse
- Allow the older children to floss – some assistance may be needed
- To correctly floss, insert the dental floss gently between the teeth and along the gum line, gently scrape in an up and down motion to remove plaque and tarter build up
- This is a good time to put on a familiar children's tune or develop your own songs about tooth care
- Remember to store the toothbrushes appropriately
- Wash hands
- This activity is best done after breakfast and lunch, or just before naptime
- Remember to use the model teeth and tooth brush to demonstrate
- Let the children see you brushing your teeth
- Children will model what they see!

Invite an oral hygienist or dentist to visit your program and share more information on good dental health habits. Inform parents of the visit and send home information on dental health prevention for young children.

**Resources**

- Contact Colgate Bright Smiles, Bright Futures for fun downloadable games and color pages that promote dental health. There is also parent information that can be downloaded and sent home. www.colgatebsbf.com
- The local library has children's books on dental care available for check out.
- The local health department may have resources and handouts on dental care for both children and their parents.
- Contact your local dentist in your community about education materials such as disclosing tablets that color plaque left after brushing. Ask him if he will be a resource for dental emergencies. ASK FOR FREEBIES!
- www.adha.org/kidsuff American Dental Hygienists Association
- www.crestsmiles.com/crest_kids
- www.colgate.com/kids-world

# Chapter 2

# Policies and Procedures


**Establishing Written Policies for Your Facility** **p. 33**
**Sample Child Care Policy** **p. 34**

# ESTABLISHING WRITTEN POLICIES FOR YOUR FACILITY

It is a good idea to put policies and procedures for your child care facility into writing. Written policies identify guidelines for health and safety practices and are a basis for communication and clarification.

**When developing policies for your child care facility, it is important to:**

- Be familiar with state licensing requirements and city ordinances regarding health and fire safety. (Check with DHS licensing and the local health and fire departments);
- Use local resources (child care health consultants, nurses, physicians, local health agencies) to help develop policies;
- Individualize the policy for your facility and program;
- Write specific and detailed policies. Clearly state expectations and responsibilities;
- Specify how the policies will be enforced;
- Provide copies of policies to staff. Ask them to keep you informed about how policies are working;
- Review the policies with the parents upon enrollment. Have them sign two copies, one to keep on file and one to take home. Encourage feedback from parents; and
- Review your policies at least once a year. Make changes as needed.

# SAMPLE CHILD CARE POLICY

## Days and Hours of Operation

Welcome to the *Healthy Times Child Care Facility*. Our hours of operation are from 6:30 A.M. to 6:00 P.M. Monday through Friday. The child care facility will be closed on the following holidays:

(List holidays here)

## Enrollment

Prior to your child's attendance, a conference with the parent or legal guardian and the child is required to acquaint each new family with the environment and the schedule for child care.

The following forms will be completed and submitted to *Healthy Times Child Care Facility* prior to the child's first day of attendance. The information on the forms will remain confidential and will be shared with other caregivers only as required to meet the needs of the child:

- Application for Child Care Services, which includes immunization record
- Child Care Emergency Information
- Consent for Child Care Program Activities
- Special Care Plan (if needed)
- Child Care Agreement

## Compliance File

Upon enrollment and acceptance of a child into care, the parent(s) or legal guardian(s) is informed of the location of the OKDHS Compliance File, which is openly accessible and available to parents.

## Authorized Release Of Child From Child Care

*Healthy Times Child Care* will maintain in the files, written authorization by the child's parent or legal guardian, the names, addresses, and telephone numbers of individuals approved to pick up the child from child care.

Any authorized person who is not recognized by staff will be required to provide photo identification before the child is released.

No child will be released without the presence or permission of the custodial parent or legal guardian.

*Healthy Times Child Care* staff will notify the police if an unauthorized person seeks custody of the child.

**Persons Who May Pose a Safety Risk**

No child will be released to anyone who cannot safely care for the child. Staff will notify the local police department to manage an adult under the apparent influence of drugs/alcohol or an individual who poses a safety risk, and the emergency contact person will be called to make arrangements for the child's care. If no one is available to care for the child after the hours of child care, child protective services will be contacted for guidance.

**Arrival of School-Age Children**

When a school-age child attends the child care facility after school and arrives by school bus or walks from the school, an agreed upon arrival time will be written in the Child Care Agreement. If the child does not arrive within ten minutes of this time, staff will immediately contact the parent or legal guardian.

**Exclusion of Ill Children**

Children will be excluded or sent home from child care with the following signs or symptoms:

- Fever, defined as 100.4 degrees or higher.
- Diarrhea, defined as runny or watery stools two or more times.
- Vomiting two or more times in a 24-hour period.
- Undiagnosed body rash, except diaper rash.
- Sore throat with a fever and swollen glands.
- Yellowish skin or eyes.
- Eye discharge, defined as thick mucus or pus draining from the eye or pink eye.
- Severe coughing, where a child gets red or blue in the face or makes a high-pitched whooping sound after coughing.

- Signs or symptoms of possible illness such as lethargy, irritability, persistent crying or any other unusual signs until a medical evaluation allows inclusion.

- Children may also be sent home if staff is unable to offer the extra care needed to comfort a sick child without compromising the care of the other children.

**Management of Illnesses**

Any child showing possible signs or symptoms of a contagious illness will be separated from the group and observed.

- The child's symptoms will be logged, noting time and circumstances.

- A child's temperature may be taken.

- If a child meets any of the above listed exclusion criteria, a parent or guardian will be contacted to pick up the child.

- The child will be moved to another part of the room or a separate room until the parent or guardian arrives.

- The child will be supervised at all times by someone familiar with the child.

- Bed rest will be encouraged but not forced.

**Administration and Storage of Medication**

- *Healthy Times Child Care* staff will administer medication only if the parent or legal guardian has provided written, dated consent with the exact dosage and times to be administered.

- For prescription medications, the parent or legal guardian will provide caregivers with the medication in the original, child-resistant container that is labeled by a pharmacist with the child's name, the name and strength of the medication, and specific, legible instructions for administration, storage and disposal.

- For over-the-counter medications, the parent or legal guardian will provide the medication in the original child-resistant container. The medication will be labeled with the child's first and last names; specific, legible instructions for administration and storage supplied by the manufacturer; and the name of the health care provider who recommended the medication.

- For medication that may be used "when needed", the parent or legal guardian will be responsible for obtaining this information in writing from the child's health care provider at least annually.

- Medications will be kept at the temperature recommended by the manufacturer, will not be used beyond the date of expiration on the container, and will be stored separately from food and kept in a safe place out of children's reach.

- A medication log will be maintained by the child care staff to record the instructions for giving the medication, the time it is given, the staff person who administers the medication, and any spills, reactions or refusals to take the medication.

- Staff will be trained in Medication Administration and medication errors will be controlled by checking the following five items each time medication is given:

  - Right child

  - Right medicine

  - Right dose

  - Right time

  - Right route of administration

**Management of Injuries**

Every effort will be made to keep the children at *Healthy Times Child Care* safe and free from injury. Indoor and outdoor play space and equipment will be inspected daily for hazards and children will be supervised at all times. In the event that an injury does occur:

- Properly maintained first aid kits are located in each room of the facility out of the reach of children, are brought outdoors when playing outside, and are located in each vehicle used for transporting children.

- Each staff person working with a group of children has had training in age-appropriate First Aid and CPR.

- All caregivers have immediate access to a phone to summon the Emergency Medical Services when needed.

- A caregiver will then notify the parent or legal guardian of the emergency.

- If the child is transported to the hospital, a staff member will accompany the child and remain until the parent or guardian assumes responsibility.

- An injury report form will be completed as soon after the incident as possible. A copy will be given to the child's parent or guardian, with the original kept on file.

- *Healthy Times Child Care* will notify the Oklahoma Department of Human Services Licensing Services within 24 hours of any injury to a child requiring emergency medical attention.

**Transportation**

All vehicles used for transporting children:

- Are registered and insured according to state law;

- Are equipped with a first aid kit and emergency contact information for all children being transported;

- Have a heater capable of maintaining a temperature of 65 degrees Fahrenheit in the vehicle, and a ventilation system;

- Are equipped with a safety checklist, injury report forms, and a trip log to record destination, mileage, times of departure and return, and a list of passengers.

Children transported are properly secured in a child passenger restraint system (car seat) or individual seat belt, in compliance with applicable state law.

*Healthy Times Child Care* maintains on file, written permission from parent or legal guardian to transport children.

**Field Trips**

- Parents or guardians will be notified in advance of all field trips, and provided with the date, times and destination.

- A first aid kit, emergency contact information, and emergency transport authorization information for the children in the group will be taken on all trips.

- The location of rest rooms and sources of water will be determined in advance. Children may only use a public rest room when accompanied by a *Healthy Times* staff member.

- Children will be closely supervised at all times, with each child assigned to an adult for every part of the trip.

## Behavior and Guidance Policy

*Healthy Times Child Care* is committed to a philosophy of using positive guidance, redirection, planning ahead to prevent problems, encouraging children to use appropriate behavior, setting clear, consistent rules and fostering the children's ability to become self-disciplined.

- All staff at *Healthy Times Child Care* will attend training in behavior and guidance methods.
- Staff will encourage children to respect other people, to be fair, to respect property, and learn to be responsible for their actions.
- Staff will set age-appropriate expectations for children and guide them in solving problems.
- Aggressive physical behavior toward children or staff is unacceptable.
- Physical restraint will not be used except as necessary to ensure a child's safety or that of others, and then in the form of holding by another person as gently as possible only for as long as necessary for control of the situation.
- Staff are prohibited from using punishment of a physical or psychological nature, or punishing a child in association with food, rest or toilet learning.
- Medicines or drugs that affect behavior will not be used except as prescribed by a child's health care provider and with specific written instructions (following the Medication Administration section of these policies).
- Time-out will be used if other management techniques are ineffective. "Time-out" or removal of a child from the environment may be used selectively for children over 18 months of age. The period of "time-out" will be just long enough to enable the child to regain self-control, not to exceed more than one minute for each year of a child's age. Caregivers will monitor the effectiveness of "time-out" and seek the help of a mental health consultant when approved behavior management strategies don't seem to be working.

## Mandatory Reporting of Child Abuse

All staff at *Healthy Times Child Care* will report any suspicion of child abuse or neglect to the local office of the Oklahoma Department of Human Services or the Statewide Child Abuse Hotline (1-800-522-3511). Failure to report is a misdemeanor offense and upon conviction is punishable by law.

# Chapter 3

# Child Development and Guiding Children's Behaviors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# AGES AND STAGES

*Adapted from curriculum developed through Child Care Careers, Inc. and the Birth to Six Wheel, from the Washington State Department of Social Services.*

Planned daily activities are important because they provide an opportunity for children to learn and have fun. They also provide structure so child will know what to expect.

A schedule of daily activities should be appropriate to each child's developmental level. All children need to be guided, taught and nurtured as they grow and develop at a pace that is comfortable for them.

Although each child grows and develops at his or her own rate, there are predictable patterns of child development. Caregivers should be familiar with the developmental patterns of children's growth. Below are some of the ages and stages of development for the typical child.

## Birth to 3 months

- Lifts head and chest when on stomach.
- Moves arms and legs easily.
- Follows your movements by turning head from side to side.
- Easily takes a bottle or breast and sucks well.
- Startles or cries at sudden loud noises.
- Looks at you. Watches your face.
- Makes gurgling or cooing sounds.
- Smiles in response to your smile to talking.
- Quiets easily when comforted.

## 3 to 6 months

- Plays with feet when on back.
- While on stomach, pushes up on hands, lifting up their head and chest.

- Holds head upright and steady without support.
- Rolls from stomach to back and back to stomach.
- Plays with hands by touching them together.
- Reaches for a toy.
- Picks up toys placed within reach.
- Turns head towards sounds.
- Laughs out loud.
- Uses vowels /o/ & /u/.
- Begins to show likes and dislikes.

## 6 to 12 months

- Sits without help while playing with toys.
- Crawls on belly or hands and knees.
- Pulls to stand next to solid objects or using an adult for support.
- Transfers small objects from one hand to the other.
- Imitates waving bye-bye.
- Enjoys games like peek-a-boo and pat-a-cake.
- Lets you know needs with motions and sounds.
- Copies speech sounds (ba-ba/ da-da/ ga-ga).
- Takes turns while playing with adult (action, sounds or facial expressions).
- Shows understanding of simple question.
- Knows parents from strangers.

## 12 to 18 months

- Walks alone.
- Picks up small objects (raisin size).
- Puts objects in and dumps from containers.
- Puts one object on top of another.
- Feeds self with a spoon.
- Holds and drinks from a cup with some spilling.
- Points to several things or pictures when named.
- Says ten different words by 18 months, in addition to "Mama" or "Dada."

## 18 months to 2 years

- Walks up and down stairs with hand held.
- Scribbles.
- Moves body in time to music.
- Begins to ask questions, "Juice?" and "Bye-bye?"
- Puts two words together ("more juice?").
- Learns to say "no" (the beginning of choice making).
- Takes off socks and shoes.
- Looks at storybook pictures with an adult.
- Makes simple choices among toys (puzzles or trucks).
- Mimics other child's play (pouring sand, throwing ball).
- Wants to do things "all by themselves."

## 2 to 3 years

- Walks well, runs, stops, steps up, and squats down.
- Stacks more than two objects.
- Uses the spoon and cup when eating.
- Follows two-step directions. ("Get the book and put it on the table.")
- Names five to six body parts.
- Takes part in simple conversations.
- Answers simple questions. ("What do you want for lunch?")
- Points to or names objects when told their use. ("What do you drink with?")
- Helps with simple tasks (picking up toys).
- Uses two-three word sentences regularly.
- Prepares for toilet learning.
- Dresses and undresses with help for fasteners.

## 3 to 4 years

- Jumps, runs, throws, climbs, and uses good balance.
- Rides a tricycle.
- Draws up, down, around, and sideways using a crayon.
- Uses materials and toys to make things.
- Enjoys picture books and being read to.
- Works puzzles with several individual pieces.
- Understands words that tell where things are (behind, under, in, on).
- Uses speech that is easily understood.

- Asks a lot of "why" or "what" questions.
- Enjoys playing with other children.
- Waits for a turn some of the time.
- Answers simple "where" and "who" questions.

## 4 to 5 years

- Enjoys tumbling or other games that use large muscles, like the legs.
- Hops on one foot.
- Draws a face that looks like a face.
- Cuts with scissors.
- Puts on clothing with a little help.
- Asks questions using "what, where, who, and why."
- Says most speech sounds clearly, except for "s, z, th, and r."
- Uses words that show size and number (big, many).
- Begins to understand concepts of numbers, space, and time.
- Says both first and last name.
- Has an active imagination and is interested in fantasy and make-believe.
- Enjoys playing with children of the same age.
- Begins to learn the rules of playing together.
- May have fears and anxieties.

## 5 to 6 years

- Enjoys catching, throwing, and kicking a ball.
- Has good balance when playing large muscle games (tag, tumbling, and baseball).

- Enjoys cutting with scissors.
- Dresses self, including buttoning, snapping, and zipping.
- Shows interest in writing words.
- Talks like the family talks (uses the same kinds of words and sentences).
- Enjoys jokes and humor.
- Follows three-step directions in the order given.
- Says full name, age and sex.
- Enjoys playing organized games with other children (Simon Says).
- Likes to please and can often settle arguments by themselves.
- Can do small chores and tasks and are pleased with responsibility.
- Is sociable, likes to play with others, takes part in group activities, and cooperates.

## 6 to 7 years

- Enjoys spontaneous dramatization and likes to pretend.
- Becomes competitive and has trouble losing.
- Is eager to learn, exuberant, restless, and easily fatigued.
- Learns best through active participation.
- Is proud of self and skills.
- Likes school.
- Sharing is still not easy.

## 7 to 8 years

- Likes active play.
- Learns hopscotch, jump rope, and bounces balls.

- Begins to ride bicycles.
- Likes jigsaw puzzles and magic tricks.
- Plays pretend and likes to use props, e.g., post office, kitchen, grocery store items, and costumes.
- Plays more with children of own gender.
- Sensitive to the reaction of others and needs adults' approval.
- Shows concern about right and wrong.
- Takes things from others (still doesn't understand the concept of ownership).
- Is involved in more solitary play.
- Begins collecting things, e.g., cards and rocks.

## 8 to 9 years

- Is outgoing and interested in people.
- Is sensitive to criticism.
- Has new awareness of individual differences.
- Begins to form a group of friends, and best friends are of the same sex.
- Enjoys team games, comics, television, and adventure stories.
- Is beginning to read well enough to enjoy many books.
- Likes table games, e.g., checkers, cards, and jigsaw puzzles.
- In dramatic play, likes to arrange and produce shows.
- Likes to have all kinds of gadgets and tries to make things.
- Enjoys collecting and arranging collections.

## 9 to 10 years

- Is capable of prolonged interest.

- Wants to do well, but becomes discouraged by pressure.
- Often argues over fairness in games, has bursts of emotion.
- Reads and/or watches television more.
- Plays table games with a higher level of difficulty.
- Enjoys pets.
- May be involved with Lego sets and/or chemistry sets.
- Enjoys active play, e.g., running and hiding games, skating, and swimming.
- Has a strong sense of right and wrong.

## 10 to 11 years

- A wide range of individual differences in maturity level.
- Frequently overly critical, changeable, rebellious, and uncooperative.
- Unsure of bodily changes, may be moody.
- Is interested in team games, pets, television, radio, and movies.
- Needs to feel a sense of belonging, acceptance by peers, and is subject to peer pressure.
- Has frequent arguments with those in authority.
- Is interested in earning money.
- Enjoys competitive games and games that involve problem-solving and thinking skills.
- Likes to socialize.

# POSITIVE GUIDANCE

As a caregiver, you have the responsibility to help guide children toward appropriate behavior. Using positive guidance can help teach the child self-control, responsibility, and to make wise choices. When young children use inappropriate behavior it may be because they do not understand the social rules yet and need help in directing his or her behavior. Inappropriate behavior can be thought of as an opportunity for teaching new behavior.

**How to help the child behave appropriately**

- **Set clear rules.** A few necessary, clear, and reasonable limits that are enforced consistently, give children the security that adults are helping them behave. When possible, allow the children to help develop the rules. Too many rules set everyone up for failure because they cannot be remembered and they cannot be enforced with consistency. Rules are for protecting the health, safety, and property rights of the child and others.

- **"Do as I do."** The most powerful teaching skill is modeling the behavior that is expected from the child. Children have always imitated the adults in their lives. They will copy manner, tone of voice, language, and actions (both inappropriate and appropriate). Setting a good example for children is critical.

- **Tell them what you want.** Children respond better to being told what to do rather than what not to do. Focus on the desired behavior instead of the one to be avoided.

- **Talk respectfully.** Communicating with a child cannot be done effectively from a distance. The time spent talking to a child and making eye contact with her is quality time.

- **Give chances to choose.** Giving a child a choice allows him some appropriate power over his life and encourages decision-making. The choices offered must be within acceptable limits and the child's developmental and temperamental abilities. The adult may say the rule and then the choice. For example: "It's nap time. Do you want to sleep with the green blanket or the yellow blanket?" or "It's time to go to the car. Do you want to walk with giant steps or baby steps?"

- **Notice good behavior.** Most children spend a great percentage of time behaving appropriately. Encourage the child in a way that lets him know that he is exhibiting the desired behavior. Positive behavior will increase if you give it attention.

- **Make an investment.** Each child needs some individual attention every day, such as talking, playing, singing, and reading.

**How to handle misbehavior**

In spite of the best planning and positive guidance, there will still be some misbehavior. Some helpful responses include:

- **Ignoring.** This works best with a new, annoying, but not harmful behavior like bad language or tantrums. Effective ignoring involves not talking to or looking at the child or using any body language that indicates attention.

- **Redirecting.** This approach involves helping the child find an alternative activity that is similar to what he was doing. Examples:

  "I can't let you throw your truck, but you may throw the ball outside."
  "You may not kick the door, but you may kick this ball."

- **Cooling off.** A cooling off period can sometimes help hurtful behavior or an angry outburst. A cooling off period is not used as a punishment. The child can be sent to a calming place to rest, read, or do something pleasant until he gains control of himself and changes his behavior. A cooling off period is also a good way for adults to calm down before taking action and to demonstrate an acceptable way of handling anger.

- **Fix-up.** When a child damages something, they need to help in fixing it or cleaning up. If they hurt another child, they should help in relieving that hurt. Examples:

  "You knocked over the houseplant. Please help me sweep up the dirt."
  "You made Johnny cry. Please tell Johnny that you are sorry and help him feel better."

- **Allowing consequences.** We help children learn to be responsible when we allow them to experience the consequences of their behavior. Example: When a child breaks a toy by playing too roughly, then the toy is no longer available.

**Remember**, the goal is not to control children and make them obey, but to give them the skills to make decisions, promote self-control, and to learn responsibility for their behavior.

# COMMUNICATION IS THE KEY

The language and daily interactions we have with children set the tone for the kind of relationship we have with them. Language that helps children feel safe and supported promotes positive emotional growth and development.

- Weave nurturing moments into the daily life of the classroom.
- Individually greet children and parents as they arrive in the morning and tell them good-by as they leave at the end of the day.
- Get to know each child as an individual.
- Clearly and simply state what you expect children to do.
- Have age appropriate expectations.
- Remember young children use inappropriate behavior because they may not understand the social rules yet.
- Talk to young children using language they understand.
- Show children by modeling or using pictures.
- Encourage children in ways that shows the behavior exhibited is desirable and appreciated.
- Be enthusiastic and generous with encouragement.
- Tell a child what to do instead of what not to do.

Examples:

| Avoid Saying | Say |
|---|---|
| | |
| **Don't run!** | Use your walking feet. |
| **Quit climbing on the chair.** | Sit with your feet on the floor. |
| **Don't touch!** | Look with your eyes. |
| **No yelling.** | Use your inside voice. |
| **Stop playing with your food.** | Food goes on the spoon and in your mouth. |

| | |
|---|---|
| **Don't squeeze the kitten.** | Hold the kitten gently. |
| **No hitting!** | Hands are for playing and hugging. Use your words if you're upset (give child appropriate words to use) |
| **Don't throw your truck.** | Roll your truck on the floor. |

# BITING IN THE TODDLER YEARS

Biting is very common among groups of young children, for all types of reasons. But whatever the reason for biting, most parents find it shocking and disturbing, and they want it to stop – quickly! Understanding why the young child bites is the first step in preventing biting as well as teaching the child alternatives to biting.

**Most common reasons and solutions for biting**

**The experimental biter:** It is not uncommon for an infant or toddler to explore their world, including people, by biting. Infants and toddlers place many items in their mouths to learn more about them. Teach the child that some things can be bitten, like toys and food, and some things cannot be bitten, like people and animals. Another example of the Experimental Biter is the toddler who wants to learn about cause and effect. This child is wondering, 'What will happen when I bite my friend or mommy?' Provide this child with many other opportunities to learn about cause and effect, with toys and activities.

**The teething biter:** Infants and toddlers experience a lot of discomfort when they're teething. A natural response is to apply pressure to their gums by biting on things. It is not unusual for a teething child to bear down on a person's shoulder or breast to relieve some of their teething pain. Provide appropriate items for the child to teeth on, like frozen bagels, teething biscuits, or teething rings.

**The social biter:** Many times an infant or toddler bites when they are trying to interact with another child. These young children have not yet developed the social skills to indicate 'Hi, I want to play with you.' So sometimes they approach a friend with a bite to say hello. Watch young children very closely to assist them in positive interactions with their friends.

**The frustrated biter:** Young children are often confronted with situations that are frustrating, like when a friend takes their toy or when daddy is unable to respond to their needs as quickly as they would like. These toddlers lack the social and emotional skills to cope with their feelings in an acceptable way. They also lack the language skills to communicate their feelings. At these times, it is not unusual for a toddler to attempt to deal with the frustration by biting whoever is nearby. Notice when a child is struggling with frustration and be ready to intervene. It is also important to provide words for the child, to help him learn how to express his feelings, like "That's mine!" or "No! Don't push me!"

**The threatened biter:** When some young children feel a sense of danger they respond by biting as a self-defense. For some children biting is a way to try to gain a sense of control over their lives, especially when they are feeling overwhelmed by their environment or

events in their lives. Provide the toddler with nurturing support, to help him understand that he and his possessions are safe.

**The imitative biter:** Imitation is one of the many ways young children learn. So it is not unusual for a child to observe a friend bite, then try it out for herself. Offer the child many examples of loving, kind behavior. Never bite a child to demonstrate how it feels to be bitten.

**The attention-seeking biter:** Children love attention, especially from adults. When parents give lots of attention for negative behavior, such as biting, children learn that biting is a good way to get attention. Provide lots of positive attention for young children each day. It is also important to minimize the negative attention to behaviors such as biting.

**The power biter:** Toddlers have a strong need for independence and control. Very often the response children get from biting helps to satisfy this need. Provide many opportunities for the toddler to make simple choices throughout the day. This will help the toddler feel the sense of control they need. It is also important to reinforce all the toddler's attempts at positive social behavior each day.

As with almost all potentially harmful situations involving children, prevention is the key. Adults must be active observers of children to prevent biting. in those times when close supervision doesn't work, the adult must intervene as quickly and as calmly as possible.

**When intervening *before* the potential bite has occurred…….**

- Talk for the child by offering words like, "I see that you wanted that toy!"
- Demonstrate patience and understanding for the frustration the child is experiencing.
- Offer solutions like, "We have another red truck right over here. Let's go get it."
- Demonstrate alternate ways of interacting and say something like, "She likes it when you rub her arm." Try to stay focused on the positive behavior you want to see, without reminding the child of the negative behavior.

**When your child bites……**

- Comfort the child who was bitten.
- Cleanse the wound with mild soap and water. Provide an ice pack to reduce pain and swelling.

- Provide comfort for the wounded child by saying something like, "That really hurt! You don't like it when your friend bites your arm!"

- Calmly approach the child who bit. Many times these children feel overwhelmed and afraid after they bite. They need comfort, too.

- Comfort the child who bit by saying something like, "You seem sad that your friend's arm is hurt from the bite."

- Help the child who bit to understand the hurt their friend is feeling by offering to let her talk with her friend. Say something like, "Would you like to see Sally now? You can tell her that you hope she feels better soon." Older toddlers can learn a lot from being allowed to comfort their friend after a bite has occurred. The child who bit may want to see the injury. That's okay if the injured child wants to show it. But do not force either child to have this interaction, unless both are willing.

- Reinforce the rule that we don't hurt people. Help both children understand that your job is to keep everyone safe. Say, "I know you are angry. But I can't let you bite people."

- When the environment is calm again, remind the children what they can do to assert themselves, like say "No! That's mine!" or "Back away!" or if they are preverbal, teach them to 'growl like a tiger' to express themselves. The goal is to teach assertiveness and communication skills to both the child who bites and the child who gets bitten.

**Never hit or bite a child who has bitten; that will teach the child that violence is ok.**

Young children need lots of practice to learn the fine art of interacting with their friends in a positive way. They need positive guidance and support from parents. When children gain maturity and experience, and become preschoolers (3+ years old), they will likely have developed more appropriate ways of interacting.

For more information contact your county health department.

Source:

Child Guidance Program, Family Health Services

Oklahoma State Department of Health

# TOILET LEARNING IN CHILD CARE

Learning to use the toilet is an important developmental milestone that often occurs during the years a child has entered an out-of-home child care program. Parents and child care providers should work as partners to support each other and the child during this learning process.

## When Is a Child Ready?

Every child develops differently, so the start of toilet learning should be based on the child's developmental level rather than age or the adult's eagerness to start. However, it is recommended that a child be at least 24 – 27 months old.

Signs of readiness include an increased awareness of a need to go, curiosity in other's bathroom habits, demonstrated interest in the toilet, having words for using the toilet and an understanding of "wet" verses "dry". In order to start learning to use the toilet a child must be able to:

- Follow simple instructions
- Cooperate with adults
- Stay dry for at least two hours at a time during the day
- Understand words about the toileting process
- Get to and from the bathroom area
- Help pull diapers or loose pants up and down

## Techniques for Success

- Include toilet learning activities as part of the daily curriculum. Read stories, sing songs and play games about using the potty.
- Because toilet learning involves so many steps (discussing, undressing, going, wiping, flushing, and handwashing), reinforce the child's success at each step.
- Accept (and help the child accept) that occasional accidents are normal.
- Never force a child to sit on the toilet for long periods of time.

- Children should be dressed in clothing that can be easily pulled up and down on their own.

- Provide child-sized toilets or have an adaptive seat and a secure step stool to make them feel child-sized.

If a child resists toilet learning, he or she may not be ready for the process or find it too stressful. If a power struggle begins, wait a few weeks and try again. Remember to transfer responsibility to the child, provide lots of positive feedback for using the toilet, and change wet or soiled clothing immediately.

**Adaptations for Children with Special Needs**

A child with special needs may require a unique set of plans and procedures, more time, and more flexibility from adults, but the same toilet learning methods apply. Simplify expectations, be persistent, create small, achievable steps and acknowledge progress along the way.

Toilet learning is a multi-step process and can take from two weeks to six months. Setbacks are common and should not be considered failures. Children will be more successful when parents and child care providers agree on strategies and techniques and work together as a team.

(This information is adapted from the California Childcare Health Program Health & Safety Notes)
www.ucsf.childcarehealth.org

# SEPARATION ANXIETY

At birth, infants have no concept of their caregivers as separate from themselves. At around six to eight months, infants begin to understand that parents and caregivers are separate. By about nine months old, infants can call up a remembered mental image of the parents when they are not present and realize the parents are GONE! They have no way of understanding whether or when their parents will return.

This experience makes many infants and young children anxious. This can happen even when a parent puts an infant to bed and is in the next room. This can be a challenging time but is the beginning of the period of infant development called "separation anxiety" and is a sign of developmental gains.

Nearly all children will experience some developmentally appropriate anxiety when separated from their primary caregivers, usually between six and 20 months, and peaking at 13 to 18 months. The way children express their anxiety depends on personality, previous experiences with separation and the responses of adults in the environment. Common ways of showing anxiety over separation are crying, clinging and tantrums.

**Ways Parents Can Help Ease Their Child's Separation Anxiety**:

- Accompany your child for a visit to the child care program before he starts, or consider a phase-in period.
- Stay with your child for a short period of time when dropping her off.
- Drop your child off when he is not tired or hungry, tell him when you will return and have a loving, brief and firm goodbye ritual.
- Never "sneak out" without saying goodbye; this undermines your child's trust and she will always be fearful of you "slipping away" when she is not looking.
- Resist the temptation to come back to check on your child (this can be done with a phone call to your child's teacher).
- Avoid sharing your own anxieties over separation with your child. This will only confirm what he already fears.
- Learn the names of the teachers and the other children, and what the routine is so you can talk with your child about the people and events in her life.
- Offer a "transitional object": a photograph, blanket or cuddly toy from home, reminding your child that he is loved and you will return.

- Pay attention to and acknowledge your own feelings about leaving your child.

**Ways Child Care Providers Can Help Ease Separation Anxiety**:

- Play separation and return games like "Peekaboo" and "Where's the Baby?" with infants and toddlers.
- Offer comfort during the day and praise participation in activities.
- Avoid moving quickly or touching the child unless you are sure she wants to be touched.
- Identify the child's interests and involve him in them when he arrives.
- Pair the child with a "buddy" who can help her learn new routines and explain the environment.
- Say in words what you think the child is feeling, particularly if he is sad or crying; reassure him that his parent(s) will return.
- Read books about the topic of separation from parents, such as: *Are You My Mother*? By P.D. Eastman, *The Good-Bye Book* by Judith Viorst, *The Kissing Hand* by Audrey Penn, and *Owl Babies* by Martin Waddell.
- Repeat familiar nap or mealtime routines from home.

If a child's anxiety worsens despite using the above techniques, lasts for more than four weeks and she is unable to do anything without her parent or primary caregiver by her side, talk with the family about professional intervention.

Children are identified as having separation anxiety disorder, a much less common mental health condition, when they experience developmentally inappropriate distress, or excessive anxiety around separation for at least four weeks. Intervention is necessary for these children and there are treatments that will spare them a great deal of distress as they grow.

(This information is adapted from the California Childcare Health Program Health & Safety Notes)
www.ucsfchildcarehealth.org

# CHILDREN AND STRESS

Stress is part of our everyday life and we now know more about the short-term and long-term effects of stress, especially on children. Prolonged, unreleased stress and/or sudden, very intense stress cause physical and emotional disease. Children learn how to cope with stress early in life by watching those around them (parents, siblings, caregivers and friends) deal with the pressures of life. So, our approach needs to identify and modify sources of stress early in children's lives **and** teach and model healthy coping techniques for children of all ages.

## Sources of Children's Stress

- Family stressors include birth of a sibling, moving, death of a family member including pets, poverty, neglect or abuse, divorce and separation from a parent or domestic violence.

  Two common myths about divorce are:

  - Children are just as relieved as their parents are to see the end of a bad relationship,
  - Because divorce is more common and many of their friends' parents are divorcing then the trauma is greatly reduced. (Kostelnik 2006, p. 170) Although living with parents who argue is stressful for children, being separated from a parent is still more upsetting for children, especially under the age of five. The uncertainty about what the divorce means for the child's own security and attachment can cause great anxiety.

- Stressors outside the family might include chronic illness or other health issues, school, poor-quality child care, natural disasters, war and violence.

## How Children Cope with Stress

- Face the stress and adapt to it.

- Avoid the stress by using defense mechanisms. Children typically use one of four avoidance techniques: denial, regression, withdrawal or impulsive acting out. (Kostelnik 2006, p. 186) These avoidance techniques may provide temporary relief, which allows a child to regain his equilibrium. When these techniques are used long-term they become self-destructive.

- **Signs of Stress**

  - Sleep disturbances
  - Physical complaints (stomach aches and headaches)
  - Changes in appetite
  - Changes in speech patterns or abilities
  - Difficulty making choices
  - Problems with attention or concentration
  - Withdrawal
  - Aggressive behavior

If a pattern of these behaviors is noticed through careful observation, then asking the following questions may be a helpful starting point.

- Is there anything in the environment or teaching practices that can be changed to help reduce the child's stress? (For example room arrangement, increase quiet or vigorous activities, alter the pace of the day, limit teacher rotations.)

- Are there any changes in the behavior or attitudes of the significant adults that might reduce the child's stress?

- If the child's behavior is extreme, is there a way to shift the extreme behavior so it more closely resembles a healthier coping response?

**Ways to Support the Child**

- Provide and maintain helpful routines so the child knows what to expect.

- Allow for natural expression of emotions through talk, play and art.

- Provide understanding and caring communication with child. (Beware of offering "quick fixes" to the child without fully understanding the situation.)

- Intervene in aggressive behaviors.

- Build relaxation periods throughout the day. Everyone can practice stretching, tensing and relaxing muscle groups, and deep breathing.

- Provide children's books as a way to explore and express emotions.

- Teach alternative strategies for destructive or inappropriate behavior.

- Provide daily opportunities for vigorous exercise. This is a natural stress reducer and maintains health.

- Teach children positive self-talk in stressful situations. (Young children may need to say these things out loud: "I can stay calm," "I'm scared, but I can handle this," "I can breathe in and out slowly to help myself," "I can choose to yell instead of hitting.")

- Help children practice positive imagery. Encourage them to see themselves act positively in a potentially stressful situation.

- Discuss feelings, thoughts and behaviors that people can use when they're afraid, angry or overwhelmed by what is happening.

- Collaborate with parents to reduce child's stress. Parents may appreciate handouts or newsletters on separation anxiety, effects of media on children, relaxation breathing techniques, etc.

Sharing your observations with the family in a safe and supportive environment and offering resources may help everyone cope in a more positive way.

Helping children deal with stress can be distressing for the caregiver. Feelings of sadness or anger are normal. Caregivers may need to talk to a trusted coworker or supervisor or a professional. Remember to practice self-care techniques (exercise, regular breaks, nutritious meals and adequate sleep). Also recognize limitations and ask for help when needed.

Stress is inevitable in our world, but we have the ability to adapt and learn something positive from these situations.

**References**

Kostelnik, M., Whiren, A., Soderman, A. & Gregory, K. (2006). *Guiding Children's Social Development: Theory to Practice,* New York.

Rose, B. (2005). *Health & Safety Notes-Supporting Families Experiencing Domestic Violence,* California Childcare Health Program, Oakland, CA at www.ucsfchildcarehealth.org

# BULLY AWARENESS AND PREVENTION

**What is bullying?**

Repeated acts of intentional physical, emotional, or social harm between individuals and/or groups of unequal power.

**Physical bullying**

- Harm to body or property
  - Hitting, kicking, pushing, destroying someone's things

**Emotional bullying**

- Harm to self-esteem
  - Name-calling, threatening, intimidating, teasing

**Social bullying**

- Harm to group acceptance
  - Excluding someone from a group

**Warning signs of a bully victim**

- Withdraws socially, becomes isolated, feelings of rejection
- Complains of feeling sick often
- Does not want to go to school/child care
- Brings home damaged belongings or reports them "lost"
- Physical evidence: bruises, scratches

**Warning signs of a bully**

- Picks fights
- A poor winner (sportsmanship) and/or a poor loser

- Gets satisfaction from others fears, discomforts, or pain
- Displays uncontrolled anger
- History of violent and/or aggressive behaviors

**Ways to prevent children from becoming a bully victim**

- Instill self-confidence
- Establish good social skills
- Teach child to speak out for himself-herself
- Teach child to seek help from more then one source: adult, teacher, parent, family member

**Ways to prevent children from becoming a bully**

- Present yourself as a model of nonviolent behavior
- Clearly state that violence in an unacceptable behavior
- Teach anger management strategies
- Model healthy methods of dealing with frustration
- Seek help from mental health/school counselors
- Be consistent and appropriate when guiding children's behavior

For more information
1-800-789-2647
www.samhsa.gov
www.modelprograms.samhsa.gov

# Chapter 4

# Injury Prevention & Infection Control


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# CHILDHOOD INJURY PREVENTION

Injury prevention is the understanding that injuries are not random uncontrollable events, but preventable incidences with identifiable risk factors.

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 in the environment.

Teach children safety rules and awareness throughout the day.

**Steps to prevent injuries:**

- Never leave infants or young children alone on tables, beds, couches, vehicles, or any surface from which they can fall.
- Keep sides of crib up and latched. Use only cribs, porta-cribs, and playpens that meet current federal safety guidelines.
- Keep a harness or safety strap on babies in high chairs.
- Keep play areas uncluttered.
- Keep playground equipment in good condition.
- 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.

## Motor vehicle safety

- Motor vehicle crashes are the leading cause of death among children.

- Always properly secure children in a child passenger restraint system (car seat) or seat belt, in compliance with state law.

- Four out of five car seats are used wrong. Could one of them be yours? Common mistakes of car seat use include:

  - Not buckling the seat into the vehicle properly;
  - Car seats that are not secured tightly - when properly secured the car seat should not move more than one inch side to side at the belt path;
  - Improper installation of a locking clip - when using a locking clip be sure it is installed one inch from the latch plate on the seat belt;
  - Not properly securing the child into the car seat - harness straps should be snug, not tight. If the harness can be easily pinched to form a loop it is too loose;
  - Not facing infants, under 20 pounds and under one year of age, toward the rear of the vehicle;
  - Using a car seat with a harness when the child exceeds the weight limit for the harness - weight limits are printed on the car seat label. Move the child to a car seat with a higher weight limit.
  - Improper use of seat belts - children are moved from harness type car seats to seat belts too soon. Booster seats are to be used to assure proper seat belt fit.

- Technical questions can be answered by Safe Kids Oklahoma: (405) 271-5695.

## Water safety

- Children less than five years of age have the highest rate of drowning and near drowning of all age groups.

- Completely surround swimming pools with childproof fences and keep gates locked.

- Constantly supervise children in a bathtub or involved in water play.

- Keep toilet lids down and empty buckets 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.

- Be sure there are adequate personnel to watch ***all*** children if they are taken swimming.

**Burn prevention**

- Each year in Oklahoma, approximately 150 children under five years of age die from burns or require treatment in a burn center.
- Install and maintain smoke detectors; test monthly and replace batteries as necessary.
- When cooking, keep children out of the kitchen.
- 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 irons, and their cords out of reach of children.
- Set hot water thermostats between 100 and 120 degrees to prevent tap water injuries.

**Choking prevention**

- The most common foods children choke on are hot dogs, candy, grapes, and nuts; (avoid feeding children these foods or slice them in thin, lengthwise strips).
- Children under three years of age should not be allowed to play with any items that fit through an empty toilet paper roll.

**Suffocation prevention**

- Each year in the U.S., approximately 200 children under one year of age die from suffocation.
- Infants should never sleep on waterbeds, sofas, soft mattresses or other soft surfaces.
- Tie up or clip off blind and drapery cords; keep cribs away from cords.
- Infants less than one year of age should not be on adult or youth beds; (they may fall off the bed or become entrapped between the mattress and a wall, bed frame, headboard, or footboard).
- Avoid the use of drawstrings or necklaces around the necks of young children. These strings may catch on something and strangle children.
- Plastic bags, including garbage and dry cleaning bags, should be kept away from children.

**SIDS (Sudden Infant Death Syndrome) Awareness and Sleep Safety**

SIDS is the sudden and unexplained death of an infant under one year of age.

Each year in the U.S., over 2,000 infants die of SIDS. Doctors do not know what causes SIDS, but they have found some ways to reduce the risk of SIDS.

- Do not overheat the room where infants sleep, or dress infants too warmly.
- **Always** place infants to sleep on their backs.
- Place infants in safety-approved cribs with firm mattresses and tight-fitting sheets.
- Remove pillows, quilts, comforters, sheepskins, bumper pads, stuffed toys, and other soft products from the crib.
- If using a blanket, put baby with feet at the end of the crib. The blanket should reach no higher than the baby's chest. Tuck the ends of the blanket under the crib mattress.
- Do not expose infants to cigarette smoke before or after birth. The risk of SIDS doubles around cigarette smoke.
- If possible, encourage mothers to breastfeed their babies. Breastmilk helps keep babies healthy.

**Firearms safety**

- Store all weapons in a locked container, cabinet or closet.
- Store ammunition in a locked area, separate from weapons.

**Fall prevention**

- Falls are the leading cause of unintentional injury among children.
- Children in shopping carts should be secured with a seat belt and watched closely.
- Avoid the use of baby walkers as they can tip over.
- Place safety gates at the top and bottom of stairs.
- Do not place outdoor equipment such as swings, slides and climbing apparatus on a hard surface.
- Anchor all equipment not designed to be portable, to the ground.

- Place outdoor equipment in a safe location.

**Poison prevention**

- Keep all medications and poisonous household products out of the reach of children and in their original containers.
- 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.
- 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 4 feet above the floor, out of the reach of children, and install cabinet and drawer latches.

**Bicycle safety**

Head injury is the leading cause of death in bicycle crashes. The single most effective safety device available to reduce head injury and death from bicycle crashes is a bicycle helmet. Bicycle helmets can reduce head injuries by 85%.

- All bike riders should wear a helmet every time they ride. Select a helmet that fits snugly and sits flat atop the head.
- Always keep a lookout for obstacles in the bike path.
- Always be aware of the traffic flow.
- Make sure the bike fits the child's height, weight and age.
- Inflate tires properly.
- If riding on the street, ride single file in the same direction as other vehicles and obey traffic laws.

**Sun safety**

Prolonged exposure to sun, repeated sunburn, and even one severe sunburn may lead to skin cancer later in life.

- In the hottest part of the summer, children should do most of their outdoor play before 10:00 A.M. and after 3:00 P.M.

- All outdoor playgrounds should have shaded areas.
- Children over six months of age should use sunscreen with an SPF of at least 30 and it should be applied 30 minutes before going outside.
- Reapply sunscreen every 30 minutes, even on cloudy days.
- Sunscreen should not be used on children under six months of age because the chemicals may be too strong for their skin.
- Children under six months of age should stay out of direct sunlight because their skin is thinner and more sensitive to the sun.
- Wear lightweight, loose-fitting clothing in the sun.
- Receive parents' written permission to apply sunscreen to their children. (This can be done using the same permission form for medication).

A website with good sun safety information is www.ppsinc.org/skin

# 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 Response Plan (ERP) for a wide range of emergency situations.

Your Emergency Response Plan should be in writing and include reporting emergencies, protecting from outside threats, and evacuating in case of fire, flood, tornado, blizzard, power failure, or other natural or man-made disasters that could create structural damage to the facility or pose health hazards.

Conduct fire, tornado and off-site evacuation drills so that all staff and children become familiar with the procedures. Prepare an emergency supply kit and take on your practice drills. Provide information about your emergency response plan to families whose children attend your child care program.

**Types of emergencies/disasters to cover in Emergency Response Plans:**

- Lost or missing child
- Abduction by non-custodial parent
- Injuries requiring medical or dental care
- Natural disasters such as tornado, blizzard, flood, earthquake
- Human threats such as bomb threat or hostage situation
- Fire
- Power or water failure

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

- Caregivers maintain current First Aid and CPR training.
- Children and caregivers practice drills for fire, tornado, and evacuation from site on a regular basis.
- Children and caregivers know at least two exits from the rooms and building.

- Emergency equipment is regularly tested and restocked or replaced.
- Caregivers have at least two evacuation location sites (one nearby, one farther away) and at least two ways to reach the alternate sites.

**Communicating your Emergency Response Plan (ERP):**

- Share your ERP with parents upon enrollment and at least yearly thereafter
- Train staff yearly in the ERP
- Provide a copy of the ERP to all staff
- Give copies of all changes or updates in your ERP to staff and parents
- Share the ERP with local emergency responders such as the fire department

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

**Available resources**

- National Child Care Information Center: Emergency Preparedness for Child Care Programs
  www.nccic.org/emergency/topic_emprep.cfm
- U.S. Department of Education Emergency Planning
  http://www.ed.gov/admins/lead/safety/emergencyplan/index.html
- National Association of Child Care Resource and Referral Agencies
  "Is Child Care Ready?"
  www.naccrra.org
- American Academy of Pediatrics "Disaster Planning Guide" Family Readiness Kit
  www.aap.org
- Institute for Business and Home Safety
  Non-Structural Mitigation for Child Care Centers
  www.IBHS.org/docs/childcare.pdf

# EMERGENCY SUPPLIES LIST

These items are needed at your child care facility in case of evacuation or natural disaster. Place items in an easy-to-carry waterproof container. The supplies should be stocked to last to 3 – 6 hours. This list should be adjusted to fit the specific needs of each Child Care Facility. Check them off as you gather them.

___ Battery powered radio (a weather radio is best)

___ Battery powered flashlight for each staff member

___ Extra batteries for flash lights and radio

___ First Aid Kit

___ Identification cards for all children and staff

___ List of emergency phone numbers for each child

___ 6 hour supply of all baby food, including formula and breastmilk

___ Baby bottles

___Bottled water

___ Snacks for children and staff

___ All prescription medication for the children in care

___ Paper cups, paper towels, paper plates, and plastic utensils

___ Diapers, diaper wipes, ointments or powders for infants and children still in diapers

___ Plastic trash bags

___ Books, small toys, and games for the children

___ Extra blankets, towels, sheets, clothes, etc.

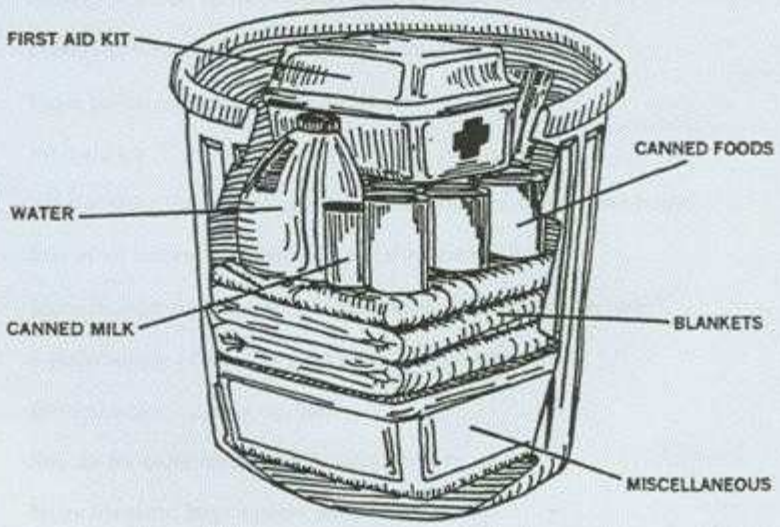
# Home Emergency Supplies

## Car Mini-Survival Kit

- ☐ Non-perishable food - store in clean coffee cans
- ☐ Bottled water
- ☐ First aid kit and book
- ☐ Flares
- ☐ Fire extinguisher — A-B-C Type
- ☐ Blanket or sleeping bag
- ☐ Sealable plastic bags
- ☐ Flashlight - fresh and spare batteries and bulb
- ☐ Essential medication
- ☐ Tools - screwdriver, pliers
- ☐ Short rubber hose - for siphoning
- ☐ Small package of tissues
- ☐ Pre-moistened towelettes
- ☐ Local maps
- ☐ Extra clothes, jeans, sweater
- ☐ Sturdy shoes or boots

## Storage of Emergency Supplies

Some families prefer to store their emergency supplies in one location. Choose a place in your home which would be relatively safe in time of an earthquake (such as a closet or under a bed). The perishable supplies will remain stable longer if stored in a cool, dark location.




One suggested method for storing emergency supplies is to place them in a large, covered trash container. They can be layered as shown and all kept together in the large covered container.

*Note: It is best to store plastic water containers on top of the contents rather than on the bottom where they could possibly crack and leak from the weight of heavy objects placed on top of them.

# FIRST AID KITS

Readily available first aid kits should be maintained in the center or home, and when transporting children. The kits should be inaccessible to children.

**First aid kits should contain:**

- Disposable, nonporous gloves;
- Blunt-tipped scissors;
- Tweezers;
- Thermometer;
- Bandage tape;
- Sterile gauze pads;
- Rolled, flexible or stretch gauze;
- Non-medicated adhesive strips;
- Current standard first aid text or equivalent first aid guide;

The telephone number for the Poison Control Center should be written in or on the first aid kit. **1-800-222-1222**

**First aid kits taken when transporting children should also include:**

- Liquid soap and water or individually packaged towelettes;
- Pen or pencil and note pad;
- Cold pack;
- Coins for use of a pay phone;
- The poison control center telephone number, **1-800-222-1222**; and
- Plastic bags for disposal of items contaminated with blood and/or body fluids.

# COMMUNICABLE DISEASE

**What is a communicable disease?**

A communicable disease is an illness caused by spreading germs from a person or an animal to another.

**What causes a communicable disease?**

A communicable disease results from the interaction between a child (or adult), the environment (home, child care, playground, school), and germs.

**What are germs?**

"Germ" is a commonly used term which refers to more specific things such as bacteria, viruses, fungi, or parasites, which can cause disease.

**Bacteria**

- Bacteria are small organisms, which can be seen with an ordinary microscope, and can live on most surfaces.
- Some well-known diseases caused by bacteria are strep throat, impetigo, some pink eye, and some pneumonia.
- A doctor usually prescribes medications, called antibiotics. Antibiotics kill the bacteria, or sometimes just stop their growth.
- There are vaccines against several bacterial diseases.

**Viruses**

- Viruses are smaller than bacteria and can grow only within living cells.
- Some well-known diseases caused by viruses are colds, chicken pox, measles, German measles, mumps, and polio.
- Antibiotics have no effect on viruses. Rest and drinking plenty of fluids are the best thing for someone with a viral infection.
- There are vaccines against several viral diseases, for example, measles.

## Fungi

- Fungi prefer growing in moist, warm places, however, some like Ringworm, can grow on dry skin.

- There are effective medications for fungal diseases. They work best when the conditions favorable to fungal growth are removed.

## Parasites

- Parasites are organisms, which live in or on animals and people, and can be worms or insects.

- Common parasites are pinworms, roundworms, and head lice, which may cause secondary infections.

# COMMUNICABLE DISEASE IN CHILD CARE SETTINGS

Infectious diseases are common in children. The children you care for can easily pass germs around because they share toys and spend many hours together.

As a child care provider, you need to take steps to decrease the spread of disease in your child care home or center so that you and your children stay healthy. It is important to understand how diseases are spread so you will know how to prevent them from spreading.

## Ways Diseases Spread

### Respiratory Secretions (nose, throat, and mouth)

Hands and other surfaces soiled with nasal and throat discharges are responsible for much of the spread of disease. Sneezing and coughing by a child with respiratory illness can spray germs onto surfaces throughout a room, allowing germs to spread to other children. Some of the illnesses that are passed in this way are:

- Chickenpox
- Common Cold
- Flu
- Measles
- Meningitis
- Mumps
- Pertussis
- Strep Throat

### Fecal-Oral

Germs, which are present in the bowel movements (feces, stools) of ill children and some well children (carriers), may be spread directly from soiled hands to another person's mouth. Germs may also spread by touching objects, surfaces, or food soiled with feces. The areas most often soiled with feces are hands, frequently touched items such as faucet handles, toilet flush handles,

toys, tabletops, and especially surfaces or areas where diapers are changed. Some of the illnesses spread in this way are:

- Hepatitis A
- Salmonella
- Shigella

**Direct contact (skin/hair or lesions)**

Illnesses can also be spread by direct contact with infected parts of the body. Some of these illnesses are:

- Impetigo
- Conjunctivitis

Skin infestations are spread by contact with an infested body area. Some of these conditions are:

- Head lice
- Scabies

# INFECTION CONTROL

**Factors that contribute to the spread of disease in child care settings**

- Young children have no concept of hygiene, and constantly place objects in their mouths.
- Diaper changing areas that do not have sinks nearby.
- Small room-size relative to the number of children cared for in the room.
- Large numbers of children together in a single room, even a large room.
- High child-to-caregiver ratio.
- Limited bathroom facilities with many children sharing a bathroom.
- Staff who circulates among different age groups.
- Staff who prepare food as well as care for children.
- Failure of staff to observe good hygienic practices, such as washing hands before meals and after diaper changing, or cleaning and sanitizing diaper changing surfaces after each use.
- Presence of ill persons, especially with diarrhea.
- Improper disposal of soiled diapers.
- Mixing children in diapers with other non-diapered children.
- Children and staff handling pets.

**Preventing the spread of germs**

The basic solution to reduce the risk of illness is really quite simple. Germs thrive in warm, wet, and stuffy places. Clean, dry places are much less likely to harbor them. You can help keep germs from spreading by keeping your hands and your surroundings as clean and dry as possible.

Hand washing is the *most important* way to prevent the spread of disease. It reduces the number of germs that may be spread.

**Proper hand-washing techniques**

- Use warm running water and preferably liquid soap.
- Wet hands and lather with soap, rubbing front and back of hands and wrists and between fingers for at least twenty seconds.
- Rinse under running water from wrists to fingertips.
- Dry hands with a paper towel.
- Use a paper towel to turn off faucet and open the door.

**Everyone should wash hands:**

- Upon arrival at the child care facility;
- Before eating or handling food, or assisting a child with eating;
- Before and after diapering;
- After handling and cleaning up body fluids; after wiping noses, mouths, bottoms, and touching cuts, sores, or drainage;
- After handling or feeding pets;
- After outdoor activities; and
- After using the toilet.

Assist children with hand washing until they become skilled at it. You can make it fun for children by singing songs and reading books about the importance of hand washing. Teach them to wash their hands for the amount of time it takes to sing the ABC's. All children should be supervised when washing hands.

**Cleaning and sanitizing guidelines**

- Diaper changing area
    - Clean with soap and water after every use to remove visible soil.
    - Spray with sanitizing solution after each use, leave on 30 seconds and wipe or air dry.
- Potty chairs
    - Empty contents into the toilet.
    - Wash the chair with soap and water and dispose of water in toilet.

  - Spray with sanitizing solution after each use and allow to air dry.

- Bathroom
  - Clean and sanitize daily.
  - Clean anytime visible soil is present.

- Kitchen
  - Clean & sanitize (including eating areas and high chairs) before and after each use.
  - Clean anytime visible soil is present.

- Toys
  - Keep the toys of sick children separate.
  - Only allow stuffed toys that are machine washable.
  - Wash and sanitize all mouthed toys after each use.
  - Clean and sanitize all toys as needed (at least weekly).

- Cribs, cots and mats
  - Sanitize crib, cots, mats and mattresses at least weekly.
  - Change crib sheets daily and cot or mat sheets at least weekly, or whenever wet or soiled.
  - Sanitize mattresses with each linen change.

- Play areas
  - Remove food and litter immediately.
  - Vacuum/sweep daily and whenever soiled.
  - Mop and sanitize floors daily, and whenever soiled.

- Clean surfaces that infants and young toddlers are likely to touch with soap and water *every day.*

- Wash and disinfect low shelves and doorknobs *every week.*

**Sanitizing solution**

- **For diaper changing area.**
  - One tablespoon of bleach to one quart of water.

- **For cots, tables, counters, and toys**.
  - One teaspoon of bleach to one quart of water.

**Guidelines for the use of gloves**

- Gloves should be considered in the following situations:
    - When changing diapers for a child with diarrhea.
    - When cleaning surfaces that have been contaminated with blood, vomit, feces (stool), or urine.
    - When providing first aid where contact with blood or body fluids is likely.
- A fresh pair of gloves must be used for each child. Dispose of gloves after each use.
- All gloves should be disposable, water proof, and in good repair.
- Do not wash gloves for re-use.

**To remove gloves without contamination**

- With both gloves on, pinch the palm of your left glove with the fingers of the right hand.
- Pull your left glove off over your hand and fingers and hold it with your right hand.
- Slide your left hand under the cuff of your right glove, at the wrist.
- With your left hand pull the right glove off, over the right hand and the left glove, turning it inside out as it comes off.
- Throw the gloves away.
- Wash your hands.

**Other helpful hints**

- Make sure that children have their own individual crib, cot, mat, blanket, or mattress when taking naps.
- Make sure children do not share food, bottles, cups, pacifiers, plates, utensils, or toothbrushes. Remind them that sharing during meals can spread germs.
- Use a separate tissue for each child and dispose in waste container, washing hands afterwards.
- Cover mouth and nose when sneezing and coughing, and teach children to do the same (teach cough into your arm or sleeve).

# PROPER DIAPERING PROCEDURE

## Purpose

- To prevent the spread of germs in the urine or stool to staff's or child's hands, the diapering surface, containers of supplies, cabinet doors, or any other surface the children and staff might touch.

## Preparing for Diapering

- Have diaper area set up and changed before bringing each child to the area.
- Change table paper (if used) to cover the table from the child's shoulders to heels (in case it becomes soiled and must be folded over to give a clean surface during the change).
- Supplies should be removed from containers and placed in reaching distance, but not on changing surface, before starting the diaper change.
- Have enough wipes for the diaper change (including wipes for child's bottom and hands as well as adult's hands).
- Have a clean diaper ready.
- Use a plastic bag for soiled clothes, and have clean clothes ready if soiled clothing is anticipated.
- If using gloves use non-porous gloves.
- If using diaper cream, dab cream on a disposable piece of paper or tissue to apply to child's skin.

## Diapering Procedure

- Prepare for diapering as indicated above.
- Place child on clean diapering table. Remove clothing to access diaper. If clothes are soiled, place the soiled clothing into a plastic bag.
- Remove soiled diaper and place into lined, hands-free trash container. (To limit odor, seal in a plastic bag then place in a trash container).

- Use wipes to clean child's bottom from front to back.
- Use a clean wipe for child's hands.
- Use another clean wipe to remove soil from adult's hands.
- Throw all soiled wipes into a lined, hands-free trash container.
- Put a clean diaper and clothing on the child.
- Place child at sink and wash hands following the proper handwashing procedures. (If the same sink is used for diapering/toileting as for food preparation, then faucet handles and sink must be sanitized with bleach-water solution after each diapering/toileting use).
- Clean the diapering area with soap and water after every use to remove visible soil.
- Spray diapering surface with bleach-water solution. Leave on two minutes and wipe or air dry.
- Any toys or objects the child has played with during the diaper change must be sanitized.
- Wash hands using the proper handwashing procedure, without contaminating any other surfaces.
- Be sure that the diaper changing surface is dry before use with another child.
- Record the diaper change in the child's daily log.

# PROPER HANDWASHING PROCEDURE

**Adults and children should wash their hands:**

- Upon arrival at the child care facility
- After touching trash cans or lids
- Before and after eating
- After toileting
- After caring for or playing with animals
- After cleaning up spills
- After wiping nose or coughing into hand
- After diapering or assisting a child using the toilet
- After messy play such as painting or gluing
- Before and after group water play in the same water table or other container
- Before and after administering medication
- When leaving the facility

**Proper handwashing procedure:**

- Moisten hands with warm running water and use liquid soap.
- Rub hands together front, back, wrists, and between fingers for at last 10-20 seconds. (Sing 2 verses of Twinkle Twinkle, or a favorite handwashing song).
- Rinse wrists to fingertips until free of soap under warm running water.
- Dry hands with paper towel or rub hands together under an air dryer.
- Use a paper towel to turn off faucets and throw the paper towel into a hands-free trash container.

**Gloves, wipes, or alcohol-based hand sanitizers:**

- Wipes and hand sanitizers do not count as substitutes for handwashing and should only be used when soap and running water are not available. (Field trips, playground)

- If gloves are used, hands need to be washed with soap and water before applying the gloves and after the removal of the gloves.

- Alcohol-based sanitizers should only be used where no other alternative exists. It is important to follow the manufacturer's instructions and keep the sanitizer clearly labeled and out of the reach of children.

# SIGNS OF ILLNESS

**Any of these signs of illness should be reported to the parents by phone immediately:**

- **Fever** is a temperature over 100.4°. It is often the first sign of illness and should be reported to the parents. Temperatures less than that are not a cause for concern. Exercise or excitement might make the temperature go up. A person's normal body temperature varies with the time of day (lower in the morning, higher in the late afternoon). It also varies from child to child; 98.6 may not be normal for many children.

- **Diarrhea** means frequent loose stools. Do not confuse it with frequent soft stools (bowel movements) that are common in young infants. Diarrhea may indicate illness.

- **Vomiting** may indicate illness. Report vomiting to parents.

- **Unexplained sleepiness** may be an indicator of an illness. Observe the child closely if he is sleepy when he is not expected to be.

- **Localized pain**, if it is steady and will not go away may indicate illness, especially if in the ears or abdomen.

- **Difficulty in breathing** may indicate an illness. Contact Emergency Medical Services if necessary.

- **Constipation** is hard marble-like bowel movements and is common in children, especially in those who eat minimal amounts of fruits and vegetables. If there is pain with bowel movements, or blood in the stool, or on the toilet paper, it should be reported to the parents.

- **Skin rash** may be a sign of illness or it may be from an allergy. Isolate child until parent arrives.

- **Skin discoloration** may be a sign of illness if the discolored areas are red or numerous. Normal bumps and falls also may cause skin discoloration.

- **Swelling** or any abnormal enlargement may indicate injury or illness.

**Watch for and notify parents of any unusual behavior (i.e., irritability, fussiness, prolonged crying, etc.).**

## Your Response to Signs of Illness in Children

### Serious Signs of Illness

*Call parents immediately! Watch the child closely. Do not leave alone. Emergency treatment may be required.*

- Severe coughing, high pitched whistling sound, redness or blueness in face, difficulty breathing
- Vomiting with other signs such as headache or fever
- Fever 100.4° or greater, extreme tiredness, difficult to awaken
- Sore throat, difficulty breathing and swallowing

### Signs of a Probable Communicable Illness

*Call parents. Ask parents to take child to doctor. Isolate the child until parents arrive.*

- Redness, swelling, drainage of eye
- Unusual spots/rashes with fever or itching
- Sore throat
- Crusty, bright yellow, gummy skin sores
- Diarrhea (more than three loose stools a day)
- Vomiting (more than two times a day)
- Yellow discoloration of skin and/or the whites of eyes
- Clay colored stools or tea colored urine

### Signs of a Possible Communicable Illness

*Watch child closely. Notify and discuss signs with parents.*

- Earache (check for fever or discharge)
- Headache
- Itching of scalp (Check for nits. If present, isolate until treated.)

- Fever less than 100.4°
- Runny nose (Check temperature)

# DAILY HEALTH CHECK

Upon arrival at the child care facility, 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 and check for:

- Behavior – typical or atypical for time of day and circumstances
- Overall appearance
- Skin – pale, flushed, rash (feel child's skin by touching affectionately)
- Eyes, nose, mouth – note color; is there any discharge? Is child rubbing eyes, nose or mouth?
- Hair – in a lice outbreak, look for nits
- Obtain information from 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 any unusual events taken place?
    - Have bowel movements and urine been normal? When was the last time child used toilet or was changed?

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

If a possible communicable disease is discovered during the Daily Health Check, the parent may be asked to take the child home.

# HOW TO DECREASE THE SPREAD OF DISEASE

**What can be done to keep diseases from spreading in a child care facility?**

Child care providers can use the same approach that health care professionals use to protect themselves from diseases.

That approach is ***personal cleanliness***. Hand washing, using soap lavishly and often along with other hygienic measures, can break the chain of infection that allows diseases to spread from person to person in child care.

It may be easier to appreciate the qualities of personal hygiene if the nature and transmission of diseases are clearly understood.

Germs are living species that are invisible without a microscope and may cause illness. Once germs leave the body through coughs, sneezes, saliva, blood, bowel movements or urination, they die unless they find their way into another human body.

There are several ways to decrease the spread of disease in a child care setting:

- Use soap and water when washing hands and dry with a paper towel.
- Use individual tissues for wiping and blowing noses.
- Dispose of tissues immediately into a waste container and follow by washing hands before touching anything else.
- Wash hands before food preparation, after toileting, diaper changes, and after wiping noses.
- Use soap and water when hands are visibly soiled, and alcohol-based hand gel to disinfect hands that are visibly clean. If alcohol-based hand gel is used by children it should be dispensed by an adult and used under supervision.
- Environmental cleaning: clean surfaces when soiled and more often if frequently touched or during cold and flu season.

# Chapter 5

# Childhood Injuries & Illnesses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# ALLERGY

**What is it?**

An allergic reaction is a special type of inflammatory (reddening and/or swelling) response in various parts of the body to a substance that has been inhaled, eaten, injected (from stings or medicine), or they can come into contact with the skin. Allergies can be as minor as sneezing and itching. For some children, however, allergies can become very serious or even life-threatening. Whether minor or serious, allergies can be prevented and controlled.

**How can it be recognized?**

Allergies produce many different symptoms, including swelling, rashes, congested or runny noses, wheezing, vomiting, and diarrhea.

**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?**

Many, many things. Lotions, oils, perfumes, cigarette smoke, wool, polyesters, and other fabrics often cause them. Foods (chocolate, nuts, cow's milk, wheat, soy, shellfish, peas, eggs, and others) may produce allergic reactions. The pollen from grass, trees, and shrubs can cause allergic reactions. Prescription and over-the counter medications can cause allergic reactions. Animal dander and saliva and venom from insect stings can cause allergic reactions.

**What should be done?**

Find out about a child's allergies at the time of enrollment. Keep this information on file; this information may be crucial in the event of an emergency. Avoid the offending substance if possible.

If a child has asthma, this information should also be on file along with the recommended treatment and the doctor's name and phone number.

Do not give medication ***of any kind*** to an allergic or asthmatic child, unless it is definitely recommended by the child's doctor.

Follow the recommendation of the parent and doctor if the child has an allergic reaction.

# ASTHMA

Asthma is a chronic disease of the tubes that carry air to the lungs. These "airways" become narrow and their linings become swollen, irritated, and inflamed. This results in a serious respiratory problem in which breathing is difficult and often accompanied by a wheezing or whistling sound. Most children with asthma have attacks only occasionally, and at other times, they are fine. Children with asthma can be sensitive to irritants including colds and other viral infections, cigarette smoke, cold air, and particles or chemicals in the air. These sensitivities are called "triggers." Allergies to dust, cockroaches, animals, pollens, and molds can also be triggers. Often asthma attacks are mild and will calm down with rest and treatment with prescribed medications. If symptoms develop, act quickly.

To fill out a checklist "How Asthma-Friendly is Your Child Care Setting?" visit this website: www.nhlbi.nih.gov/health/public/lung/asthma/chc_chk.htm

Discuss a child's asthma history with the parent at enrollment. Be sure to get complete information regarding medications, a description of the child's symptoms, and a plan of what to do during an attack.

**Common symptoms to observe in infants**

- Breathing rate increases (to over forty breaths per minute while asleep).
- Breathing becomes noisy.
- Sucking or feeding slows or stops.
- Skin between infant's ribs is sucked inward (retractions).
- Nostrils open wider (nasal flaring).
- Cry may change in quality (becomes shorter or softer).
- Grunting sounds.
- Coloring of face is pale or red, fingernails and lips bluish.

**Symptoms in children**

- Discomfort or tightness in chest.
- Increased rate of breathing per minute.

- Breathing becomes noisy.
- May not be able to complete sentences (shortness of breath).
- Wheezing sound, especially when breathing out.
- Frequent coughing and spitting of phlegm (mucus).
- May or may not have fever.
- Sitting with shoulders hunched up or leaning forward.
- Skin sucked in under the breastbone, in the notch of the neck and, in between and under the ribs.
- Flaring nostrils.
- Bluish lips or nail-beds.

**Procedure**

- Remove the child from the irritant, if known. (Common triggers include exercise, allergic reaction, cold weather, smoke, and a viral illness like a "cold" or scratchy throat.)
- Remove the child from strenuous play activities (running, jumping, etc).
- Try to keep the child calm and relaxed. Keep the child sitting upright.
- Encourage the child to drink fluids (but nothing ice cold).
- Administer medications as indicated by the parent and physician.
- Notify all staff of signs that may signal an impending attack.
- If you are unsure, it is better to call the doctor than wait until the child is in severe distress. Every child is different and will need an individualized treatment plan.

**Refer to the Special Health Care Plan in Appendix L to develop an individualized asthma plan.**

# BITES

**Animal or human bites and scratches**

- Wash the bite or scratch immediately with soap and running water.
- Confine the animal immediately until an animal control officer arrives. This may prevent the child having to take the series of rabies shots.
- Notify the child's parent and recommend medical evaluation. Check to see when the child last had a tetanus shot.
- Cat bites (especially of the hand) can become quickly infected and need prompt attention. Claw wounds are treated the same as bite wounds, since they are contaminated with saliva.
- Check the wound daily. Get immediate medical supervision if redness, swelling, pus, or pain is noted.

An animal bite that occurs in a child care setting should be reported to your local or state health department. Bites from the following animals can carry rabies and may need medical attention:

- Dog
- Cat
- Raccoon
- Coyote
- Skunk
- Fox
- Bat

If bite is from a snake, hold the bitten area still and below the level of the heart. Call Poison Control Center: 1-800-222-1222

- Wear disposable gloves when exposed to blood or other body fluids.
- Wash the bite area with soap and water.

- Press firmly with clean dressing if bleeding.

- Notify parent.

Check child's immunization record for DT, DPT (tetanus). If greater than 5 years since last tetanus vaccine, contact health care provider.

**Insect bites or stings**

Children with a history of allergy to stings should be known to all staff. An emergency care plan should be developed. A child may have a delayed allergic reaction up to 2 hours after the sting. Adults supervising child during normal activities should watch for any delayed reaction.

- If the child is bitten or stung by an insect, try to identify the type of insect, (spider, wasp, bee, etc.).

- If the sting is from a honeybee, remove the stinger by gently scraping along the site with a plastic card.

- Wash the site with soap and lukewarm water.

- Cover the site with a clean cold compress to reduce swelling and discomfort.

- Get immediate medical attention if the following occurs:

  - difficulty breathing;
  - dizziness;
  - flushing of the skin or swelling of the face; or
  - general body itch;
  - nausea or vomiting;
  - rashes or welts; or
  - tightness in the nose, throat, or chest.

- If the child goes into shock (cold, clammy skin and weakness) call emergency services. Lay the child down and elevate his legs, and keep the child covered until medical help arrives. ***Do not leave the child alone.***

**Tick bites**

- Remove the tick by placing tweezers close to the head of the tick and pull away from the point of attachment. Apply steady upward traction until the tick is removed.

- Notify the parent to take the child to the doctor if the head remains attached.

- Wash the area with soap and water.

- Describe the tick to the parents (or save in a ziplock bag) and be sure to tell them to watch for a fever or rash within 30 days, following the bite.

- Get immediate medical attention if the following occurs:

  - difficulty breathing;
  - dizziness;
  - flushing of the skin or swelling of the face; or
  - general body itch;
  - nausea or vomiting;
  - rash or welts;
  - tightness in the nose, throat, or chest;
  - If the child goes into shock (cold, clammy skin and weakness) call emergency services. Lay the child down and elevate his legs, and keep the child covered until medical help arrives. ***Do not leave the child alone.***

**Child bites**

- Wash the bite immediately with soap and running water. Human bites are more likely to become infected than animal bites.

- If the skin is broken and the child is not properly immunized, a Tetanus shot may be necessary.

- Notify parents.

- Watch for signs of infection, such as redness, swelling, or pain.

# BUMPS OR FALLS

**Broken bones (fractures), dislocations, sprains, or strains**

These injuries could include the following symptoms and should be treated as if they **could be** fractured:

- Pain in one area
- Swelling
- Feeling "heat" in injured area
- Limited movement
- Bent or deformed area
- Numbness or loss of sensation

Contact parent. Rest injured body part by not allowing child to bear weight on it or use it. Apply cold pack, covered with a cloth or paper towel to minimize swelling.

- Do not move an injured part of the body.
- Elevate the body part if possible.
- Immobilize and gently support the injured area.
- Keep the child warm and comfortable until parent arrives.
- Don't give the child anything to eat or drink.

**Bruises**

- Apply a cold compress or washcloth for 30 minutes to the bruised area. ***Do not*** place ice next to the skin.
- Rest the injured area as much as possible.

# BURNS AND SCALDS

A burn on the face, neck, hands, feet, or genitals, and any large burn should be treated by a doctor.

**Minor burns without blisters**

- Cover the burned area with a towel soaked in cool water.
- **DO NOT USE ICE.**
- Notify the parents.

**Burns with blisters**

- Cover the burned area with a towel soaked in cool water at least fifteen minutes.
- **DO NOT USE ICE.**
- Do not break a blister or apply any medication.
- Notify the parents.

**Deep burns**

- Call for emergency assistance ***immediately***.
- ***Do not apply*** cold water or any medication.
- Put out smoldering clothing with water (do not remove).
- Keep the child warm with a clean sheet and then a blanket until help arrives.
- Notify parents.

**Electrical burns**

- Call for emergency assistance ***immediately***.
- Disconnect electric power before touching the child.

- **DO NOT** touch the child with bare hands. Pull the child away from power source using something made from wood such as a broom handle, or a thick dry cloth. ***Do not*** use metal objects.

- Assess breathing and circulation. Begin rescue breathing/CPR if necessary.

- Notify parents.

**Chemical burns**

- Call for emergency assistance ***immediately*** while flushing burn and ask for instructions – **Poison Control Center**: **1-800-222-1212**.

- Flush the chemical from the burned area with lots of cool, running water, until medical help arrives. Remove any clothing that has the chemical on it, if possible.

- If an eye is burned by a chemical, flush the eye with water until medical help arrives.

**Note: If child arrives with pattern burns, such as iron or cigarette shape burns, consider the possibility of child abuse.**

# CAMPYLOBACTER

**What is it?**

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

**How can it be recognized?**

Diarrhea is the major symptom. Stomach cramps, fever, nausea, vomiting, and generally "not feeling well" can also occur. Bacteria can be identified through a stool culture.

**How long does it take from exposure to development of Campylobacter (incubation)?**

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 (stool) of infected people or animals (fecal-oral spread), spreads the bacteria. Hand washing before and after food preparation limits this kind of spread.

**What should be done?**

- Isolate the child.
- Notify the parents.

**When can the child be re-admitted?**

After doctor approval.

**What can be done to prevent the spread of Campylobacter?**

- Wash hands properly with soap, after each diaper change and bathroom use.
- Sanitize changing tables with bleach solution after each use.
- Teach children to wash hands.

- Always refrigerate meat products.
- Carefully wash hands before and after preparing foods.

**Who should be notified?**

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

# CHICKENPOX

**What is it?**

Chickenpox is a contagious disease caused by a virus.

**How can it be recognized?**

The four stages of the rash are:

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

They appear in crops, over a period of up to four days. Several stages may be present at the same time. The child may have papules, 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 appear a few days before the rash.

**How long does it take, from exposure to development of the disease (incubation)?**

Two to three weeks.

**When is it contagious?**

From five days before the rash appears until six days after the appearance of the first crop of blisters, or until the spots are all dried and crusted, whichever is longer.

**How is it spread?**

By droplets from the nose, mouth or throat, usually expelled by 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 other children.

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

**When can the child 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 are immunized.
- 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.

# CHOKING

It is recommended that all employees complete full Cardiopulmonary Resuscitation course for Infants and Children that includes Foreign Body Obstructed Airway. Foreign body airway obstruction should be suspected in infants and children who demonstrate the sudden onset of respiratory distress associated with coughing, gagging, high-pitched, noisy breathing, or wheezing. If the child is crying, or talking, **DO NOT** attempt removal. Place child in upright position and encourage coughing, **DO NOT** leave the child alone. If the child cannot talk or cough do the following.

**For infants**

- Open the infant's airway.
- Attempt rescue breathing.
- If the first attempt is unsuccessful in raising the chest, reposition the head and reattempt ventilation.
- If ventilation does not raise the chest, give five back blows and five chest thrusts.
- Hold the infant face down, resting on the forearm, support the infant's head firmly holding the jaw. Rest your forearm on your thigh to support the infant. The infant's head should be lower than the hips.
- Deliver up to five back blows forcefully between the infant's shoulder blades, using the heel of your hand.
- Turn the infant with the head and neck supported and hold the infant on his back draped over your thigh. The infant's head remains lower than the trunk.
- Give up to five quick downward chest thrusts by placing two-three fingers on the lower half of the breastbone.
- After **one minute of this procedure, activate Emergency Medical Services.**
- Look into the infant's mouth, if you see the object and can remove it, reach in with your small finger and remove it. Attempt to ventilate.
- If you still get no chest rise or response from the infant, resume back blows and chest thrusts.

- Continue back blows and chest thrusts until EMS arrives.

**Children (1 year to 8 years old)**

Abdominal Thrusts With a Conscious Child:

- Stand or kneel behind the child. You can also place the child in your lap while sitting in a chair.
- Place the thumb side of one fist against the child's abdomen in the middle, just above the navel.
- One hand would be effective with small children while larger children may require you to place your other hand over your fist.
- Thrust in and up. Each thrust should be a separate and distinct movement.
- **Activate Emergency Medical Service**
- Continues thrusts until the object is expelled or the child loses consciousness.
- If the child loses consciousness, lay the child on his back on a hard surface.
- Attempt to ventilate. If you get no chest rise, do the following:

Abdominal Thrusts on the Unconscious Child

- Kneel beside the child.
- Place the heel of one hand on the child's abdomen in the middle slightly above the navel.
- Small children may only need one hand, larger children will require that you place the other hand over the first.
- Thrust down and upward toward the head. This creates pressure to remove the object.
- Open the airway. If you see an object, remove it with your finger.
- Continue these steps until ventilations are successful or until EMS arrives.

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# Steps for Choking Emergencies

Local Emergency Telephone Number _____

## START HERE

### 1. CHECK

- CHECK scene for safety, then
- CHECK person.
  - If coughing, encourage the person to continue coughing.

### 2. CALL

- Send someone to CALL 9-1-1 or local emergency number.

### 3. CARE

- Get permission to give CARE and CARE for the choking person.

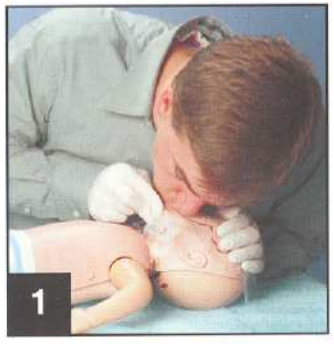
## INFANTS under age 1

**If infant cannot cough, cry or breathe (choking)...**

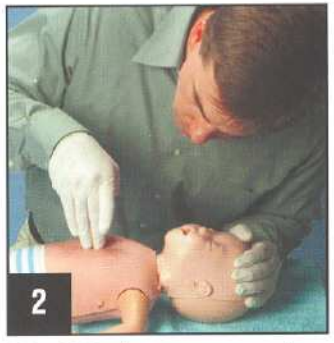

- Give **5** back blows


- If the object is not forced out–give **5** chest thrusts

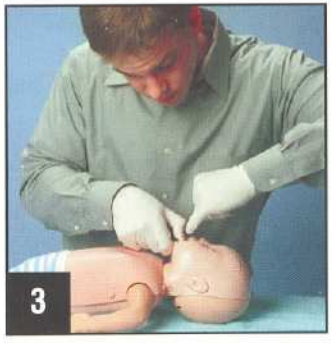
**If infant becomes unconscious...**




- Try **2** rescue breaths; if air does NOT go in–




- Give **30** chest compressions TIP: Remove breathing barrier




- Look for an object in the mouth and remove if one is seen

- **CONTINUE** sets of back blows and chest thrusts until—
  - Object is forced out.
  - Infant can breathe or cough forcefully.
  - Infant becomes unconscious.

- **IF BREATHS DO NOT GO IN**
  Continue steps 1-3 until the object is removed and the chest clearly rises with each rescue breath.

- **IF BREATHS DO GO IN**
  - Check for signs of life (movement and breathing).
  - If no breathing, give **2** rescue breaths and begin CPR.
  - If breathing normally (irregular, gasping or shallow breaths are not effective breaths), roll onto one side while waiting for help to arrive.

# CHILDREN ages 1 to 12

## If child cannot cough, speak or breathe (choking)...


▶ Give **5** back blows


▶ If the object is not forced out–give **5** quick, upward abdominal thrusts

▶ **CONTINUE** sets of back blows and abdominal thrusts until—

- Object is forced out.
- Child can breathe or cough forcefully.
- Child becomes unconscious.

## If child becomes unconscious...


▶ Try **2** rescue breaths; if air does NOT go in –


▶ Give **30** chest compressions
TIP: Remove breathing barrier


▶ Look for an object in the mouth and remove if one is seen

▶ **IF BREATHS DO NOT GO IN**

Continue steps 1-3 until the object is removed and the chest clearly rises with each rescue breath.

▶ **IF BREATHS DO GO IN**

- Check for signs of life (movement and breathing).
- If no breathing, give **2** rescue breaths and begin CPR.
- If breathing normally (irregular, gasping or shallow breaths are not effective breaths), roll onto one side while waiting for help to arrive.

# ADULTS age 12 or older

## If adult cannot cough, speak or breathe (choking)...


▶ Give **5** back blows


▶ If the object is not forced out–give **5** quick, upward abdominal thrusts

▶ **CONTINUE** sets of back blows and abdominal thrusts until—

- Object is forced out.
- Adult can breathe or cough forcefully.
- Adult becomes unconscious.

## If adult becomes unconscious...


▶ Try **2** rescue breaths; if air does NOT go in –


▶ Give **30** chest compressions TIP: Remove breathing barrier


▶ Look for an object in the mouth and remove if one is seen

▶ **IF BREATHS DO NOT GO IN**

Continue steps 1-3 until the object is removed and the chest clearly rises with each rescue breath.

▶ **IF BREATHS DO GO IN**

- Check for signs of life (movement and breathing).
- If no breathing, give **2** rescue breaths and begin CPR.
- If breathing normally (irregular, gasping or shallow breaths are not effective breaths), roll onto one side while waiting for help to arrive.

# The Skills To Save A Life

## Don't Delay—Get Trained!

American Red Cross lifesaving training can give you the skills and confidence to safely act in an emergency.

First aid, CPR and automated external defibrillation (AED) training can mean the difference between life and death.

**For more information, contact your local American Red Cross chapter or visit *www.redcross.org***

This poster should not be used as a substitute for training. If you do not have a breathing barrier or disposable gloves available, do not delay care.



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# Lifesaving CPR Steps

Local Emergency Telephone Number _____

## START HERE

### 1. CHECK

- CHECK THE SCENE for safety, then
- CHECK THE PERSON for consciousness.
  - Get permission to give care, as appropriate.
  - Tap shoulder and shout, "Are you okay?"

### 2. CALL

- IF NO RESPONSE, CALL 9-1-1 or have someone CALL 9-1-1 or local emergency number.
- IF YOU ARE ALONE AND CARING FOR A CHILD OR INFANT –
  - And you witnessed the child or infant suddenly collapse CALL 9-1-1.
  - If you did not see the child or infant suddenly collapse, give about 2 minutes of CARE, then CALL 9-1-1.

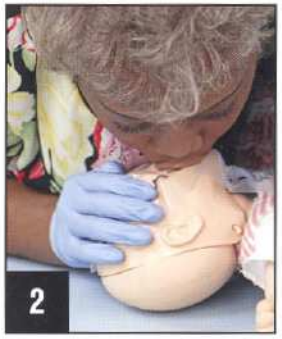
### 3. CARE

- OPEN THE AIRWAY (tilt the head back, lift the chin).
- CHECK FOR SIGNS OF LIFE (movement and breathing) for no more than 10 seconds (irregular, gasping or shallow breaths are not effective breaths).
- IF NO BREATHING, give 2 rescue breaths and begin CPR. For an adult or child use an AED if one is immediately available and you are trained to do so (follow protocols).
- IF BREATHING NORMALLY place in a recovery position (roll onto one side) while waiting for help to arrive.

## If no signs of life, give CPR

## INFANTS under age 1


▶ Compress chest **30** times




▶ Give **2** rescue breaths

**Repeat cycles of 30 compressions and 2 rescue breaths until the scene becomes unsafe, you find a sign of life, you are too exhausted to continue or a trained responder arrives and takes over.**

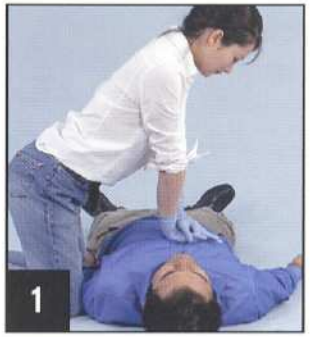
## CHILDREN Ages 1 to 12


▶ Compress chest **30** times


▶ Give **2** rescue breaths

**Repeat cycles of 30 compressions and 2 rescue breaths until the scene becomes unsafe, you find a sign of life, an AED is ready to use, you are too exhausted to continue or a trained responder arrives and takes over.**

## ADULTS Age 12 or older




▶ Compress chest **30** times


▶ Give **2** rescue breaths

**Repeat cycles of 30 compressions and 2 rescue breaths until the scene becomes unsafe, you find a sign of life, an AED is ready to use, you are too exhausted to continue or a trained responder arrives and takes over.**

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# COLD RELATED INJURIES

## Chilling

Chilling is one of the first stages of cold injury. Rapid lowering of body temperature can occur quickly and may lead to more serious cold injury.

## Frostnip

Frostnip is the next stage of cold injury. It is a reversible condition in which the skin loses color. The area affected may become numb or may even lose all sensation of cold and discomfort. As the area is re-warmed, a tingling may be felt.

## Frostbite

Frostbite may be indicated by a red surface that becomes white or very pale. The skin may remain soft, but some crystals of ice have formed in the tissues. Frostbitten skin looks waxy and may appear mottled, blue or purple, and feels cold to the touch.

## Care of cold injuries

- Take the child to a warm place and provide warm clothes.
- Have the child drink warm fluids.
- If frostbite is suspected, contact the parents to seek medical attention and soak the frostbitten parts in warm water.
- Do not rub or place heat (such as a water bottle or electric blanket) on affected areas, as it could cause further damage.

# COMMON COLD

**What is it?**

The common cold is caused by many different viruses. Children under age five are expected to get colds several times each year.

**How can it be recognized?**

Runny or stuffy nose, sneezing, coughing, mild sore throat, with little or no fever.

**How is it spread?**

Colds are spread by coughing and sneezing and by contact with contaminated hands, tissues, and other articles soiled by nose and throat discharge (respiratory spread).

**How long does it take from exposure to development of a cold?**

Between twelve and seventy-two hours, usually forty-eight hours.

**When is it contagious?**

For about one day before symptoms begin and during the first five days of illness.

**What should be done to prevent the spread of colds?**

- Teach the child to cover mouth and nose when sneezing or coughing.
- Dispose of tissues soiled with nose and throat discharges.
- Wash hands after contact with soiled tissues or after contact with nose and throat discharge.

**What should be done?**

- No specific treatment is available. Nothing can shorten the duration of a cold.
- Ibuprofen or Acetaminophen-containing medicines should be used only if the child has a fever, sore throat, or muscle aches, and you have written parental permission. Avoid drugs that have several ingredients because they increase the risk of side effects.

**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.

**Comments**

Watch for new or more severe symptoms. They may indicate other more serious infections.

**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. Exclusion of the child with the common cold is not necessary.

# CONJUNCTIVITIS (PINK EYE)

**What is it?**

Conjunctivitis is an infection of the eye. Either bacteria or a virus can cause it.

**How can it be recognized?**

The affected eye can produce lots of tears and discharge, itching, and the white part of the eye becomes pink.

**How long from exposure until the disease develops (incubation)?**

One to three days.

**When is it contagious?**

As long as discharge is present, consider the child contagious. A doctor's diagnosis is needed.

**How is it 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.

**What should be done?**

- Notify the parents and encourage medical supervision for the child.
- Practice frequent hand washing, especially when wiping a child's face or eyes.
- Separate a child with active infection from other children.
- If the disease is determined to be bacterial in origin, the parents in your center should be made aware that Pink Eye has occurred and encouraged to watch closely for signs of the illness in their child.

**When can the child be re-admitted?**

- Bacterial – 24 hours after antibiotic treatment has begun.
- Viral – A note from physician that verifies that Bacterial Conjunctivitis has been ruled out.

- In both cases, the child who returns to child care, should be well enough to participate in the normal daily activities.

# CRADLE CAP (Seborrhea)

**What is it?**

Cradle Cap is an oily, yellow scaling or crusting on a baby's scalp. It is common in babies and is easily treated. It most often affects the scalp, but frequently also involves 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 being well cared for.

**What causes cradle cap?**

Cradle cap is the normal buildup of sticky skin oils, scales, and sloughed 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.

# CUTS, SCRAPES OR SCRATCHES

**Small cuts, scrapes or scratches**

- Wear disposable gloves.
- Wash the injury thoroughly with soap and water. Check for foreign objects imbedded in the cut.
- Apply direct pressure over the cut with a clean cloth or gauze until bleeding stops.
- Apply a clean dressing.
- ***Do not*** apply ***any*** medication, as it may damage the tissue.

**Large cuts**

- Wear disposable gloves.
- Stop heavy bleeding by applying pressure directly over the wound with a clean cloth or gauze. It is advisable to keep a supply of 4x4 sterile gauze pads.
- Place additional layers of cloth or gauze to the wound if blood saturates the original dressing. ***Do not*** remove the blood soaked dressings.
- Cover the wound with several layers of cloth or gauze after the bleeding has diminished.
- If the arm or leg has been cut, elevate it to decrease the blood flow. ***Never*** apply a tourniquet.
- ***Do not*** give the child fluids.
- Activate EMS if you are unable to control excessive bleeding or if the child appears to be going into shock.
- Any wound that is excessively deep, wide, or has foreign objects imbedded (such as dirt, gravel, etc.) should be seen by a physician.

**For any cut or scrape check child's immunization record for DPT/DT (tetanus). If greater than 5 years since last dose, have parents contact health care provider.**

# 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.

**How can it be recognized?**

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 such as pneumonia.

**How long from exposure until the disease develops (Incubation)?**

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 CMV 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?**

No, since several children and staff are already carrying the virus.

**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 doctor about CMV. It is recommended that pregnant staff members not work in classrooms with diapered children.

**What can be done to stop 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.

# DIABETES IN CHILDREN

The Oklahoma State Health Department strongly urges child care providers to contact the American Diabetes Association (ADA) when enrolling a diabetic child. The ADA has an excellent education division, and they are most willing to provide help and guidance.

Diabetes is a chronic metabolic disease that impairs the body's ability to use food properly. Diabetes responds readily to treatment in most cases. **A child with diabetes should be known to the child care staff.** A history should be obtained and an individualized ***"Diabetes Care Plan"***, including emergency care, should be developed by the parent, medical care team, and the child care provider. This plan should address the specific needs of the child and provide specific instructions for each of the following:

**Specific needs**

- Blood glucose monitoring, including the frequency and circumstances requiring testing.
- Insulin administration (if necessary), including doses/injection times prescribed for specific blood glucose values and the storage of insulin.
- Meals and snacks, including food content, amounts, and timing. Food that is not eaten at any meal must be replaced by another food of the same type. If the child refuses to eat the replacement, the parent should be called for further instruction.
- Symptoms and treatment of hypoglycemia (low blood sugar), including the administration of glucagon, if appropriate.
- Symptoms and treatment of hyperglycemia (high blood sugar).
- Testing for ketones in the urine and appropriate actions to take for abnormal ketone levels.

**Hyperglycemia (High Blood sugar) causes**

- Missed insulin injections or not taking enough insulin;
- Eating too much food;
- Illness or infection;
- Stress; and
- Less exercise than usual.

**A child with diabetes could have the following symptoms:**

- Excessive thirst
- Frequent urination
- Dry, flushed skin
- Irritability and feeling upset
- Change in personality
- Sweating and feeling “shaky”
- Confusion or strange behavior
- Rapid, deep breathing
- Dizziness
- Headaches
- Listlessness
- Rapid pulse
- Paleness
- Cramping
- Seizures
- Stomachaches
- Visual problems
- Treatment for Hyperglycemia
- Refer to Diabetes Care Plan for insulin dosage.
- Call parents.
- Always have doctor’s name and phone available.

A diabetic child under the care of a physician should produce little more stress for the child care facility than does any other child.

**Develop an individualized diabetes care plan by referring to the Special Health Care Plan in Appendix L, or download a Diabetes Care Plan by visiting: www.diabetes.org/advocacy-and-legalresources/discrimination/school/504plan.jsp**

# DIAPER RASH

## What is diaper rash?

Diaper rash can be any rash that develops inside the diaper area. In mild cases, the skin might be red. In more severe cases, there may be painful open sores. Diaper rash is usually seen around the abdomen, genitalia, and inside the skin folds of the thighs and buttocks. Mild cases clear up within 3 to 4 days without any treatment. If a rash persists or develops again after treatment, consult provider.

## What causes diaper rash?

Medical experts believe diaper rash is caused by too much moisture, chaffing and rubbing, prolonged contact of the skin with chemical irritants (feces, urine, detergents, etc.), which become trapped in the diaper area and cause irritation, yeast infection, bacterial infection and allergic reaction to diaper material.

When skin stays wet for too long, the layers that protect it start to break down. When wet skin is rubbed, it also damages easily. Moisture from a soiled diaper can harm baby's skin and make it more prone to chafing. When this happens, a diaper rash may develop. Further rubbing between the moist folds of the skin only makes the rash worse. This is why diaper rash often forms in the skin folds of the groin and upper thighs.

Babies taking antibiotics or nursing babies whose mothers are taking antibiotics are more likely to get diaper rashes caused by yeast infections. Yeast infects the weakened skin and causes a bright red rash with red spots at its edges. These can be treated with over-the-counter antifungal medications. If symptoms persist, contact provider.

## What can I do to prevent diaper rash?

- Change diapers frequently.
- Do not put the diaper on airtight. Keep the diaper loose enough to prevent wet and soiled parts from rubbing against the skin so much.
- Gently clean the diaper area with clear water and pat the skin dry. The use of soap is not necessary after every diaper change or every bowel movement. (Breastfed babies may stool as many as 8 times a day.)
- Allow the skin to air dry for ten to fifteen minutes; then, before diapering, apply a thin layer of a protective ointment or cream such as zinc oxide – **after obtaining written parental permission**.
- Do not use cornstarch or powders.

- If the rash worsens or if it does not improve after four to five days of treatment, seek medical attention.

**What can I do if diaper rash is present?**

- Change wet or soiled diapers often.
- Use clear water from a squirt bottle to cleanse the diaper area – lets you clean and rinse without rubbing.
- Pat dry; do not rub. Allow the area to air dry fully.
- Use creams or ointments only with permission from parents.
- Notify the parents to seek medical attention if blisters or pus-filled sores are present.

# DIARRHEA

**What is it?**

Diarrhea is usually a contagious disease caused by a virus or bacteria. It is not contagious if it is caused by allergy, food poisoning, emotional upset or undigestible foods.

**How can it be recognized?**

The stool is watery. An increase in the amount of stool may be noticed. Following are some of the organisms known to cause diarrhea:

| | |
|---|---|
| • Rota-Virus<br>• Norwalk Virus<br>• Hepatitis A Virus<br>• Salmonella<br>• Giardia | • Shigella<br>• Campylobacter<br>• Clostridum Difficile<br>• E-coli |

**How long does it take from exposure to development of Diarrhea (incubation)?**

It may take up to 72 hours if caused by a virus or bacteria.

**When is it contagious?**

Diarrhea should always be considered contagious until a physician 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's mouth, usually by way of unwashed hands.

**What should be done?**

- Isolate the child
- Notify the parents of the child
- Give the child extra fluids

**Important facts about diarrhea**

Remember that diarrhea is stools that are watery or loose and occur more often than normal for the individual child. One newborn may have seven to ten stools a day, while another might have stools only every other day. Both may be normal if that is usual for that baby.

**When to call a physician**

- The stools are very bad smelling, or there is blood, or mucous in the stool. An occasional green stool is not harmful.
- The diarrhea is accompanied by a fever.
- The child seems overly tired or does not act right (examples are too sleepy or too fussy).
- The child has less urine, seems to have a dry mouth, or does not have tears when crying.
- There is severe stomach pain.
- The baby is under a year old.
- The diarrhea does not get better.

**When can the child be re-admitted to the center?**

With the approval of the doctor or after the diarrhea is gone.

**What can be done to prevent the spread of diarrhea?**

- Staff members should wash hands properly with soap after using the bathroom, or changing a diaper, or taking a child to the bathroom. Staff should wash the hands of diapered children in running water every time their diapers are changed.
- Diaper changing table should be sanitized with bleach solution and bleach solution must stay on surface for 30 seconds.
- Children should be taught to wash hands with soap after using the bathroom.
- Toilet bowls should be cleaned and sanitized frequently.
- Tables used for changing diapers must not be used for food preparation.
- Staff who work in food preparation should not work in the classroom with children who are in diapers.

**Note**

Also – see Campylobacter, Giardiasis, Salmonella, and Shigella

# DIPHTHERIA

**What is it?**

Diphtheria is a serious bacterial disease which is spread person to person by infected secretions. 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 frequently causes heart and nerve problems.

In the 1920's, diphtheria was a major cause of illness and death for children in the U.S. Although it is rare in the U.S. today, it appears that the bacteria continues to get passed among people. Diphtheria is common in other parts of the world. With the increase in international travel, diphtheria and other infectious diseases are only a plane ride away.

**How can it be recognized?**

The symptoms of diphtheria vary depending on what part of the body is infected. The most common infection occurs in the throat and tonsils causing symptoms from a slight fever, chills, and sore throat to a severe feeling of general illness. Other symptoms which might occur include hoarseness, barking cough, runny nose, scaly rash, and open skin sores.

**When is it contagious?**

Usually an infected person is able to spread diphtheria for two to four weeks after symptoms develop. The rare chronic carrier (a person with continual infection) may be infectious 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?**

Antibiotics and antitoxin are used to treat diphtheria. The patient may also need help in breathing. Often the patient should be isolated.

**Who should be notified?**

People who live in the same household as a person with diphtheria and people who have close, habitual contact with a diphtheria patient should receive treatment.

**When can the child be re-admitted?**

The child can return to child care after being treated, with a doctor's permission.

**What can be done to stop the spread of Diphtheria?**

The best way to stop diphtheria is to immunize all children with a series of four doses of DTP (diphtheria, tetanus, pertussis) vaccine beginning at two months of age. Adults should receive a booster dose of Td (tetanus, diphtheria) every ten years.

# DROWNING

**If you have a water emergency follow these steps:**

- Remove the child from the water.
- Activate **Emergency Medical Service – Call 911.**
- Open the child's airway and check for breathing.
- If the child is not breathing, attempt ventilation.
- If ventilation causes chest rise, give another breath.
- Check pulse, if no pulse begin CPR.
- Continue CPR until EMS arrives.

# EAR INFECTIONS

**Who gets ear infections?**

- A middle ear infection is a very common childhood illness.
- Ear infections occur more often in children ages birth to six years.
- By the age of six years, 90% of all children will have had an ear infection. Young children have more colds and respiratory infections, and they have Eustachian tubes that are shorter, narrower, and more horizontal. The Eustachian tube is an important part of the ear structure. It connects the middle ear and the throat.
- Children who have allergies have more ear infections.
- Children who drink from a bottle while they are lying down also have more ear infections. By the age of four years, children usually develop fewer infections because the Eustachian tube gets longer, bigger, and more vertical.

**Ear infection causes and symptoms**

A child's Eustachian tube is more likely to swell and become blocked when he has a cold.

If the Eustachian tube becomes blocked, fluid and bacteria or viruses get trapped in the middle ear. Then a middle ear infection can develop.

An earache is the most common sign of an ear infection.

**A child who has not started to talk, can not tell you when his ear hurts.**

You should look for other symptoms.

- Fever
- Shaking
- Repeated tugging at the ear
- Irritability or fussiness
- Listlessness
- Disturbed sleep

- Headache
- Nausea & vomiting
- Loss of appetite
- Loss of hearing

**Effects of ear infections**

- If an ear infection is not treated or does not respond to treatment, a temporary hearing loss can occur.
- A hearing loss for only two to three months may impair a child's language and learning skills.
- 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.

**Signs to look for:**

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

**How to prevent ear infections**

- Protect against colds since middle-ear infections often develop when a child has a cold:
  - Wash hands frequently to reduce the spread of germs;
  - Don't allow a child to share food, utensils, or toothbrushes with other children;
  - Wash toys regularly, especially ones that young kids put in their mouths.
- Keep child away from a smoking environment. Secondhand smoke increases the rate of upper respiratory illness in young children, which can lead to middle ear infections.

- Keep a child upright while feeding. Make sure the baby has finished taking the bottle before being put in bed. The liquid can back up into the Eustachian tube, creating a breeding ground for bacteria.

# EAR INJURIES

**Bleeding from the ear**

- Contact the Emergency Medical System (EMS) or get medical help if there is bleeding or drainage from inside the ear.
- Wear disposable gloves.
- Do not put pressure on or try to stop the bleeding from inside the ear.
- Do not attempt to clean out ear.
- **Never insert cotton swabs into ear canals.**
- If the bleeding is from a cut or tear on the outside of the ear, apply direct pressure to control the bleeding. Then, clean the wound and cover it with a dry, sterile dressing.

**Object in the ear**

- Turn the child's head with the affected ear pointing down.
- The object may fall out or become easy to grasp.
- Do not try to pull out difficult-to-remove objects.
- If the object does not come out, contact the parent to seek medical attention.

**Insect in the ear**

- Turn the child's head so that the affected ear points up.
- The insect can then fly or crawl out. If the insect does not come out, contact the parent to seek medical attention.

# EARACHES

**Earaches require medical intervention**

- Call parents to take the child to the doctor.
- An infection, impacted wax, or a foreign object in the ear canal may cause earaches.
- Infants and children with earaches may experience hearing loss before, during, and after the episode.

**Hearing should be checked regularly. Hearing screenings are available at county health departments.**

You can refer parents for hearing screening information to (800) 766-2223.

**Characteristics of hearing impairments**

- May not respond to loud sounds.
- May not respond to soft sounds.
- May not turn toward the source of sounds.
- May pull on his/her ears.
- May make loud, piercing cries for no apparent reason.
- May have delayed language development or have language development that has stopped progressing.
- May not talk.
- May use poor articulation.
- May consistently misunderstand directions.
- May appear to have a short attention span.
- May frequently ask, “Huh?” or “What?”

# ENCEPHALITIS

**What is it?**

Encephalitis is a viral inflammation of the brain. It may be a complication of flu, measles, mumps, chickenpox, or another disease.

**How can it be recognized?**

- Headache, stiff neck, sleepiness, fever, and delirium (mental confusion or excitement).
- There may also be convulsion, coma, and paralysis.

**How long does it take from exposure to development of Encephalitis (incubation)?**

That depends upon the virus causing the disease.

**When is it contagious?**

It depends on the cause. A doctor's diagnosis is needed.

**How is it spread?**

- It cannot be transmitted if it is a complication of measles, mumps, flu, or chickenpox.
- Other viruses can be spread **by** the bite of infected mosquitoes or mites causing Encephalitis.

**What should be done?**

- Notify the parents of the child.
- Recommend they call the child's doctor.
- Inform parents of other children that Encephalitis is **not usually** spread from child to child.

**When can the child be re-admitted?**

When recovered from illness and released by the doctor.

**Who should be notified?**

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

# EPILEPSY

Epilepsy is a disorder of the central nervous system. The brain cells create abnormal electrical discharges that produce a set of uncontrollable movements called seizures or convulsions. The loss of control is temporary and the brain continues functioning normally between the seizures. Epilepsy is not contagious. The three most common types of generalized seizures are Tonic-Clonic (formerly called grand mal) and Absence Seizures (formerly called petit mal), and Partial Seizures.

## Tonic Clonic

Tonic-Clonic seizures involve the whole body and are usually the most frightening. They usually last only a few minutes, during which the child becomes unconscious and may shake violently, drool, bite the tongue, lips or cheeks, and have no control over bowel or bladder function. Often the seizure is preceded by a special feeling or warning sign called an aura. Although frightening, it is not dangerous to the child if it does not last more than ten minutes.

## Absence Seizures

Absence seizures are most common in children ages six to fourteen, but may begin as early as ages three to four. They cause “blank spells,” a loss of consciousness, staring, blinking, and slight twitching. They are often mistaken for daydreaming or inattentiveness. Sometimes the head or eyes may turn upward or to the side. Objects held in the hands may be dropped. Attacks usually last only a few seconds. They may occur dozens or even hundreds of times a day.

## Partial Seizures

Partial seizures may involve a sensation such as a change in taste, smell, or sound. Sometimes these occur before a larger seizure. Complex partial seizures may involve jerking one side of the body or the child may appear to be in a trance, wander, blink eyes, pick at clothes, or mumble things that don’t make sense.

## How to help during seizures

Find out from the parents what a typical seizure for their child looks like. Keep a record of what happened during the seizure, including the length.

- ***Stay calm***, don’t try to restrain or revive the child. Help ease him to the floor.
- **Remove hazards** such as hard, hot, or sharp objects that can cause injury if the child falls or knocks against them.
- **Don’t move the child** unless the area is clearly dangerous. Loosen tight clothing and remove glasses. Tell onlookers that the child is having a seizure, that it will soon be over,

and that he is feeling no pain. Don't try to bring the child out of the seizure by using cold water, slapping, or shaking him. It won't work and could be harmful.

- **Protect airway** by gently turning the child on his side so any fluid in the mouth can drain safely. Never try to force the mouth open or force anything into the mouth.

- **Don't call a doctor or ambulance unless** it is a first time seizure. Let the seizure run its course. If the seizure nears five minutes in length, if another seizure starts right after the first, or if another begins within ten minutes, then call the ambulance.

- **When the seizure ends** let the child rest or sleep. Be calm and reassuring because the child may feel embarrassed or disoriented after the attack. Call the parents.

# EYE HEALTH

**Warning signs that may indicate a problem**
**(infants up to 1 year of age)**

If your baby can't make steady eye contact by 2 or 3 months of age, or seems unable to see, consult your provider. A constant crossing of the eyes or one eye that turns out is usually abnormal; however, most babies do occasionally cross their eyes during their fist 6 months of life. Babies older than 3 months of age can usually follow or "track" an object with their eyes as it moves across their field of vision.

**Warning signs for your preschool child**

The presence of any of the following requires immediate consultation with child's provider. If the eyes become misaligned (strabismus) – this may be a situation that is easily corrected with glasses or it may represent a more serious eye disorder. The presence of a white pupil suggests a umber of eye disorders ranging from a cataract to a tumor of the eye. The sudden development of pain and redness in one eye or both eyes can represent a number of different conditions ranging from simple pink eye to blinding eye problems. Immediate evaluation by the provider is needed.

**Warning signs at any age**

Notify parent if any of the following are noted:

- Eyes flutter from side to side or up and down.
- Eyes are always watery.
- Eyes are always sensitive to light.
- Any change in the eyes from their usual appearance.
- White, grayish-white, or yellow-colored material in the pupil.
- Redness in either eye that doesn't go away in several days.
- Continued pus or crust in the eye.
- Eyes look crossed, turn out, or don't focus together.
- Child often rubs the eye(s).

- Child often squints.
- Child often tilts or turns his or her head.
- Eyelids appear to droop.
- Eye(s) appear to bulge.

**Black eye**

This condition is caused by trauma and bruising is a late sign.

- Apply cold pack to the eye area for 10 minutes (as tolerated by a younger child) four times a day.
- Do not apply pressure to the eye.
- Seek medical attention for any complaints of blurred vision, pain with movement of the eye, or apparent bleeding.

**Small object in the eye**

- Hold the upper lid down and slightly away from the eye by the lashes. Tell the child to keep blinking to flush the eye with tears.
- Try flushing the eye with cool water running from the inside corner to the outside corner of the eye.
- If neither of these methods work, close the eyelid of the injured eye and cover the eye with loose eye pad or gauze.
- Call the parent and request medical attention for the child.

**Chemicals in the eye**

- Call poison control with the name of the chemical 1-800-222-1222.
- Flush the eye with running water from the inside corner to the outside corner.
- Activate the emergency response system.
- Keep flushing the eye until emergency help arrives.

**Piercing object in the eye**

- Place the child in the sitting position.
- Do not try to remove the object.
- Call Emergency Medical Services – call 911.
- Immobilize the object as best you can by placing a paper cup over the eye with a hole in the bottom of the cup for the object to protrude through, or use a bulky gauze dressing.
- Carefully bandage the cup in place, covering the other eye to keep blood, fluid or dirt out and to minimize eye movement.
- Do not leave the child alone while eyes are covered.

# EYE INJURIES

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- Do not leave the child alone while eyes are covered.

# FEVER

A child's temperature varies with his activity. It is lower in the morning and higher in the afternoon and after activity. 98.6° may or may not be normal for each child. Any fever over 100.4° probably means illness.

- Isolate the child.
- Notify the parents to come for the child.
- Give the child clear liquids, if desired. *Do not* give any medication unless provided by the parent.

**Medication**

Before giving *any* medication, obtain a *signed* statement from the parent or guardian giving the child's name, kind of medicine, amount, and hours to be given. Medication should be clearly labeled with name of child, amount to give and when to give it, and in its original container.

**When to call parent**

Call parent immediately if child has a fever and

- Looks very ill, is unusually drowsy, or is very fussy.
- Has been in an extremely hot place, such as an overheated car.
- Has additional symptoms such as a stiff neck, severe headache, severe sore throat, severe ear pain, an unexplained rash, or repeated vomiting or diarrhea.
- Has a condition that suppresses immune responses, such as sickle-cell disease or cancer, or is taking steroids.
- Has had a seizure.
- Is younger than 2 months of age and has a temperature of 100.4 or higher.

**When can the child be re-admitted?**

- If a contagious disease causes the fever, refer to that disease in this chapter, for re-entry.
- If the temperature remains normal for 24 hours, without any signs of illness, re-admit the child.

# FIFTH DISEASE

**What is it?**

Fifth disease is a contagious disease spread by a virus. It is usually a mild rash illness of children. The risk of fifth disease is to the unborn babies of pregnant women. If exposed, she should see her obstetrician.

**How can it be recognized?**

One to two weeks after infection, some children will have a low-grade fever and will feel tired. A red rash generally appears on the cheeks, giving a "slapped face" appearance. The rash may then spread to the rest of the body and tends to come and go. Sometimes the rash looks "lacy" with vague signs of illness or no symptoms at all except for the rash.

**How long does it take from exposure to development of Fifth Disease (Incubation)?**

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 stop the spread of Fifth Disease?**

- Anyone with cold or flu-like symptoms should cover their mouths or noses when coughing or sneezing.
- Careful hand washing is the best protection against the spread of Fifth Disease.

**Who should be notified?**

Notify parents of the child, as well as other parents in your center.

**Note**

Pregnant employees and people with chronic red blood cell disorders should seek their doctor's advice before working with small children.

Public Health Fact Sheet

# Flu Facts

Public Health Fact Sheet

**What is influenza?**
Influenza, commonly called "the flu", is caused by a virus that primarily affects the nose, throat, bronchial airways, and lungs. Influenza A or B may circulate in the United States during late fall and winter. Each type of influenza virus has many different strains, which tend to change from year to year.

**What are the symptoms of influenza?**
Compared with other viral respiratory infections that also tend to occur during the fall and winter months, influenza infection usually causes a more severe illness. Fever of 100° F to 103° F (possibly higher in children), chills, sore throat, stuffy nose, cough, extreme fatigue, and body aches are typical symptoms. Nausea, vomiting, and diarrhea can sometimes accompany influenza infection, especially in children, however these symptoms are usually not the primary problem. The term "stomach flu" is sometimes used to describe gastrointestinal illnesses (diarrhea, nausea, vomiting), but this is a misnomer because bacteria, protozoa, or viruses other than influenza cause these infections.

**How is influenza spread?**
Influenza is spread from person to person by respiratory droplets expelled during talking, coughing, laughing or sneezing. Transmission may also occur by direct contact with contaminated objects and then touching one's mouth or nose. The contagious period can vary, but generally begins the day before symptoms appear and then continues for up to one week.

**How soon after exposure do symptoms of influenza appear?**
The incubation period, or the time from exposure to the first onset of symptoms, is one to five days. Most people who have influenza recover completely in one to two weeks, but some persons develop serious and potentially life-threatening medical complications, such as pneumonia. In an average year, flu-related complications are associated with an estimated 114,000 hospitalizations and 36,000 deaths in the United States.

**How is influenza diagnosed?**
Health care providers will often diagnose a case of flu based on the typical symptoms of fever, chills, headache, cough, and body aches and the knowledge that influenza virus has been laboratory confirmed in the same geographic area. Rapid screening tests for flu may be performed at a physician's clinic. The specific lab test needed to diagnose influenza and characterize the strain of virus is culture and growth of the virus from a nose or throat swab.

**What is the treatment for influenza?**
Most persons who get the flu are adequately treated with fluids and rest. Prescriptions are available to prevent or reduce the severity of influenza, but some antiviral medications are only effective against type A influenza virus. All antiviral drugs must be started within 48 hours of illness onset to be effective. Antibiotics do not work against the influenza virus and therefore will not help a person recover from the flu.

**Who are the high-risk groups targeted for influenza vaccination in Oklahoma?**
– Persons in the following groups are considered at increased risk for severe flu-related complications and should be vaccinated:

- children six through 23 months of age
- persons 65 years of age or older
- persons two through 64 years of age with serious underlying chronic medical conditions: heart disease, lung disease including asthma, metabolic disease including diabetes, kidney disease, blood disorder, or immunodeficiency. Hypertension is not considered a high-risk condition.

Continued on other side

- persons with any condition that may effect breathing such as disorders affecting brain function, spinal cord injuries, seizure disorders, or other disorders affecting muscle and nerve function
- residents of nursing homes and long-term care facilities
- children six months through 18 years of age on chronic aspirin therapy
- women who will be pregnant during influenza season

– Persons who can spread the disease to those at increased risk for severe flu-related complications should be vaccinated including:

- health-care workers involved in direct patient care
- out-of-home caregivers of children under 6 months of age
- household contacts of those at increased risk for complications such as children or adults with severe heart or lung disease or immunosuppressive conditions

**What can be done to control or prevent influenza?**

Receiving an influenza vaccination each year is considered to be your best defense against seasonal influenza. Influenza vaccines provide protection against two strains of type A influenza and one strain of type B influenza. Because influenza viruses are prone to frequent "drifts" in their genetic makeup, the composition of the vaccine changes from year to year to best target the strains of virus expected to be circulating in the coming season. The 2006-2007 influenza vaccine protects against H3N2 influenza A Wisconson-like virus, the H1N1 influenza A New Caledonia-like virus, and the influenza B Malaysia-like virus.

It takes 10-14 days after receiving a "flu shot" injection for one's body to produce protective levels of antibodies. Immunity develops more quickly after receiving an intranasal vaccine (FluMist®).

Good hygiene habits prevent and reduce the transmission of influenza and other respiratory viruses by:

–covering your mouth and nose with a disposable tissue when sneezing or coughing
–disposing of tissues properly
–washing hands frequently
–using alcohol-based hand sanitizers if hands are not visibly soiled

When sick with a fever and cough:

- stay home from work, school, church, or other daily activities outside of the home
- avoid other crowded areas or events like shopping malls or sports arenas
- do not visit nursing homes, hospitals, or other long-term care facilities
- do not visit people at increased risk for severe flu-related complications

**What about the nasal spray influenza vaccine that does not require a shot?**

FluMist® is the first flu vaccine in the United States that is given as a nasal mist instead of a shot. FluMist® is approved for active immunization of healthy children, adolescents, and adults 5 to 49 years of age. After vaccination with FluMist®, disease-fighting antibodies develop in your nose and your bloodstream. FluMist® is made from a weakened version of a live influenza virus, but it is designed to help protect the body from the flu without actually causing a case of the flu. Because the intranasal vaccine does contain live virus, persons who are in close contact with others who have conditions that severely suppress their immune system should not receive FluMist®.

**How can people get an influenza vaccination?**

Persons should contact their healthcare provider or local county health department to see if vaccine is available and inquire about clinic times



Communicable Disease Division
Oklahoma State Department of Health

For further information call or visit us on the World Wide Web
Communicable Disease Division
Oklahoma State Department of Health
Phone (405) 271-4060
http://www.health.ok.gov/program/cdd/

# GIARDIASIS

**What is it?**

Giardiasis is an intestinal infection caused by a parasite. It is diagnosed by examining the stool for the parasites.

**How can it be recognized?**

Some infected people have no symptoms. These people are called *carriers*. People who feel sick may experience some or all of the following: diarrhea, gas, bloating, abdominal cramping, nausea, 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 is it spread?**

The parasites are found in the stool. Spreading takes place when hands, toys or other objects, or food become contaminated with bowel movement (stool) of infected people. The parasites are then taken in by mouth (fecal spread). Unwashed hands are the usual route of infection.

Drinking water from lakes, streams, or ponds that are contaminated by infected animals and humans can cause infection. Well water is not usually contaminated and is usually safe to drink.

**How long does it take from exposure to development of Giardiasis (incubation)?**

Usually three to twenty-five days or longer - median, seven to ten days.

**When is it contagious?**

As long as the organism is present in the stool. In most cases the germs will be completely gone in four to six weeks.

**When can the child be re-admitted?**

After treatment by a physician and the diarrhea has stopped.

**How is it treated?**

Giardiasis is treated by medication prescribed by a physician. Testing and treatment of children, with no symptoms, is usually not necessary.

**What can be done to prevent the spread of Giardiasis?**

- Ask other parents to notify caregiver if their child develops symptoms.
- W*ash hands*, especially after toilet use, diaper changes, and before meals. Help children wash their hands at these times.
- F*requent hand washing.*
- Disinfect diaper-changing areas after each use.
- Exclude any child or adult with diarrhea.

**Who should be notified?**

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

# H FLU DISEASE (HIB)
## (HAEMOPHILUS INFLUENZA) TYPE B

**What is it?**

H flu is a bacterium that can cause pneumonia or nose, throat, joint, or skin infections in children, and is a cause of *Meningitis* in children under five years of age. These are very serious, ***sometimes fatal***, illnesses in susceptible children. Children in group settings are at higher risk of catching this illness.

**How can it be recognized?**

- Early symptoms may include sore throat, earache, fever, coughing, difficulty breathing, joint pain or skin lesions, and headache.
- Symptoms that may appear suddenly are high fever, irritability, intense headache, nausea or vomiting, stiff neck, and sometimes a pinpoint rash.

**How long does it take from exposure to development of the disease (incubation)?**

Two to four days.

**When is it contagious?**

From the week previous to onset of symptoms until within 24 to 48 hours after starting effective antibiotic treatment.

**How is it spread?**

By droplets from the nose, mouth, or throat.

**What should be done?**

- Isolate the child.
- Notify parent of ill child.
- Recommend they call a physician *immediately*.

- Staff and children should wash hands thoroughly after handling infected child's belongings. Observe for symptoms in other children, especially the first week after exposure.

**When can the child be re-admitted?**

After the child has a signed release from a doctor.

**What can be done to prevent the spread of HIB?**

- Encourage parents of all attending children between two months and five years of age to have their child vaccinated.

- HB vaccine is required for children between these ages who are attending early childhood programs.

- Proper and frequent hand washing will prevent the spread.

**Who should be notified?**

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

**HIB is a preventable disease. Immunize early.**

# HAND, FOOT & MOUTH (HFM) DISEASE
## (COXSACKIE VIRUS INFECTION)

**What is it?**

HFM disease is an infection caused by Coxsackie virus.

**Who can get HFM disease?**

Anyone, although it is more common in children.

**How is it spread?**

The secretions in the throat or in the feces (stool) spread the virus. Washing hands after handling soiled tissues or changing diapers is the best way to stop the spread of the virus.

**What are the symptoms of HFM disease?**

The major symptom is small sores or lesions in the mouth, on the hands, and on the feet. The lesions can look like the early stages of Chickenpox. A low-grade fever can also occur. Many adults do not develop symptoms after they are infected.

**How soon after infection do symptoms appear?**

The symptoms usually start three to five days after exposure to the virus.

**How long can an infected person carry the Coxsackie virus?**

The Coxsackie virus may be found in the throat of an infected person for two weeks (even if there are no lesions in the mouth) and in the stool for one month after infection. Infected persons who do not appear to be ill may also spread the virus.

**How is HFM disease diagnosed?**

Most cases are diagnosed by clinical symptoms.

**What is the treatment for HFM?**

There is usually no specific treatment for HFM disease.

**When can the child be readmitted?**

The child does not need to be excluded from care unless:

- The child has mouth ulcers and blisters and does not have control of drooling.
- The child is unable to participate in daily activities and staff cannot care for the child without compromising the care of the other children.
- The child meets other exclusion criteria.

**What precautions should pregnant women take?**

Pregnant women should always wash their hands carefully after handling wet or soiled diapers and after contact with urine or saliva. Pregnant women working in child care facilities should not kiss babies or young children on the mouth (hugging is okay). Pregnant women should ask their doctor about Coxsackie virus infections.

**What can be done to prevent the spread of the disease?**

- Good hand washing is the best way to prevent infection with the Coxsackie Virus.
- Avoid direct contact with urine, feces and saliva.

# HEAD INJURIES

Almost all children bump their heads every now and then. While these injuries can be upsetting, most head injuries are minor and do not cause serious problems. In very rare cases, problems can occur after a minor bump on the head. This information will assist in understanding the difference between a head injury that needs only comfort and minor care and one that requires immediate medical attention.

- Treat the injury as a cut if the skin is broken.
- Apply a cold compress to the injured area.
- Notify the parents that the child has received a head injury.

**Minor care is needed for children who**

- Were well before the injury
- Act normally ***after*** the injury
- Have no cuts on the head or face (called a closed head injury)
- Have no other injuries to the body

**Medical attention is needed for children who**

- Are younger than 2 years of age
- Have possible neck injuries
- Already have nervous-system problems, such as seizures or movement disorders
- Have difficulties or delays in their development
- Have bleeding disorders or bruise easily
- Are victims of child abuse

**(*Any of these indicate the need for IMMEDIATE medical attention – call 911.)***

- Slurred speech
- Dizziness

- Clumsiness or difficulty walking
- Vomiting
- Unequal size of pupils
- Oozing of blood or watery fluid from the nose or ears

**If the child loses consciousness, assess the child for breathing and call Emergency Medical Services - call 911.**

# HEAD LICE (PEDICULOSIS)

**What are they?**

Tiny insects that live only on people's scalps and hair are commonly called head lice.

**How can they be recognized?**

The adult louse is about the size of a sesame seed. They attach their eggs (called nits) to strands of hair close to the scalp. Nits are tiny, pearl gray, oval-shaped specks that are attached firmly to the hair. Frequent scratching of the head is usually a first clue.

**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 are they spread?**

Lice are spread *only* by crawling from person to person directly or onto shared personal items, such as combs, brushes, head coverings, clothing, bedding, and towels (direct exposure).

**When can the child be re-admitted?**

The child may return to the center after the first treatment. Ask the parent to bring an empty bottle or box to show proof of treatment. It is *recommended* that children not be allowed to return until *all* nits are gone.

**What should be done to prevent the spread of Pediculosis?**

- Isolate the infected child and notify parents to pick up the child.
- Other close contacts should be checked to determine if there are any other cases.
- Infants, pregnant or nursing women, or people with extensive cuts or scratches on the head or neck should always consult a doctor before treatment.
- Discourage sharing of personal items or head to head contact games. Each child's coat, sweater, and cap should always be stored separately.

- Launder bedding in hot water for twenty minutes, vacuum carpets, clean infant seats or cots.

**Who should be notified?**

Notify parents of children in the infected child's class, and staff members who have worked closely with the child.

# HEAT RASH

**What is heat rash?**

Heat rash (prickly heat) is a read or pink rash usually found on body areas covered by clothing. It can develop when the sweat ducts become blocked and swell and often leads to discomfort and itching. Heat rash is most common in babies in hot, humid climates.

**What causes heat rash?**

Heat rash can be caused by dressing baby too warmly, but it can happen to any baby in very hot weather. A baby should be dressed as an adult would be to be comfortable at he same temperature and activity level. Babies' hands and feet may feel cool to your touch because most of their blood is near the stomach, helping digestion, but that does not mean they need to be dressed too warmly in hot weather.

**What are symptoms of heat rash?**

Heat rash looks like dots or tiny pimples. In young children, heat rash can appear on the head, neck, and shoulders. It may be under the chin, armpits, or on the chest and abdomen. Usually it goes away by itself when the child cools off.
The rash areas can get irritated by clothing or by scratching, and rarely, a secondary skin infection may develop.

**What can relieve symptoms of heat rash?**

- Start by cooling child down. Remove or loosen clothing and move child to a cool, shady spot.
- Cool the affected areas directly, using cold wet washcloths or a cool bath.
- Let the skin air dry instead of using towels.
- Do not apply lotions, oils, or baby power.

# HEAT RELATED INJURIES

## What are heat-related illnesses?

Exposure to abnormal or prolonged amounts of heat and humidity without relief or adequate fluid intake can cause various types of heat-related illness. Children adjust more slowly than adults do to changes in environmental heat. They also produce more heat with activity than adults, and sweat less. Sweating is one of the body's normal cooling mechanisms. Children often do not pause to rest when having fun and may not drink enough fluids when playing, exercising, or participating in sports.
Children with chronic health problems, or those who take certain medicines, may be more susceptible to heat-related illnesses.

There are three types of heat-related illnesses:

- Heat cramps
- Heat exhaustion
- Heat stroke

## Heat Cramps

Heat cramps are muscle spasms in the arms, legs, or abdomen. They are the least severe heat emergency, but if not taken care of may result in heat exhaustion or heat stroke.

## Care for heat cramps

- Move the child to a cooler place.
- Give the child water to drink (approximately ½ glass every fifteen minutes).
- Observe the child for signs of heat exhaustion.

## Heat exhaustion

Heat exhaustion is the next step of a heat emergency. The child may appear excessively fatigued, have extreme thirst, flushed skin, reduced sweating, headache, weakness, and dizziness. Nausea and vomiting may also occur, as well as an above normal temperature.

## Care for heat exhaustion

- Move the child to a cooler place immediately.

- Lay the child on his back and elevate the legs.
- Remove or loosen clothing.
- If the child's temperature is elevated, cool by using wet cloths or by soaking the child in cool water (not cold).
- Place the child in front of a fan to increase evaporation.
- Keep the child's skin wet.
- Have the child sip clear fluids ***ONLY*** if child is fully awake and alert.
- Contact the Emergency Medical Services – 911 - if the child is listless, lethargic, irritable, starts vomiting, or is not feeling better in fifteen minutes, or if the child's temperature is over 101 degrees.

**Heat stroke**

Heat stroke is a life threatening condition marked by disorientation, loss of consciousness, red, hot or pale skin, dry skin, headache and vomiting, and a very high body temperature (above 105 degrees).

**Care for heat stroke**

- Contact the Emergency Medical Services – call 911.
- Cool the child quickly by completely wetting clothing with room temperature water. ***DO NOT USE ICE WATER.***
- Lay the child down and elevate the feet and legs.
- Do not give the child anything to eat or drink.
- Stay with the child and monitor breathing and pulse. Be prepared to administer CPR.

# HEPATITIS A

**What is it?**

Hepatitis A is a viral inflammation of the liver.

**How can it be recognized?**

Symptoms include mild fever, loss of appetite, fatigue, nausea, vomiting, stomach pain, dark urine, and sometimes yellow discoloration of eyes and skin (jaundice). Young children may not seem sick or may appear to have a mild illness like "stomach flu," but they can very easily spread Hepatitis A to adults.

**How long does it take from exposure to development of infection (incubation)?**

It can be from two to six weeks.

**When is it contagious?**

It is contagious from two weeks before the symptoms appear to one week or more after onset of yellow discoloration. Some people spread the disease without being noticeably sick. Most children under three years of age have no symptoms when they have Hepatitis A.

**How is it spread?**

The hepatitis A virus is found in the feces (stool) of infected persons. It is spread by direct, close contact with items that have been contaminated with human feces, such as diaper changing. Hepatitis A may be spread by food that has been prepared by an infected person with poor hand washing habits. Hepatitis A may also be spread by water contaminated with human feces.

**What should be done about it?**

- Isolate the child.
- Notify the parents.
- Medical attention is required.

**When can the child be re-admitted?**

When released by the doctor.

**What can be done to prevent the spread of hepatitis A?**

- Hepatitis A is preventable by proper hand washing after each trip to the bathroom, proper hand washing after each diaper change, and proper hand washing before handling food.

- Sanitize diaper-changing table after every diaper change with a solution of one teaspoon of bleach per quart of water – also sanitize wipe containers and bleach bottle at end of each day.

- Using diaper table for that purpose only – *never* place any other objects on it (i.e. toys, food, etc.); consider it a toilet.

- Prevention of Hepatitis A is possible through a series of two injections of vaccine between two to six years.

**Who should be notified?**

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

# HEPATITIS B

**What is it?**

Hepatitis B is an infection of the liver caused by the Hepatitis B virus. The virus is found primarily in the blood of an infected person and occasionally in some other body fluids. It is more common in adults than in children. Long-term infection ("carrier") is common and may result in chronic liver disease or even cancer.

**How can it be recognized?**

If present, symptoms may include abdominal discomfort, loss of appetite, nausea, fever, tiredness, joint pain, dark urine, and yellow skin or eyes (jaundice). Young children may not seem sick or may appear to have a mild illness like “stomach flu.” A blood test is needed for diagnosis of Hepatitis B.

**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 (like the lining of the mouth). Infected mothers can transmit it to a newborn during birth.

**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 remains in their blood. Some people may carry and transmit the virus for life.

It is not necessary to exclude children with Hepatitis B from child care.

**What should be done?**

- If a person has an exposure to someone infected with Hepatitis B, refer them to their physician.
- Use proper hand washing and disinfecting techniques.
- Try to prevent scratching, biting, or fighting.

- Do not allow anyone else to use the child's toothbrush and nail clippers.

**When can the child be re-admitted?**

When released by the doctor.

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

- Avoid direct contact with blood of any other person.
- Protect all staff and children by following special procedures for cleaning and handling all body fluids.
- Wear disposable gloves to create a barrier when caring for open sores, wounds, etc. Wash hands after removing gloves.
- Clean up all blood spills with soap and water, then sanitize with a bleach solution.
- Biting should be taken seriously, because of the potential danger of infections that occur from biting.
- Do not share items such as toothbrush, razors, or earrings.
- Prevention of Hepatitis B is possible through a series of three injections of vaccine between birth through eighteen months.

**Treatment**

There is no treatment available.

**Who should be notified?**

Notify the state or local health department, they will provide you with further information.

# HEPATITIS C

**What is it?**

Hepatitis C is a disease of the liver caused by the hepatitis C virus which is found in the blood of persons who have this disease. You may be at risk for hepatitis C and should contact a physician for a blood test if you:

- Were notified that you received blood from a donor who later tested positive for hepatitis C.
- Have ever injected illegal drugs, even if you experimented a few times many years ago.
- Received a blood transfusion or solid organ transplant before July 1992.
- Received a blood product for clotting problems produced before 1987.
- Have ever been on long-term kidney dialysis.
- Have evidence of liver disease (e.g., persistently abnormal ALT levels).

**How can it be recognized?**

If present, symptoms may include jaundice, fatigue, abdominal pain, loss of appetite, fever, diarrhea, intermittent nausea, and vomiting.

**How is it spread?**

The transmission of the Hepatitis C virus is primarily by contact with the blood of an infected person, but may also spread by sexual and perinatal contact.

**What should be done?**

- Treat all blood and body fluids with caution.
- Wear disposable, latex or vinyl gloves when handling blood-contaminated items. Wash hands after removing gloves.
- Clean up all blood spills with soap and water, then sanitize with a bleach solution.
- Do not share toothbrushes, razors, earrings, or personal items.

- Biting should be taken seriously, because of the potential danger of infections that occur from biting.

**Treatment**

There is currently no immunization for the prevention of Hepatitis C. Drugs are licensed for the treatment of persons with chronic hepatitis C. This treatment is effective in 10 - 40% of the persons.

**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, most commonly causes blister-like sores in the mouth and around the lips and on tissues that are in contact with the mouth, such as a sucked thumb or finger.

**How can it be recognized?**

Symptoms include fever, irritability, tender swollen lymph nodes, painful, small, fluid-filled blisters in the mouth, on the gums and lips. Blisters may weep clear fluid and are slow to crust over.

**How long does it take from exposure to development of infection (incubation)?**

It can be from two days to two weeks.

**When is it contagious?**

During the first infection, people shed the virus for at least a week and occasionally for several weeks after symptoms appear. After the first infection, the virus may be reactivated and virus shedding can occur for 3 to 4 days after symptoms appear.

**How is it spread?**

Direct contact through kissing and contact with open sores. Also contact through saliva (e.g., from mouthed toys).

**What should be done about it?**

- Notify parents to watch for symptoms.
- Take extra precautions to control the transmission of infected secretions.

**When can the child be readmitted?**

The child does not need to be excluded from care unless:

- The child has mouth ulcers and blisters and does not have control of drooling.
- The child is unable to participate in daily activities and staff cannot care for the child without compromising the care of the other children.

- The child meets other exclusion criteria.

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

- Exercise careful and frequent handwashing.
- 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.
- Avoid kissing or nuzzling children when a cold sore is present.
- Do not share food or drinks with children or staff.
- Avoiding any touching of cold sores with hands is difficult, but should be attempted. When sores have been touched, careful handwashing should follow immediately.

# HUMAN IMMUNODEFICIENCY VIRUS / ACQUIRED IMMUNODEFICIENCY SYNDROME (HIV/AIDS)

**What is it?**

HIV/AIDS is an infectious disease caused by a virus that progressively destroys the body's immune system.

**How can it be recognized?**

Children with HIV infection may show few signs or symptoms. Some may have enlarged lymph nodes, swelling of salivary glands, enlargement of the liver, frequent infections including pneumonia, diarrhea and thrush, and they may fail to grow and develop well.

**How long does it take from exposure to development of infection (incubation)?**

If the infection is acquired before or during birth from infected mothers, infants typically develop signs or symptoms between 12 and 18 months of age, although some remain symptom-free for more than 5 years.

**When is it contagious?**

Infected individuals can transmit the virus throughout their lifetime.

**How is it spread?**

The HIV/AIDS virus is spread through contact of mucous membranes or openings in the skin with infected blood and body fluids that contain blood, semen, and cervical secretions. It can also be spread from mother to infant through breastfeeding.

**What should be done about it?**

- Universal precautions should be followed when blood or blood-containing body fluids are handled.
- Admit children who are known to be infected with HIV whose health status makes their participation acceptable for their health and the health of others.
- If a child has one or more potential risk factors for transmission of blood-borne pathogens, such as generalized skin rash or bleeding problems, the child should be assessed by a health professional.

- Notify parents of children with HIV to consult with their child's health professional after exposure to a potentially harmful infectious disease.

- All staff working in the child care setting should receive annual education on blood-borne pathogens and universal precautions.

**What can be done to prevent the spread of HIV/AIDS?**

Follow universal precautions when handling blood or blood-containing body fluids.

- Wear disposable gloves.

- Absorb as much of the spill as possible with disposable materials; put contaminated materials in a plastic bag with a secure tie.

- Clean contaminated surfaces with soap and water.

- Rinse with water.

- Sanitize the clean surface by wetting with a spray application of freshly diluted bleach water solution and leave on surface at least two minutes.

- Dispose of all soiled items in plastic bags with secure ties.

When assisting a child who is bleeding, always put on disposable gloves.

# IMPETIGO

**What is it?**

Impetigo is a common skin infection caused by streptococcal or staphylococcal bacteria.

**How can it be recognized?**

Symptoms include small, red pimples or fluid-filled blisters with crusted yellow scabs found most often on the face.

**How long does it take from exposure to development of infection (incubation)?**

Skin sores develop in 7 to 10 days after bacteria attach to the skin.

**When is it contagious?**

It is contagious until the skin sores are treated with antibiotics for at least 24 hours or the crusting lesions are no longer present.

**How is it spread?**

Impetigo is spread through direct contact with an infected person or from contaminated surfaces.

**What should be done about it?**

- Isolate the child.
- Notify the parents.
- Medical attention is required.

**When can the child be re-admitted?**

24 hours after beginning medication, as long as the child is able to participate in daily activities and does not meet any of the other exclusion criteria.

**What can be done to prevent the spread of impetigo?**

- Practice frequent and thorough handwashing.

- Exclude infected individuals until antibiotics started for 24 hours.
- Clean infected area with soap and water.
- Loosely cover infected area to allow airflow for healing and avoid contact with others.
- Wash hands after coming into contact with sores or when changing bandages.
- Place contaminated clothing in plastic bags and send home to be laundered.

**Who should be notified?**

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

# MASHED FINGERS

- Contact Emergency Medical Services - call 911 if injury is severe.
- Rest the injured finger(s).
- Apply ice bag or cold cloths for 30 minutes or until the swelling stops. ***Do not*** place ice next to the skin. Be sure the ice is wrapped in a cloth.
- Treat as a minor cut if the skin is broken.
- Any deformity may mean a broken bone. ***Do not*** move injured finger(s).
- Contact parents. Recommend medical supervision if a break is suspected.

# MEASLES (RUBEOLA)
# (HARD MEASLES, RED MEASLES, 10-DAY MEASLES)

**What is it?**

Measles is a contagious disease spread by a virus.

**How can it be recognized?**

Fever, cough, red eyes, runny nose, followed by a rash three to seven days after fever starts. Rash is blotchy and generally appears first on the face.

**How long does it take from exposure to development of the disease (incubation)?**

About ten days, varying from seven to eighteen days from exposure to onset of fever and usually fourteen days until rash appears.

**When is it contagious?**

From beginning of the cough and cold symptoms until five days after the rash appears.

**How is it spread?**

Airborne by droplet spread, direct contact with nasal or throat secretions of infected person, and by articles freshly soiled with nose and throat secretions (respiratory spread).

**What should be done?**

- Isolate the child.
- Notify the child's parents.
- Encourage medical supervision.

**When can the child be re-admitted?**

Six days after appearance of the rash.

**What can be done to prevent the spread of Measles?**

- Parents are required to have their children immunized.
- Exclude children with undiagnosed rashes.
- Prevention of Measles is possible through an injection of vaccine between twelve and fifteen months with a booster at four to six years.

**Who should be notified?**

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

# MENINGOCOCCAL DISEASE
# (MENINGOCOCCAL MENINGITIS – MENINGOCOCCEMIA)

**What is it?**

Meningococcal disease is an infection caused by a bacteria. Serious illness usually occurs in young children and some young adults.

**How can it be recognized?**

Serious illness caused by this bacteria appears suddenly. High fever, excessive high-pitched crying, intense headache, nausea, vomiting, stiff neck, and frequently a rash are symptoms of this illness.

**How long does it take from exposure to development of the disease (incubation)?**

Two to ten days.

**When is it contagious?**

From a week prior to onset of symptoms until 24 – 48 hours after starting antibiotic treatment.

**How is it spread?**

By direct contact, saliva, and discharges from the nose and throat of infected persons (respiratory spread). Many healthy persons carry the bacteria in the nose and throat.

**What should be done?**

- Isolate the child.
- Notify the child's parents and insist parent seek immediate medical attention.
- Staff and children should wash hands thoroughly after handling ill child's belongings.
- Observe other children for signs of illness.

**When can the child be re-admitted?**

After the child is released by the doctor.

**Note**

Generally, it is not advisable to transfer healthy children to other child care facilities, since they have already been exposed. It is usually better to keep them in the facility where staff members will be more alert to recognize early symptoms.

**Who should be notified?**

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

# MONONUCLEOSIS
# (KISSING DISEASE OR MONO)

**What is it?**

Mononucleosis is a mildly contagious viral infection.

**How can it be recognized?**

Fever, sore throat, loss of appetite, fatigue, occasionally a skin rash, swelling of lymph nodes (glands in the neck), often mild or no symptoms in young children.

**How long does it take from exposure to development of the disease (incubation)?**

Four to six weeks.

**When is it contagious?**

Some cases have shown a prolonged (up to a year) period of communicability. Most, however, are no longer contagious once treatment is started and the doctor releases the child.

**How is it spread?**

By saliva and discharges from the mouth and throat. Coughing, sneezing, kissing, direct contact, such as eating or drinking after an infected person or handling personal items (respiratory spread).

**What should be done?**

- Call the parent.
- Recommend medical supervision.

**When can the child be re-admitted?**

After the child is released by the doctor.

**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.

# MUMPS

**What is it?**

Mumps is a viral infection.

**How can it be recognized?**

Fever, swelling, and tenderness of one or more salivary glands, which are below, behind, and in front of the lower part of the jawbone. The cheeks look swollen.

**How long does it take from exposure to development of the disease (incubation)?**

Usually about eighteen days.

**When is it contagious?**

From six days before symptoms to nine days after the swelling begins.

**How is it spread?**

By saliva and discharges from the mouth and throat. Coughing, sneezing, kissing, direct contact, such as eating or drinking after an infected person or handling the personal items of an infected person.

**What should be done?**

- Isolate from other children.
- Notify parents to pick up the child.

**When can the child be re-admitted?**

Nine days after the swelling began.

**What can be done to prevent the spread of mumps?**

- Proper hand washing by children and staff.
- Prevention of Mumps is possible through an injection of vaccine between twelve and fifteen months with a booster at four to six years .

**Who should be notified?**

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

# NOSEBLEEDS (OR INJURIES)

## Nosebleeds

Nosebleeds may occur because of an injury, activity, colds, increased altitude, nose-picking, or itchy allergy.

- Wear disposable gloves to prevent possible exposure to infectious fluids.
- Keep the child calm and sitting up with head slightly forward.
- Encourage mouth breathing and discourage nose blowing, repeated wiping or rubbing.
- If blood is flowing freely from the nose, provide constant uninterrupted pressure by pressing the nostrils firmly together for ten to fifteen minutes and place a cold cloth on the back of neck.
- If blood is still flowing, notify parents.

## Objects in nose

- Lay child on stomach.
- Have child blow nose in an effort to blow out the object.
- Do not try to remove it, as this may only push it further into the nostril.
- Notify parents to take child to the doctor if it is not removed by blowing.

***Caution:*** A child with pus draining from one nostril only may have a foreign object lodged in that nostril.

# PINWORMS

**What is it?**

An intestinal infestation with thread-like worms. It is common in pre-school and school age children. Children are usually infected by children outside the family.

**How can it be recognized?**

- Itchy bottom.
- The child may be irritable and experience restlessness while sleeping.
- Sometimes thread-like worms are visible in child's stool (bowel movement), but more often they are seen on the skin at the anus.
- The child's anus may become irritated.

**How long does it take from exposure to development of the disease (incubation)?**

Two to six weeks. A swallowed egg will not mature into an adult pinworm for three to four weeks.

**When is it contagious?**

As long as worms or eggs are present in the stool.

**How are they spread?**

Fecal-oral route, which means that the germs on one person's bowel movement wind up in another person's mouth, usually by way of unwashed hands. Dogs and cats do not carry pinworms.

**What should be done?**

- Notify the child's parents; encourage parents to seek medical supervision for the prescription medication to eliminate pinworms.
- Teach the other children to wash hands carefully after using the toilet and before eating.

- Clean and sanitize toilet seats daily or as needed.

**When can the child be re-admitted?**

Upon the doctor's approval.

**Who should be notified?**

- Parents of the infected child.
- Notify other parents and staff to watch for signs and symptoms.

# POISON IVY

## What is it?

Poison Ivy (Sumac or Oak) causes a rash by the resin from the plant. This resin produces a red swelling and blistering of exposed skin. The extent of the rash depends on the individual's sensitivity to the resin and his length of exposure. This rash is not contagious to other people, contrary to popular belief. However, if an exposure has occurred and the resin has not been thoroughly washed off, it is possible to spread the resin to another person or for another body part to become affected. A person may also develop the rash by brushing against a plant, getting the resin on his/her clothing and later touching that resin on clothes. Petting an animal who has the resin on its fur can also spread the rash.

## How can it be recognized?

- Extremely itchy streaks or patches of redness and blisters on exposed body surfaces (such as the hands, arms and legs).

- The rash appears one or two days after the child was in a field or forest.

## What can be done?

If exposed, wash the skin thoroughly with soap and water within fifteen minutes. Wash all exposed clothing and clean/wash the child's shoes.

Healing will normally occur by itself within two to three weeks. Calamine lotion may be applied to relieve itching. Keep the child out of the sun and water. Avoid getting overheated. If the rash is on the child's face, or becomes severe, recommend that the parents seek medical attention. It is not necessary to exclude a child; however, if the blisters are open and oozing they should be covered.

# POISONING

**What is it?**

Any substance can cause internal damage if taken in sufficient quantity. Aspirin and other medications are the most common causes of poisoning. Others are bleaches, detergents, cleaning agents, furniture polish, kerosene, and disinfectant.

**How can it be recognized?**

Different poisons produce different symptoms; some cause diarrhea, coma, convulsions, breathing difficulties, and abdominal pain.

**What should be done?**

**Swallowed poisons:**

- Call the Poison Control Center ***immediately***.
  **1-800-222-1222**

- Read the list of ingredients on the container to the Poison Control Center staff member. Ask the child what he took if the container cannot be found and the child is verbal.

- Follow instructions of Poison Center staff member.

- Call Emergency Medical Services if the child is unconscious, groggy, or having a seizure. The child needs to be taken to the hospital *immediately*.

**Fumes, gases, or smoke**

- Get the victim into fresh air.

- Call for Emergency Medical Services - 911.

- If the child is not breathing, start airway obstruction, rescue breathing and/or CPR, and continue until help arrives.

**Skin Exposure**

- If a poisonous substance (acids, lye, and pesticides) comes into contact with a child's skin, brush off any dry material gently, being careful not to get the substance on you.

- Call the Poison Control Center and follow their instructions.

- Wash skin with large quantities of soap and water if instructed by the Poison Control Center.
- Remove any contaminated clothing, continuing to wash the area.

**Eye exposure**

- Call the Poison Control Center.
- Flush the eye for at least fifteen minutes with water, if instructed by the Poison Control Center.

**PREVENT** poisoning. Keep medicines, cleaning agents, and other hazardous items in a locked cabinet inaccessible to children.

**POST** the Poison Control Center's telephone number on all phones.

**1-800-222-1222**

**For additional information refer to the Health and Safety Checklist, Appendix H.**

# RASH

## Localized Rash Without Itching: Unknown Cause

### Description

- Red or pink rash (erythema).
- Smooth or slightly bumpy.
- Spots or solid red.
- On one part of body (localized or clustered).
- Not itchy.

### Causes

There are many possible causes, such as:

- Scalp location in a child less than three months old
  - Cradle Cap
- Face location
  - Acne
- Finger location (peeling finger tips)
  - Scarlet Fever
- Genital location
  - Diaper Rash
- Nostrils (nasal opening location)
  - Impetigo
- Variable locations
  - Boils
  - Impetigo
  - Newborn rashes (in a child less than 1 month old)
  - Ringworm

**Expected Course**

Depends on the diagnosis.

**Home care for localized rashes of unknown cause**

Localized red rashes can be due to some chemical or other irritant on the child's skin. In such cases, no special treatment is necessary. Wash the rash once with soap to remove any irritating substances. Thereafter, cleanse it only with water. Do not use any mediations or petroleum jelly on this rash. If the rash seems dry, apply hand lotion twice a day.

Notify the parent and recommend physician be notified immediately if:

- It looks like an infection (bright red and tender to the touch);
- The rash is purple or blood-colored spots or dots; or
- The child is acting very sick.

# RINGWORM

**What is it?**

Ringworm is a contagious disease caused by a fungus.

**How can it be recognized?**

Ringworm is usually round. It has a slightly raised outer edge and a pinkish center. It may occur on the scalp or any part of the body. It is usually itchy.

**How long does it take from exposure until the disease develops (incubation)?**

Ten to fourteen days.

**When is it contagious?**

Until effective treatment by a doctor. The fungus may persist on contaminated materials for long periods of time.

**How is it spread?**

Ringworm is spread by direct or indirect contact with the infected skin or hair of children or animals.

**What should be done?**

- Isolate the child.
- Call the child's parents.
- Recommend medical supervision.
- Practice good hygiene to keep ringworm from spreading to other children.
- When can the child be re-admitted?

After prescription treatment and release by a doctor. 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?**

Parents of the infected child.

# ROCKY MOUNTAIN SPOTTED FEVER

**What is it?**

Rocky Mountain Spotted Fever is a rickettsial disease, transmitted by infected ticks.

**How can it be recognized?**

Symptoms appear suddenly and include moderate to high fever, headache, chills, and aching. A measles-like rash appears on arms and legs about the third day and soon spreads to the palms of hands and soles of the feet.

**How long does it take from exposure until the disease develops (incubation)?**

Three to fourteen days.

**When is it contagious?**

It is not contagious from person-to-person.

**How is it spread?**

By infected ticks; however, in many cases no tick bite is remembered by the child or parent.

**What should be done?**

- Notify the child's parents immediately about symptoms.
- Recommend medical supervision. It is very important for the parent to tell the doctor about any known tick bite. Rocky Mountain Spotted Fever is often hard to diagnose in its early stages, but it responds rapidly to medical treatment.

**When can the child be re-admitted?**

After the doctor releases the child.

**What can be done to prevent Rocky Mountain Spotted Fever?**

Encourage parents to dress their children appropriately (long pants, long sleeve shirts, and closed shoes/boots) for outings in bushy, wooded, or tall grassy areas. Light colors are better than dark.

If you find a tick on a child remove it. Tell the parent what the tick looked like, or save in a sealed container to show parents.

Conduct “tick-checks” every two to three hours if spending a long period of time outdoors.

**Who should be notified?**

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

**This disease can be fatal if untreated or treatment is delayed.**

# ROSEOLA

**What is it?**

Roseola is a viral infection causing rash in infants and children that primarily occurs between 6 and 24 months of age.

**How can it be recognized?**

Usually a mild disease, Roseola starts with a sudden high fever lasting three to five days. After the temperature is gone, a lace-like rash appears, first on the trunk and then on the rest of the body. It usually occurs in children under two years of age.

**How long does it take from exposure until the disease develops (incubation)?**

Ten days.

**When is it contagious?**

During the fever.

**How is it spread?**

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.

**When can the child be re-admitted?**

When the rash is gone.

**What can be done to prevent Roseola?**

- Proper hand washing.
- Teach children to cover their nose and mouth when coughing or sneezing.
- Disinfect surfaces and toys daily and after use.
- Exclude children with rashes.

# ROUNDWORMS

**What are they?**

Roundworms are large, up to about seven inches in length. They live in the intestine.

**How can they be recognized?**

It is rare for a child to have any symptoms from roundworms. Colicky pain, diarrhea, and restless sleep can occur. The worms may be seen in the stool (bowel movement) or vomit, or may be coughed up.

**How long does it take from exposure until the disease develops (incubation)?**

One to two months.

**When is it contagious?**

As long as there are worms in the stool.

**How is it spread?**

By fecal-oral spread. Roundworms are different from bacterial and viral germs, in that the eggs from feces survive for a long time in soil: children often get roundworms from soil contaminated with feces.

**What should be done?**

- Notify the parents.
- Encourage them to seek medical attention.

**When can the child be re-admitted?**

After adequate prescription treatment and upon doctor's approval.

**What can be done to prevent Roundworms?**

Encourage good hand washing, including after playing out-of-doors.

# RSV (RESPIRATORY SYNCYTIAL VIRUS)

**What is it?**

RSV is a virus that causes cold like symptoms in infants and young children. Respiratory Syncytial Virus (RSV) infection is the most common cause of acute respiratory diseases (such as bronchiolitis and pneumonia) in infants and young children. It occurs most often in winter and early spring. RSV can be mild, but may result in serious illness for the child.

**How can it be recognized?**

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 is it spread?**

Direct or close contact with mouth or nose secretions. The virus can live on surfaces for many hours and 30 minutes or more on hands.

**How long does it take from exposure until the disease develops (incubation)?**

Usually from four to six days, but may range from two to eight days.

**When is it contagious?**

Usually three to eight days.

**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 the child immediately if he/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 frequently. Mouthed toys should be cleaned and disinfected after each use or removed until cleaning takes place.

Do not allow sharing of mouthed toys, bottles, and pacifiers.

**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.

# RUBELLA (GERMAN MEASLES)

**What is it?**

Rubella is a contagious disease caused by a virus.

**How can it be recognized?**

Mild fever and a small fine rash, which usually begins behind the ears and moves rapidly downward, covering the body in 24 hours.

**How long does it take after exposure before symptoms appear (Incubation)?**

Two to three weeks.

**When is it contagious?**

May be spread 7 days before to 14 days after the rash.

**How is it spread?**

By sneezing, coughing, direct contact with items contaminated by nasal secretions.

**What should be done?**

- Isolate the child.
- Call the parents to take the child home.

**When can the child be re-admitted?**

Seven days after onset of rash.

**What can be done to prevent the spread of Rubella?**

- Proper hand washing.
- Exclude children with rashes.

- Prevention of Rubella is possible through an injection of vaccine between twelve and fifteen months with a booster at four to six years and eleven to twelve years.

**Who should be notified?**

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

# SAFE SLEEP FOR INFANTS

## Always Back To Sleep

- Babies should be placed on their backs for both nighttime sleeping and naps.
- Babies placed on their backs are not at increased risk of choking. Babies naturally swallow or cough up fluids.
- Babies are less likely to re-breathe air during sleep while on their backs. There is more air space around baby's nose and mouth.
- Props, wedges and positioning devices are not needed to keep babies in the back position, and are not tested or proven to be safe in the crib.
- The American Academy of Pediatrics (AAP) recommends placing all healthy babies to sleep on their backs in order to reduce the risk of Sudden Infant Death Syndrome (SIDS).

## Safe Sleep Environment

- Place each baby alone in a safety-approved crib or portable crib.
- The crib has a firm mattress with a well-fitted sheet.
- Toys and other soft bedding, including bumper pads, comforters, fluffy blankets, pillows, stuffed animals and wedges are not placed in infants' cribs.
- Keep baby's face uncovered. Babies are at an increased risk of dying if their head becomes covered during sleep.
- Keep the child care environment smoke-free. Exposure to secondhand smoke increases the risk for Sudden Infant Death Syndrome.
- Prevent babies from overheating. The infant room should be maintained at a comfortable temperature.
- Infants do not have to be covered with a blanket. If a blanket is used, it should be thin and placed no higher than chest high. The infant's feet should be placed at the foot of the crib with the ends of the blanket tucked under the crib mattress.
- Make sure everyone who cares for the infants knows to place them on their backs for sleep.

**Promote Infant Safe Sleep Practices**

- Develop a written policy on infant sleep safety to share with parents when they enroll their child.
- 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.

**Back to Sleep, Tummy to Play**

Tummy time when babies are awake is important because:

- Play in this position strengthens the neck and trunk muscles needed for head control.
- This position also strengthens the shoulders, arm and hand muscles.
- Skills learned during tummy time enable an infant to move around and explore.
- Exploration leads to higher-level thinking and problem solving skills.
- Infants need time off the back of their heads to avoid a flattening appearance or uneven head shape.

# SALMONELLA

**What is it?**

Salmonella is an intestinal infection caused by bacteria, which can be identified through a stool culture.

**How can it be recognized?**

Symptoms include diarrhea, fever, abdominal pain, nausea and vomiting, sometimes with blood or mucus in the stool.

**How long does it take after exposure before symptoms appear (Incubation)?**

Six to forty-eight hours.

**When is it contagious?**

The infection can be spread throughout the period of illness and a variable period of time after the illness is over.

**What can be done to prevent the spread of Salmonella?**

- Wash hands, especially after toilet use, diaper changes, and before meals. Help children wash their hands too.
- No reptiles as pets in child care facilities (e.g. turtles, salamanders, snakes). Salmonella is a normal bacterial inhabitant of the intestinal tract of reptiles.
- Eggs and foods of animal origin must be cooked thoroughly.
- Proper sanitation methods for food processing, preparation and service.
- *Exclude* children with infectious diarrhea, allowing children to return when the diarrhea has ceased for at least 24 hours.

**How is it treated?**

Treatment with antibiotics is usually *not* recommended for Salmonella infections, unless the child is very ill (hospitalized), which is uncommon: about 25% of children will still have

Salmonella in their stools for a month after the diarrhea stops, and treatment with antibiotics makes them shed it even longer.

**When can the child be re-admitted?**

A health professional must clear the child for readmission.

**Comments**

A child under one year of age might shed Salmonella for as long as a year after the diarrhea has stopped. Keeping a child out of child care until his stool is negative would force undue hardship for the parents. Knowing that the child is a carrier, your staff should be extra careful to clean and disinfect any area where the child's diapers are changed, wash their hands and the child's hands thoroughly and often, etc., to avoid fecal-oral spread.

**Who should be notified?**

Parents should notify caregiver about their child's infection. They should *not* transfer the child to another child care facility at this time.

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

# SCABIES

**What is it?**

Scabies is an infection of the skin by mites. The female mite burrows under the skin to lay her eggs. The eggs hatch and start the infection cycle again.

**How can it be recognized?**

Tiny blisters or pimples may form where the mites burrow under the skin. They often appear as short, wavy, dirty looking lines in the skin; usually between fingers, on elbows, wrists, armpits, and groins in adults; in young children these "primary lesions" are more likely to be found on hands and feet. Itching is often severe.

**How long does it take after exposure before symptoms appear (Incubation)?**

- 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 (i.e. two children sharing a bed or clothing) is the usual way scabies is spread.

**What should be done?**

- Isolate the child.
- Notify the parent.
- Insist on medical supervision.
- Check other children for unrecognized cases.
- Notify other parents and staff.

**What can be done to prevent the spread of scabies?**

- Proper and frequent hand washing.
- Launder sheets and clothes used in the 48 hours prior to treatment.
- Treat with prescription drugs.
- Ordinarily a second treatment is recommended in one week.
- Store difficult-to-wash items (such as stuffed toys and pillows) in tightly closed plastic bags for four days before using again.

**When can the child be re-admitted?**

Twenty-four hours after treatment.

**What are possible long-term effects?**

Itching is possible for four weeks after treatment. Secondary infection (Impetigo) may occur from scratching.

# SCARLATINA
# (SCARLET FEVER)

**What is it?**

Scarlatina is a streptococcal infection, usually a strep throat with a rash.

**How can it be recognized?**

High fever, sore throat, unusual-looking tongue. The skin is flushed, but turns white (blanches) under slight pressure. There is a fine red rash, accentuated in the folds of underarm, elbow, and groin, and inside the thighs. Palms and soles peel during recovery.

Note that all signs and symptoms can be very mild.

**How long does it take after exposure before symptoms appear (Incubation)?**

One to three days.

**When is it contagious?**

From beginning of the fever until 48 hours after effective treatment with antibiotics.

**How is it spread?**

Through coughing, sneezing, and direct contact (drinking or eating after infected child or handling his/her personal items).

**What should be done?**

Isolate from other children until parents arrive.

**When can the child be re-admitted?**

After the symptoms are gone and with doctor's approval.

**What can be done to prevent the spread of Scarlatina?**

- Proper hand washing.
- Do not allow sharing of cups, eating utensils, or toys that are put in the mouth.
- Do not allow sharing of food.

- Disinfect surfaces and toys daily and after use.
- Exclude children with rashes.

**Who should be notified?**

Other parents, after a doctor confirms the case. Watch for symptoms in other children.

# SEIZURES

Seizures are caused by abnormal bursts of electrical activity in the brain. This can cause involuntary muscle spasms, or alternating contractions, and relaxation.

**A child with a history of seizures should be known to appropriate staff.** A ***seizure care plan*** should be developed containing a description of the onset, type, duration, and after effects of the seizures. For assistance developing the seizure care plan, refer to the Special Health Care Plan in Appendix L, or visit this website: www.ucsfchildcarehealth.org/pdfs/forms

For additional information on seizures see Epilepsy page 142.

**How can a seizure be recognized?**

A seizure can take many forms from a blank stare to slight or gross jerking of the arms or legs, to whole body convulsions. Unusual behavior for that child, such as running, belligerence, or making strange sounds can also indicate seizure activity.

**How to help during seizures:**

Find out from the parents what a typical seizure for their child looks like. Keep a record of what happened during the seizure, including the length.

- **Stay calm**, don't try to restrain or revive the child. Help ease him to the floor. Though a seizure is frightening to onlookers, it is generally not harmful. If breathing should stop (it rarely does), administer rescue breathing and call emergency assistance – call 911.

- **Remove hazards** such as hard, hot, or sharp objects that can cause injury if the child falls or knocks against them.

- **Don't move the child** unless the area is clearly dangerous. Loosen tight clothing and remove glasses. Tell onlookers that the child is having a seizure, that it will soon be over, and that he is feeling no pain. Don't try to bring the child out of the seizure by using cold water, slapping, or shaking him. It won't work and could be harmful.

- **Protect airway** by gently turning the child on his side so any fluid in the mouth can drain safely. Never try to force the mouth open or force anything into the mouth.

- **Don't call a doctor or ambulance unless** it is a first time seizure or if the child is having difficulty breathing. Let the seizure run its course. If the seizure nears five minutes in length, if another seizure starts right after the first, or if another begins within ten minutes, then call the ambulance.

- **When the seizure ends** let the child rest or sleep. Be calm and reassuring because the child may feel embarrassed or disoriented after the attack.

- **Note the following:**

  - When did the seizure start?
  - What precipitated it?
  - How long does it last?
  - Which body parts are affected?
  - Was there loss of consciousness?

**Who should be notified?**

Call the parents *immediately* so they may contact their physician.

**If seizure lasts more than five minutes or if child without a known history of seizures is having a seizure, activate the Emergency Medical Services – call 911.**

# SHIGELLA

**What is it?**

Shigella is a bacterial infection of the large intestine. Anyone can get Shigella. Young children, especially those in child care, are infected more often.

**How can it be recognized?**

The most common symptoms are noticed within seven days of exposure and consist of mild to severe diarrhea, stomach pain, nausea, vomiting, fever, headache and convulsions. Blood, mucous, and pus may be present in the stool. Many cases are mild or without symptoms, however, some persons, especially children, can become very dehydrated from the fluid loss. Deaths are uncommon except in the very young, old, or debilitated persons.

**How long does it take after exposure before symptoms appear (Incubation)?**

Usually one to four days after swallowing the bacteria.

**When is it contagious?**

As long as the bacteria is passed out in the stool – sometimes four weeks.

**How is it spread?**

It is spread by close contact with an infected person, eating contaminated food or contaminated drinking water. The fecal-oral route spreads shigella. This means the germs in one person's bowel movement wind up in another person's mouth, usually by way of unwashed hands.

**What should be done?**

- Isolate the child.
- Contact the parent to pick him/her up and seek medical treatment.

**How is it treated?**

Treatment with prescription medication is recommended.

**When can the child be re-admitted?**

The child must be cleared by a health professional before returning to child care.

**What can be done to stop the spread of Shigella?**

- Focus on proper hand washing at appropriate times for children and staff.
- Supervise children in hand washing after each bowel movement and before meals.
- Eliminate access to shared water play areas.
- Adhere to sanitary food handling measures.
- Sanitize diaper-changing surfaces after each use.

**Who should be notified?**

- Other parents, after a doctor confirms the case. Watch for symptoms in other children.
- Notify the local health department, they will provide you with further information.

**Remember**

**The one major preventative action is thorough hand washing** with soap and water after using the toilet, after changing or handling diapers, and prior to eating or preparing food!

# SHINGLES (HERPES ZOSTER)

**What is it?**

Shingles is a rash illness caused by the same virus that causes chicken pox. It occurs in people who have had chicken pox in the past, and usually occurs during periods of stress or serious illness. It can occur in otherwise normal children too, but much less frequently.

**How can it be recognized?**

It begins with pain or extreme sensitivity in one region of the skin. After 1 to 3 days, a red rash appears, often along with fever or headache. The rash turns into blisters. The blister stage can last up to 3 weeks before they crust over.

**How long does it take from exposure to development of the disease (incubation)?**

The virus can remain in the body in an inactive state for many years after the first infection as chickenpox. Shingles may occur many years after having chickenpox when the virus reactivates. Exposure to shingles can cause chickenpox in a susceptible person but cannot cause shingles. Exposed persons who have not already had chickenpox disease or vaccine are most likely to develop chickenpox between the 10th day and the 21st days after exposure.

**When is it contagious?**

The blisters of a person with shingles are contagious until they have dried and crusted.

**How is it spread?**

Direct contact with the fluid in the blisters can spread the virus to others. If the blisters are covered, it is not likely to spread to susceptible persons.

**What should be done?**

- Shingles is more likely to occur in adults than children. Adults or children who may have shingles should go home and contact their health care providers. Antiviral medication can prevent the lingering pain that may occur.

- Persons at higher risk include those who are very young or old, those with medical conditions (including HIV), those taking medications (including steroids or chemotherapy), or pregnant women who have not had the chickenpox disease or vaccine. These people should be referred promptly to their health care provider if they had contact with the shingles blisters. The county health department can also be of assistance for vaccination and advice.

- Keep the blisters covered by clothing or a dressing until sores have crusted.
- Perform good hand washing after touching the infected area and before touching anything else.

**When can the child be re-admitted?**

- The child does not need to be excluded if the rash can be covered.
- If a staff member or a child has a rash that cannot be easily covered, they may return to child care when the blisters are dry and crusted.

**Who should be notified?**

Notify the parents if shingles occurs in a child.

Notify the county health department if susceptible persons had contact with someone with shingles.

Public Health Fact Sheet

# Bacterial Skin Infections

Public Health Fact Sheet

**How do people get skin infections?**
Many different types of bacteria are commonly found on the skin or in the nose of healthy people. These bacteria may cause an infection when a break in the skin gives the bacteria a place to grow (such as a scratch or insect bite). Some of these bacteria are *Staphylococcus* (also known as "staph"), *Streptococcus*, and *Pseudomonas*.

**How to prevent skin infections:**
When you first notice a break in your skin, wash it with soap and running water, and 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 prevent skin infections.

**What do skin infections look like?**
Skin infections may appear in any of these manners:

- Cellulitis: Skin becomes inflamed and is usually red and sore
- Impetigo: Blistered sores or irritated skin with a honey-colored crust or scab
- Folliculitis: Infection of a hair follicle (where the hair comes out of the skin)
- Furunculosis: Deeper infection below a hair follicle
- Carbuncle: Many hair follicles close together are infected
- Abscess: A pus-filled mass below the skin's surface
- Infected laceration: A cut or scratch that becomes infected

**Keep wounds clean, and keep drainage away from other people and surfaces.**

**How should skin infections be treated?**

- Skin infections are usually mild. Most can be successfully treated with basic wound care. Keep the area clean and protected with a bandage.
- It is very important to keep all wound drainage controlled. Pus from infected wounds can contain bacteria and spread infection. Good hand hygiene after touching or caring for the wound is important in stopping further infections.
- If infections keep occurring and basic treatment is not helping, a healthcare provider may drain the pus and/or prescribe antibiotics. If you are given antibiotics, it is very important to take all the medicine exactly as prescribed.
- Incorrect use of antibiotics has caused some bacteria to become drug-resistant. When these drug-resistant bacteria cause infections, fewer antibiotics are effective and they are usually more expensive.

**Good hand hygiene:**

- ***When your hands are dirty, wash them with soap and running water.***
- ***Count to 20 while sudsing to give the soap a chance to work.***
- ***Use alcohol-based hand gel if your hands are contaminated but not visibly soiled.***

**How serious are skin infections?**
Skin infections that only involve the skin are usually mild. Though it is rare, some bacteria can cause severe illness even when treated quickly and can cause severe diseases (such as bloodstream infections) or death. Therefore, it is very important for skin infections that are not improving to be examined by a healthcare provider.

Continued on other side

**How can skin infections spread from person-to-person?**
Skin infections are almost always spread by direct contact with an infected person. They are not spread through the air. Touching surfaces that have been contaminated by a person with a bacterial infection can also spread infection. This is known as indirect contact.

**What can be done to prevent spread of skin infections to others?**
You can prevent spreading skin infections to your family members and others by following these steps:

1. Keep any skin infection sites covered at all times with clean, dry bandages, especially if pus or drainage is present.
2. Wash your hands often, especially after touching the area of infected skin. 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.
3. 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, or use an alcohol-based hand rub.
4. Do not share personal items such as towels, washcloths, razors, clothing, or uniforms that may have had contact with pus or drainage.
5. 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.
6. Put all bandages or items with any pus or drainage (including blood and nasal discharge) immediately into the trash.
7. Clean possibly contaminated surfaces with a commercial disinfectant or with a 1:100 solution of diluted bleach (one tablespoon bleach in one quart of water). This solution must be mixed daily to be effective.
8. Tell all healthcare providers who treat you that you have a skin infection.

**Performing careful, frequent hand hygiene is the most important action you can take to prevent the spread of infection!**

**Resources:**

1. CDC: Community-Associated Information for the Public, August 2003, accessed on 23 May 2006 at http://www.cdc.gov/ncidod/dhqp/ar_mrsa_ca_public.html
2. County of Los Angeles Department of Health Services: Fact Sheet for Health Care Providers: Community-Associated Methicillin-Resistant *Staphylococcus aureus* Skin Infections, 3/20/2003, accessed on 20 August 2004 at http://lapublichealth.org/acd/docs/CAMRSA_ProviderFactSheet.pdf
3. CDC: Guidelines for Hand Hygiene in Health-Care Settings, MMWR 2002;51 (No. RR-16), accessed on 20 August 2004 at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm




Communicable Disease Division
Oklahoma State Department of Health

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# SORE THROAT

**What is it?**

A sore throat is a symptom, which can be caused by many diseases or conditions. Sore throat is not a disease.

**How can it be recognized?**

Pain and soreness in the throat or difficulty in swallowing.

**How long does it take after exposure before symptoms appear (Incubation)?**

That depends on the disease the child was exposed to.

**When is it contagious?**

If caused by a virus or bacteria, a sore throat is contagious before and during the symptoms. A sore throat resulting from allergies is not contagious. A physician needs to determine the cause and whether the child is contagious.

**How is it spread?**

If viral or bacterial, it generally is spread by direct contact or discharges from the nose and throat (respiratory spread).

**What should be done?**

- Isolate the child if the sore throat is accompanied by other symptoms of disease.
- Notify parents to pick up the child and seek medical attention.
- Stress careful hand washing and avoid direct contact with nose and throat discharges.

**When can the child be re-admitted?**

It depends on the cause of the illness.

**Who should be notified?**

Notify the parent of the child. Other parents should be notified if it is caused by a contagious disease.

# SPLINTERS

- Gently wash the area around the splinter with soap and water.
- If the splinter is protruding above the surface of the skin, remove with tweezers.
- Wash again after the splinter has been removed.
- *Do not* apply medication of *any* kind, as it may cause damage to the tissue.
- If the splinter is below the skin, leave in place. *Do not* probe under the skin.
- Contact parents to seek medical attention.

# STAPH INFECTION

**What is it?**

Also known as staphylococcus aureus, it is a bacteria that is commonly found on the skin or in the nose of healthy people.

**How can it be recognized?**
It often starts as a red, raised, bump. It may be warm to touch and have a white center point. It may be puss filled.

**How long does it take from exposure to development of the disease (incubation)?**
It may take 4-10 days for Staph to grow or "colonize" in the body. However, it may not develop into an infection for several months after the initial exposure.

**When is it contagious?**
Staph is most contagious when the wound is draining or not completely healed. (Many people carry it without being sick and they are less likely to spread Staph to others).

**How is it spread?**

- Contact with contaminated toys and equipment
- Contact with soiled towels, washcloths, bedding
- Contact with fingers that have been in the nose of infected person or touched drainage from an infected area

**What should be done?**

- Notify the parents and recommend medical care.
- Cover the area with a bandage. If the bandage becomes soiled or falls off, replace it immediately.
- Wash your hands and the child's hands any time after contact with the wound, especially after changing the bandage.
- If the wound can be kept covered by a bandage, the child does not need to be excluded from child care.

**When can the child be re-admitted?**

If the infected area can be kept covered with a bandage, the child may remain in care.

If the infected area cannot be kept covered, the child may return when the area is completely healed (when there is no drainage).

**What can be done to prevent the spread of Staph?**

- Wash your hands and wash the child's hands often.
- Keep all non-intact skin covered with clean bandage
- Use gloves to change bandage.
- Do not share towels or washcloths.
- Use bleach solution or other approved sanitizing solution to clean toys and surfaces often. Mix 1 tablespoon of bleach in one quart of water and prepare fresh daily.
- Wash soiled linens and cloths in hot water with laundry detergent.
- Dry linens and cloths in a hot dryer.
- Wash dishes and utensils in hot water.
- Follow doctor's orders and complete all medications.

**Who should be notified?**

Notify the local health department if more than one case occurs within a short period of time.

# STREPTOCOCCAL SORE THROAT – "STREP"

**What is it?**

Strep throat is a bacterial infection. Not every sore throat is strep.

**How can it be recognized?**

Symptoms include fever, sore throat, and oozing and redness of tonsils and throat. It can only be diagnosed with a laboratory throat culture.

**How long does it take after exposure before symptoms appear (incubation)?**

Two to five days.

**When is it contagious?**

The infection can be passed for about 24 hours after adequate treatment begins. Untreated persons remain infectious as long as they are sick, usually three to seven days, or longer, two to three weeks.

**How is it spread?**

Inhaling respiratory droplets from an ill person spreads strep throat. It is usually spread by sneezing or coughing, or indirectly by contact with hands or objects (such as drinking cups or eating utensils) contaminated with nose or mouth discharges of an infected person (respiratory spread).

**What should be done?**

Isolate the child from the other children. Contact the parents to pick up the child.

**How is it treated?**

- Penicillin or other effective antibiotics, as prescribed by a doctor.
- To prevent potential complications, such as rheumatic fever, antibiotics should be continued for ten days.

**When can the child be readmitted?**

If the doctor diagnoses strep throat, the child may return 24 hours after antibiotics have been started.

**What can be done to prevent the spread of Strep?**

- Frequent hand washing.
- Good personal hygiene practices should be followed. Cover the nose and mouth when coughing or sneezing.
- Dispose of soiled tissues after wiping a runny nose. Always follow with proper hand washing.
- Do not share eating utensils, food, or drinking cups.
- Wash and sanitize toys mouthed by infants and toddlers.

**Who should be notified?**

Report group outbreaks to the local health department so they can assist you in controlling the spread of the illness. Routine screening of all children and employees of the child care facility is not recommended, unless evidence of an ongoing epidemic is apparent, as determined by the local health department.

# TEETHING

The teething process can begin as early as 3 months and continue until a child's third birthday. Typically between the ages of 4 and 7 months, a child's first tooth will push through the gum line. The first teeth to appear are usually the two bottom front teeth, also known as the central incisors. These are usually followed 4 to 8 weeks later by the four front upper teeth (central and lateral incisors). About 1 month later, the lower lateral incisors (the two teeth flanking the bottom front teeth) will appear. Next to break through the gum line are the first molars (the back teeth used for grinding food), then finally the eyeteeth (the pointy teeth in the upper jaw). Most children have all 20 primary teeth by their third birthday. In some rare cases, children are born with one to two teeth or have a tooth emerge within the first few weeks of like. Unless the teeth interfere with feeding or are loose enough to pose a choking risk, this is usually not a cause for concern.

## Easing Teething

Whenever a child begins teething, he or she may seem to drool more, and want to chew on things. For some babies, teething is painless. Others may experience brief periods of irritability, and some may seem cranky for weeks, experiencing crying episodes and disrupted sleeping and eating patterns. Although tender and swollen gums could cause a baby's temperature to be a little higher than normal, teething as a rule, does not cause high fever or diarrhea.
Tips to keep in mind when baby is teething:

- Teething may cause increased drooling, a desire to chew, and/or mild gum discomfort. Give baby something to chew on. Make sure it's big enough so that he or she can't swallow it, there are no sharp areas and that it can't break into small pieces. A wet washcloth placed in the freezer for 30 minutes make a hand teething aid. Be sure to launder after each use. Rubber teething rings are also good, but it is recommended to avoid those with liquid inside because they may break. Take teething rings out the freezer before it hardens too much – this can bruise already swollen gums.

- Wipe baby's face often with a cloth it remove the drool and prevent rashes from developing.

- Rub baby's gums with a clean, gloved finger.

- Never tie a teething ring around a baby's neck due to strangling danger.

- Give pain relief medications with written parental permission only.

  Usually there is no need for special medications, such as numbing gels or pain relievers. If a child is acting ill or has a temperature above 100.4 degrees, notify the parents. The child may need medical evaluation.

# TETANUS

**What is it?**

Tetanus is a disease of the nervous system caused by a bacteria that enters the body through a break in the skin. The bacteria that cause tetanus are widely distributed in soil and street dust, are found in the waste of many animals, and are very resistant to heat and germ-killing cleaners.

**How can it be recognized?**

People who get tetanus suffer from stiffness and spasms of the muscles. The larynx (throat) can close causing breathing and eating difficulties. Muscle spasms can cause fractures of the spine and long bones. Approximately 30% of reported cases end in death.

**When is it contagious?**

Tetanus is infectious, but not contagious, so unlike other vaccine-preventable diseases, immunization by members of the community will not protect others from the disease.

**What can be done to prevent Tetanus?**

Because tetanus bacteria is widespread in the environment, **tetanus can only be prevented by immunization**. Tetanus toxoid (contained in DTP, DT, DtaP & Td vaccines) can prevent this disease.

Prevention of Tetanus is possible through a series of injections of vaccine at two, four, and six months, followed by another injection between twelve and eighteen months. A booster is given at four to six years and 10 to 13 years. It is necessary to update the Tetanus booster at least every ten years for the duration of life.

**Who should be notified?**

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

# THRUSH

**What is it?**

It is a yeast-like fungus infection.

**How can it be recognized?**

By the white patches firmly attached to the inside of the mouth. It looks like curdles of milk, but cannot be scraped off.

**How long does it take after exposure until the symptoms appear (incubation)?**

Two to five days.

**When is it contagious?**

As long as the white patches are present.

**How is it spread?**

Person to person contact. Babies sharing the same bottles, cups, and eating utensils often spread thrush.

**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 stop the spread of Thrush?**

- Closely supervise the use of pacifiers and bottles.
- Use disposable eating utensils for the infected child.
- Wash and sanitize all toys mouthed by children.

**Who should be notified?**

Notify all parents of the infection. Encourage medical attention, as prescription medication will eliminate Thrush.

# TOOTH INJURIES

## Knocked out (avulsed) tooth

- If the tooth is a permanent tooth, wrap it in a wet cloth or put it in a glass of water of milk. **Do not** handle tooth by the root. ***Do not*** clean the tooth. Place gauze pad on the child's gum to stop the bleeding. Call the parents to take the child to the dentist for possible re-implantation of the tooth. **The child should see a dentist within two hours. Tooth must not dry out.**

    - Place tooth in HBSS (Save-A-Tooth Kit) if available OR
    - Place tooth in skim or low-fat milk OR
    - Place tooth in saline OR
    - Have child spit in cup and place tooth in it.

- When a *baby* tooth is knocked out, place a gauze pad on the child's gum to stop the bleeding. Notify the child's parents. They should consult a dentist within two hours.

- If a child was almost ready to lose the baby tooth anyway, usually it is not necessary to have dental treatment. For a younger child, it is important to seek dental care, since baby teeth are important for the proper spacing of permanent teeth. However, in all cases it is important to consult with a dentist within two hours.

## Broken or chipped tooth

Call the parents if a child's tooth is broken or chipped. Advise them to consult their dentist within 24-48 hours. A fractured tooth may be more sensitive to hot or cold air, food or drinks.

## Impacted (intruded) tooth

Notify the parents if a child drives the tooth into his gums during a fall. An impacted tooth can damage gums or underlying permanent teeth. Parents should seek dental consultation within 12-24 hours.

## Discolored tooth

An injury may cause a tooth to become *non-vital*. It can be discolored because of bleeding inside the tooth. Parents should seek dental consultation.

### Tooth injury prevention

To reduce dental accidents, child care providers should encourage children to use caution on stairs and climbing equipment, and to stay clear of swings or other moving objects on the playground, possibly marking boundaries so children can identify the "safe zone."

### Other oral injuries

Injuries of the teeth, gums, tongue, lips and back of the throat are common in young children. When a child suffers an oral injury, it is important to keep the child as calm as possible. It may be difficult to help a panicked child, and the injury may be worsened. Oral injuries often look more serious than they are because there are so many blood vessels in the area. If possible, clean the injured area with lukewarm water very carefully to make it easier to see the injury and to try to control bleeding. Keep the child's head upright and in a forward position to prevent the child from choking on blood.

Determine if the child has suffered a non-oral injury as well as an oral injury. Symptoms of a non-oral injury may include loss of consciousness, altered orientation or mental status, bleeding from the nose or ears, uncontrolled bleeding, severe headache, nausea or vomiting or neck pain. If the child exhibits any of these symptoms, call EMS immediately.

### Injury to tongue or lip

If a child's tongue or lip has been injured, it may bleed heavily because the area has many blood vessels. Rinse the area with water. Use a clean cloth to apply gentle, direct pressure to the injured area to control bleeding. Apply ice, wrapped in a clean cloth, to the injured area to control swelling. If the bleeding continues 15 minutes after you have taken these steps, take the child to the hospital emergency room immediately.

### Toothache

If a child has a toothache, ask the family to contact their dentist for an appointment. Rinse the child's mouth with water to help relieve the pain. Apply ice, wrapped in a clean cloth, to the sore area, or have the child bite on a wet tea bag for 10-15 minutes to help relieve the pain. Do not put aspirin on the sore area.

# 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.

**How can it be recognized?**

General symptoms may include feeling weak or sick, weight loss, fever, and night sweats. Persons with TB of the lung(s) may have complaints of cough, chest pain, and/or coughing up blood. Other symptoms depend on the particular part of the body that is affected.

**How is it spread?**

When someone with TB disease of the lung(s) coughs, sneezes, laughs, or sings, TB germs get into the air. People who share the same air space with this person may breathe in these germs.

**Who gets TB?**

Anyone can get TB. People who are at a greater risk are family members, friends, and co-workers who share the same air space with the person who has TB disease of the lung(s).

**What is the difference between TB infection and TB disease?**

- People with TB infection (without disease) have TB germs in their body, but are not sick because the germs are not active. They cannot spread the germ to others. However, if the TB germs become active, these people may develop TB disease in the future.

- People with TB disease usually have one or more of the symptoms of TB and are sick because the TB germs are active and multiplying in their body. People with TB disease in their lungs can spread TB germs to others.

- A child or staff with active TB disease must be excluded until released by a physician.

**How can I tell if I have TB?**

A TB skin test (PPD) is given to detect TB infection. If the skin test is positive, a chest x-ray and other exams will be done to make sure you do not have TB disease. Contact your local health department or your private physician to obtain a TB skin test (PPD).

**What is the treatment for TB?**

Tuberculosis drugs (antibiotics) are recommended for persons with TB disease. Some persons with TB infections may need to take the drugs to prevent TB disease. The drugs are usually taken for six to twelve months.

**What can be done to stop the spread of TB?**

- Require all staff to have a Mantoux TB test (PPD) before beginning to work at your facility.
- Frequent hand washing.
- The most important factor is for the patient to take the TB drugs, as prescribed by the doctor.
- Teach children to cover their nose and mouth when coughing or sneezing.
- Provide adequate ventilation.
- Provide space between cots and cribs (two feet).

**Who should be notified?**

Notify the state or local health department, they will provide you with further information.

# URINARY TRACT INFECTIONS (UTIs)

**What is it?**

Most urinary tract infections are caused when bacteria infect the urinary tract. The urinary tract is made up of the kidneys, ureters, bladder, and urethra, and each plays a role in removing liquid waste from the body. An infection can occur anywhere along this tract, but the lower part - the urethra and bladder - is most commonly involved. Although bacteria aren't normally found in urine, they can easily enter the urinary tract from the skin around the anus.

**How can it be recognized?**

- Pain, burning, stinging sensation when urinating
- An increased urge to urinate or frequent urination (though a very small amount of urine may actually be produced)
- Fever (though this is not always present)
- 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

**When is it contagious?**

Bacterial UTIs are not contagious.

**How is it spread?**

UTIs are not contagious, however they develop when bacteria enters the urinary tract. Poor toilet and hygiene habits can contribute to the presence of infections.

**What should be done?**

Notify the parent of the ill child and recommend they call a physician.
UTIs are treated with antibiotics.
Most UTIs are cured within a week with proper medical treatment.
Keep track of the child's trips to the bathroom and symptoms - they should improve within 2 - 3 days. Encourage the child to drink plenty of fluids.

**What can be done to prevent the spread of UTIs?**

- UTIs can occur in infants and toddlers who do not have their diaper changed often and are not cleaned correctly when they are changed.
- Girls can develop UTIs if they do not wipe correctly from front to rear.
- Girls should also avoid bubble baths and strong soaps that might cause irritation, and they should wear cotton underwear instead of nylon because it's less likely to encourage bacterial growth.
- Children should not be taught to "hold it in" when they have to go, because urine that remains in the bladder gives bacteria a good place to grow.
- In infants and toddlers, frequent diaper changes can help prevent the spread of bacteria that cause UTIs.
- When children begin self care, it's important to teach them good hygiene.

# WHOOPING COUGH (PERTUSSIS)

**What is it?**

Whooping Cough is a contagious disease spread by bacteria. Whooping Cough can occur in persons of all ages but is most common in children under five years of age, especially infants or children less than one year of age. It causes severe spells of coughing which can interfere with eating, drinking, and breathing. Whooping Cough can lead to pneumonia, convulsions, inflammation of the brain and sometimes death. Some people who recover from pertussis may suffer from mental retardation.

**How can it be recognized?**

It starts with a cold, runny nose, and an irritating cough. This progresses to a severe series of coughs ending with a high-pitched whoop. Thick, clear, sticky mucous may be coughed up at the end of the coughing spasm. The whoop starts one to two weeks after the cold symptoms and last one to two months.

**How long does it take after exposure until the symptoms appear (incubation)?**

Six to fourteen days.

**When is it contagious?**

From the beginning of the cold until five to seven days after treatment with antibiotics starts. Without treatment, an infected person can spread the disease from the time he or she starts coughing up to three weeks after the start of the coughing fits.

**How is it spread?**

It is spread through the air after an infected person coughs or sneezes, and other people breathe in infected droplets.

**What should be done?**

- Isolate from other children until parents arrive.
- Recommend medical supervision.
- Watch for symptoms in other children.

**When can the child be re-admitted?**

With the doctor's approval or three weeks after the beginning of the cough.

**What can be done to stop the spread of Whooping Cough?**

- Proper hand washing.
- Teach children to cover mouth and nose if coughing or sneezing.
- Do not allow sharing of food or drink.
- Prevention of Whooping Cough (Pertussis) is possible through a series of three injections of vaccine at two, four, and six months, followed by another injection between twelve and eighteen months. A booster is given at four to six years and again at 11 – 12 years.

**Who should be notified?**

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

# Chapter 6

# Child Abuse


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# WHAT IS CHILD ABUSE?

## What is the law?

Oklahoma statutes define child abuse as harm or threatened harm to a child's health, safety or welfare by a person responsible for the child. This includes non-accidental physical or mental injury, sexual abuse, or neglect (Title 10, Section 7102).

- Neglect is the failure or omission to provide a child food, clothing, shelter, medical care, protection, supervision, or special care made necessary by the physical or mental condition of the child. Abandonment is also a type of neglect.

- Physical abuse is non-accidental physical injury to a child under the age of 18.

- Sexual abuse, which also includes sexual exploitation, means any sexual activity or propositioning between an adult and a child for the purpose of sexually stimulating the adult, the child, or others. This can include rape, sodomy, incest, lewd or indecent acts or proposals, prostitution, obscene photography, and deliberate exposure to adult pornography or adult sex acts.

- Emotional abuse is an injury to a child's psychological growth and development resulting from incessant rejecting, criticizing, terrorizing, isolating, exploiting, corrupting, and denying emotional responsiveness.

## When to report?

A report should be made **each time** there is reasonable cause to believe that a child has been abused or neglected or is in danger of being abused. If you are worried about a child, a trained professional at the child abuse hotline will discuss these concerns with you.

## Who must report?

Every person, private citizen or professional, who has reason to believe that a child has been abused, is mandated **by law** to promptly report suspected abuse to the Oklahoma Department of Human Services (OKDHS). Failure to do so is a misdemeanor. A person making a report, in good faith, is immune from civil or criminal liability. The name of the reporter is kept confidential by OKDHS .

## How is abuse reported?

A report may be made to any county office of the Oklahoma Department of Human Services during business hours or the 24-hour statewide Child Abuse Hotline, 1-800-522-3511. Be prepared to provided specific information including:

- name, age, and gender of the child
- the location of the child
- names, address, places of employment and telephone numbers of the child's parents or guardians
- a description of suspected abuse or neglect
- the current condition of the child

Child welfare workers are responsible for investigating child abuse reports. Law enforcement officials will also investigate when a crime may have been committed.

**What if a child tells you about abuse?**

There may be times when children or adolescents tell you, directly or indirectly, about abuse in their family. Remember how very difficult it is for children to talk about their abuse, especially as they may think it will get them or their family into trouble. Therefore, it is very important for you to handle their disclosure with sensitivity.

**In responding to a child, it will be helpful if you:**

- Provide a private time and place to listen.
- Reassure them that they have done the right thing by telling.
- Inform them that you are required by law to report the abuse.
- Do not express shock or criticize their family.
- Use their vocabulary to discuss body parts.
- Reassure the child that the abuse is not their fault, that they are not bad or to blame.
- Determine their immediate need for safety.
- Let the child know what will happen when you report.

**Remember**

Many children are too young to tell about their abuse. They depend on you to notice and report. As a child care provider, you are in an excellent position to identify suspected child abuse. Often you are with the children every day. You see them and observe their

behavior. You are aware when children are behaving differently, may be ill, frightened, or in pain for a variety of reasons. You might see clues that alert you to the possibility of child abuse. The following information will describe the four major forms of abuse and clues that may help you recognize the abuse.

**Child Neglect**

Neglect is the most common form of maltreatment. Neglect is a failure to provide for the child's basic needs such as food, clothing, shelter, medical care, education or proper supervision.

**Indicators may include:**

- Child consistently arrives hungry, begs for food
- Untreated lice, distended stomach, emaciated
- Child has poor hygiene: matted hair, dirty skin, or severe body odor
- Evidence that parents have left the child alone, or have left a child to care for younger siblings when the child is too young to do so
- Child is not taken to a doctor for physical problems or medical needs
- Constant fatigue, listlessness, or falling asleep
- Frequently absent or tardy
- Abandonment

**Caretaker characteristics may include:**

- Evident of apathy or hopelessness
- Consistent failure to keep appointments
- Appears to be suffering from mental illness, development disability, drug or alcohol so severe that it interferes with ability to provide basic needs

**Physical Abuse**

Physical abuse is intentional injury to a child under the age of eighteen by a parent or caretaker. It may include beatings, shaking, burns, human bites, strangulation or immersion in scalding water with resulting bruises and welts, broken bones, scars or internal injuries.

Child abuse is typically a pattern of behavior that is repeated over time but can also be a single physical attack. It occurs when a parent or other person injures or causes a child to be injured, tortured or maimed, or when unreasonable force is used upon a child. Abuse may also result from unnecessarily harsh discipline or from punishment that is too severe.

**Scope of the problem**

In Oklahoma, over 13,300 children were confirmed victims of child abuse and neglect (in 2005). It generally is accepted that this number does not represent the actual incidence of abuse.

**Myths**

- The majority of parents who abuse their children are mentally ill.
- Physical abuse only occurs in lower socioeconomic families.
- Young children have frequent accidents that result in broken bones.
- A physician's opinion is needed before a report of physical abuse can be made.
- Only children under age sixteen can be reported as physically abused.
- Children who are being abused by their parents will ask someone for help.

**Facts**

- Fewer than ten percent of abusive parents have a severe mental disorder.
- Reports of physical abuse have been confirmed in all socioeconomic levels.
- Many broken bones in children under age two are the result of intentional injury.
- Proof of injury is not necessary to make a request for investigation.
- Physical abuse to any child under age eighteen should be investigated.
- Children are usually afraid to talk about their injuries or are too young to ask for help.

**Physical indicators may include:**

- Unexplained bruises and welts are the most frequent evidence found and are often on the face, torso, buttocks, back, or thighs. They can reflect the shape of the object used (electric cord, belt buckles) and may be in various states of healing.

- Unexplained burns are often on palms, soles, buttocks, and back and can reflect the pattern indicative of cigarette, cigar, electrical appliance, hot water, or rope burn.

**Behavioral indicators may include:**

- Backing away or ducking when approached by an adult
- Requests or feels deserving of punishment
- Afraid to go home and/or request to stay in school, child care, etc.
- Overly shy, tends to avoid physical contacts with adults, especially parents
- Displays behavioral extremes (withdrawal or aggressiveness)

**Caretaker characteristics may include:**

- Uses harsh and inappropriate discipline
- Offers illogical, contradictory, or no explanation for injury
- States child is bad, stupid, different, etc.
- Attempts to conceal child's injury
- Has unrealistic expectations beyond child's age or ability

**Sexual Abuse**

Child sexual abuse refers to any sexual act with a child by an adult or older child. It includes behaviors such as fondling or rubbing the child's genitals, penetration, rape, sodomy, verbal stimulation, indecent exposure, voyeurism, and involving a child in prostitution or the production of pornography. Incest is sexual abuse that occurs within a family. The abuser may be a parent, stepparent, grandparent, sibling, cousin or other family or household member.

**Scope of the problem**

Approximately 1,700 cases of child sexual abuse are confirmed in Oklahoma annually. It generally is accepted that these figures are significantly less than the actual incidence of abuse.

Current research indicates that one in four girls and one in seven boys will be sexually abused by the age of eighteen.

Child sexual abuse is more typically an ongoing relationship that can last up to several years. Verbal threats and coercion are frequently used to force children to participate and keep the abuse a secret.

**Myths**

- Sex offenders can be easily identified, as they are strangers who offer rides or candy to children.
- Most sexual abuse victims are teenagers who can protect themselves from exploitation.
- Children often lie about being sexually abused.
- Incest offenders only molest children in their own families.
- The lack of physical violence in child sexual abuse means children are willing participants.
- Sex offenders are severely mentally disturbed, homosexual, or mentally retarded.

**Facts**

- Eighty to ninety percent of sex offenders are known to the child; they are family members, friends, neighbors, and babysitters.
- Children of all ages are sexually abused; over 1/3 of the victims are five years old or younger.
- Children typically do not have the experience or vocabulary to accurately describe adult sexual activity.
- Research indicates that many incest offenders also molest children outside their families.
- Verbal threats and coercion are frequently used to force children to participate and keep the abuse secret.
- Many sex offenders appear to be responsible and respectable citizens. They may be married and appear to function well in many areas of life.

**How to recognize child sexual abuse**

Children are unable to give informed consent to sexual activity. Many children do not report their abuse and rely on adults to be aware of specific behavioral and physical indicators. A child who persistently shows several of the following characteristics may

be experiencing sexual abuse. Remember, one of the most reliable indicators of child sexual abuse is the child's verbal disclosure.

**Behavioral indicators may include:**

- Excessive masturbation in young children
- Sexual knowledge or behavior beyond that expected for the child's developmental level
- Depression, suicidal gestures
- Chronic runaway
- Fearfulness, anxiety
- Frequent psychosomatic complaints, such as headaches, backaches, and stomachaches
- Drug or alcohol abuse
- Avoidance of undressing or wearing extra layers of clothes
- Sudden avoidance of certain familiar adults or places
- Decline in school performance
- Sleep disturbance

**Physical indicators may include:**

- Cuts or bruises in the genital area
- Bleeding in the genital area
- Pain in the genital area when sitting or moving around
- Sexually transmitted disease.
- Pregnancy in young adolescents
- Frequent, unexplained sore throats, yeast or urinary infections

**Caretaker characteristics may include:**

- Extremely protective or jealous of child
- Encourages child to engage in prostitution or sexual acts
- Non-abusing caretaker may be frequently absent thereby allowing abuser access to child

**Emotional Abuse**

Emotional abuse includes acts that damage a child in psychological ways but do not fall into other categories of abuse. Emotional abuse includes incessant blaming, belittling or rejecting a child; constantly treating siblings unequally; or a persistent lack of concern by the caretaker for the child's welfare. It also includes bizarre or cruel forms of punishment.

**Physical & behavioral indicators may include:**

- Lags in physical development
- Failure-to-thrive
- Sucking, biting, rocking in older children
- Behavioral extremes such as compliant, passive, demanding, antisocial, destructive, overly needy
- Self-destructive, attempted suicide

**Caretaker characteristics may include:**

- Seems unconcerned about child's problems
- Withholds affection or love
- Has impossible expectations or makes unreasonable demands of child

# Chapter 7

# Including Children With Disabilities & Chronic Health Conditions


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# INCLUDING CHILDREN WITH DISABILITIES AND CHRONIC HEALTH CONDITIONS IN THE CHILD CARE SETTING

## Benefits of Inclusion

All children have special needs, some more than others. Finding care for a child with special needs can be especially difficult for families. For many of these children, the care they need is no different from that of a typical child. A child with Down Syndrome has a disability, but does not require any special adaptations to support them in child care. They may need extra time to learn to walk, talk or use the toilet, however, major changes to a child care program are probably not going to be needed. A child with cerebral palsy who uses a walker may need the furniture rearranged, such as a table moved away from the bookshelves to allow room for the walker or a chair with sides to help them with their balance.

It is important to remember that the majority of children with special needs do not need special staff or equipment. Often the child's needs are simple changes that are made for any child that needs individualization. Child care providers have always had children with disabilities in their programs, have met their needs, and included them in activities with all the children. Providers can meet all children's needs, whether they have special needs or not.

When a family who has a child with a disability, delay, or health condition calls your center or home, ask that the child visit first. Meeting the child and family to discuss the supports their child needs is very helpful. Remember, the supports are often no different from what you are already doing for other children in your program.

All children have the right to be included and to participate in child care programs. 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 classroom full of their peers talking and playing is the best place for modeling and learning. Children with special needs should participate in all activities as much as possible. They should not spend long periods of time just watching other children play or do projects. Activities that focus on fun and skill building and active participation, rather than on having a final product, will be most successful. Taking part in activities, experimenting, and being with friends are what matters. For the typical child, an inclusive environment helps them learn about differences and helping others.

## Children First Language

Children should not be referred to or labeled by their diagnosis. If you need to discuss their diagnosis, identify the child first, and then their diagnosis. For example, this is Sarah who has Down Syndrome, or this is Ashley who wears a hearing aid. It is important to understand the child's diagnosis so supports can be identified, however, the diagnosis should not be the most important part of the child.

Terms used by programs and agencies to describe children with disabilities, delays and chronic health conditions include:

- children who are developmentally disabled, developmentally delayed, or at risk for developmental delays,
- children with cognitive delays or disabilities,
- children with behavioral or emotional disabilities,
- children with hearing impairment or deafness,
- children with visual impairment or blindness,
- children with speech-language delays or disorders,
- children with traumatic brain injury,
- children with autism, and
- children with physical disabilities.

Say the child's name first, then their disability or the equipment they use.

## Care Plans

The care plan for a child with a disability should not be significantly different than the rest of the children in the program. The program intake form will often provide the information needed. Refer to Chapter 10 for sample care plans for certain chronic health conditions.

## Special Needs Rate and Certification Process

If a family is receiving DHS subsidy, you may be certified to receive a higher reimbursement rate. The child must be participating in one of the following programs:

- Special education services (public school program for children age three and older),
- SoonerStart (early intervention services for children birth to third birthday),
- Supplemental Security Income (SSI), or
- Meet the medical definition of disability as determined by the Social Security Administration.

The process includes:

- The parent or guardian identifying the child's care needs,
- The child care provider completing a child care plan to address how the child's needs will be met,
- The licensing specialist verifies that the child care provider meets minimum licensing requirements, has current CPR and first aid certification, has received on-site consultation regarding the child's care, and agrees to receive training in special needs within six months, and
- The DHS social service specialist for the family authorizing the reimbursement rate.

For additional information, contact your DHS county licensing office.

**Training**

The child's parent is the expert on their child and the best source for information.

TIC-TOC (Training Inclusive Child care equals Terrific Opportunities for Children) is a training series for child care providers intended to increase the number of children with disabilities participating in community-based child care settings. To find out about registering for the TIC TOC training call (405) 271-1836, or visit the website at www.ah.ouhsc.edu/tolbert/. Click on "Conferences and Workshops" to find the correct information.

Each regional child care resource and referral agency (R & R) holds training for child care providers on many different topics. You can locate your regional R & R through the Oklahoma Child Care Resource and Referral Association website at www.oklahomachildcare.org.

The Center for Early Childhood Professional Development has a list of training opportunities on their website at www.cecpd.org.

The SoonerStart program serves infants and toddlers to age three who have a delay or disability. With parent's permission, SoonerStart staff can come to the child care facility to work with their child and give ideas on inclusive activities. To locate the Sooner Start office near you call OASIS at (800) 426-2747. SoonerStart also provides training through their STARS program. Find out more through the website at www.ah.ouhsc.edu/tolbert/.

**Other Resources**

Family Voices is a national grassroots network of families and friends which advocates for health care services and provides information for families with children with special health care needs. www.familyvoices.org

The National Dissemination Center for Children with Disabilities (NICHCY) is a source of information on disabilities, IDEA (law authorizing special education), and research-based information on effective educational practices. NICHCY has fact sheets on specific disabilities. www.nichcy.org

Child Care Plus+ provides training, tips and help for caregivers with specific articles on working with children with disabilities. www.ccplus.org/

**The American with Disabilities Act (ADA)**

The ADA is a federal civil rights law, which was passed in 1990. Among other things, the ADA prohibits discrimination by child care centers and family child care providers against those individuals with disabilities. The basic requirements are:

- Providers cannot exclude children with disabilities from their programs unless their presence would pose a direct threat to the health or safety of others or require a fundamental alteration of the program.

- Providers have to make reasonable modifications to their policies and practices to integrate children with disabilities into their programs unless doing so would constitute a fundamental alteration.

- Providers 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.

- Providers must generally make their facilities accessible to a person with disabilities.

Child care providers are to make a case-by-case assessment of what the child requires to be fully integrated into the program. Once they know what is needed, they must assess whether reasonable accommodations can be made to allow this to happen.

The ADA sets out three primary types of accommodations (changes in policies, practices, or procedures, removal of barriers in existing programs, and provision of auxiliary aids and services-special equipment and services to ensure effective communication). Making these accommodations is required unless:

- In the case of changes in policies, practices or procedures, the accommodation would fundamentally alter the nature of the program;

- In the case of auxiliary aids and services, the accommodation would fundamentally alter the nature of the program or pose an undue burden (significant difficulty or expense)

- In the case of the removal of barriers in an existing program, the accommodations are not readily achievable (cannot be done without much difficulty or expense).

What is "reasonable" will vary, depending on the accommodations requested and the resources available to the program. Generally speaking, less will be required of a family child care home, which typically has fewer resources and staff than a center.

For more information:

The Child Care Law Center, 1-415-394-7144;
www.childcarelaw.org

The Department of Justice Hotline, 1-800-514-0301;
www.usdoj.gov/crt/ada/

# Chapter 8

# Caring for Sick Children


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# CARING FOR SICK CHILDREN

## Exclusion of Sick Children

Should children be excluded from a child care facility when they are sick? Yes, by all means.

- Illnesses can multiply in a child care facility that is lax about enforcing an exclusion policy. Children contract many illnesses during the first five years of life. If no effort is made to protect them from exposure to illnesses of other children in the group, they may be sick even more often.

- The exclusion policy is beneficial to all working parents of child care children.

- Ill children should be excluded even if they have exposed others before the illness was discovered.

- Germs do not always attack on the first exposure. Repeated exposures increase children's chances of catching a contagious disease.

- It is best for sick children to stay home where they can receive individual attention or attend a facility licensed for the care of sick children.

- It is best for the child care facility to be able to use personnel to the best advantage in supervising and caring for well children. The exclusion policy may also reduce the number of working days lost by the employees due to illness.

**All children get sick. It is a fact that must be planned into the life of working parents.**

## What to do when children become ill?

- Isolate sick children until a parent arrives. Care should be taken to avoid making these children feel guilty or punished because of the illness.

- Children should be placed in a separate room, or in the same room away from the other children. Bed rest should be encouraged, but not forced.

- Bedding, used by ill children, should be washed after they leave. If vomiting or diarrhea is a symptom, wash the toilet with soap and water and sanitize it after each use.

- Disposable covers on thermometers are recommended.

- Parents should assume care for sick children as quickly as possible.

# RECOMMENDATIONS FOR EXCLUSION OF SICK CHILDREN

- Fever, defined as temperature of 100.4 degrees or higher.
- Diarrhea, defined as runny or watery stools with increased frequency of loose stools.
- Vomiting two or more times in a 24-hour period.
- Undiagnosed body rash, except diaper rash.
- Sore throat with a fever and swollen glands.
- Eye discharge, defined as thick mucus or pus draining from the eye, matted eyelids after sleep and eye pain, along with pink or red in the whites of the eyes.
- Mouth sores with drooling.
- Severe coughing, where a child gets red or blue in the face or makes a high-pitched whooping sound after coughing.
- Abdominal pain that continues for more than two hours or intermittent pain associated with fever or other signs or symptoms.
- Signs or symptoms of possible illness such as lethargy, irritability, persistent crying or any other unusual signs until a medical evaluation allows inclusion.
- When the caregiver is not able to offer the extra care needed to comfort a sick child without compromising the care of other children.

# ADMINISTRATION & STORAGE OF MEDICATION IN CHILD CARE

- 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.

**ALWAYS WASH YOUR HANDS BEFORE ADMINISTERING ANY TYPE OF MEDICATION!**

## Oral Medications

- Use a plastic syringe or children's medication cup to measure liquid medicine accurately.
- It is usually best to give the medicine in a private place away from other children.
- Be firm, friendly, and matter of fact. Do not lie about the taste of the medicine.
- A child may have a swallow of juice or water before and after the medicine to help with the unpleasant or unusual taste, if allowed by the type of medication.

**Medication Injections**

- Child care facilities that have children receiving injected medication while at the facility are required to use sharps containers for any medical waste that is sharp and could cause a cut or wound such as syringes, needles, and lancets used to administer insulin or test blood sugar.
- Sharps containers can be purchased from the local pharmacy or through a health care supplier.
- Once the container is full, the child care facility will make arrangements with the local pharmacy, county health department, or personal physician for disposal.

**Ointments**

- Wash hands thoroughly before and after contact with the wound or rash.
- Gloves should be worn if contact will be made with broken skin or blood.
- Spread the ointment evenly.
- Remember, diaper ointments are medications.

**Ear drops**

- Lay the child down with head turned to one side to expose the treated ear.
- Administer the drops according to the written instructions on the medication permission form.
- Allow the child to continue lying down to give the drops sufficient time to absorb.

**Nose drops**

- Lay the child down or tilt the head back far enough to allow the drops to fall into the nostrils.
- Administer the drops according to the written instructions on the medication permission form.

**Eye drops**

- Lay the child down or tilt the head backward.
- Do not touch the eye with the tip of the tube.

- Holding the dispenser, rest your hand on the child's cheek lightly so that if the child moves, your hand and the dispenser follow with the move.

- Administer drops according to the written instructions on the medication permission form.

**Always check for the 5 "Rights" when you give medicine**

- The right ***child***

- The right ***medicine***

- The right ***dose***

- The right ***route (oral, ointment, drops, etc.)***

- The right ***time***

**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 physician.

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

# TAKING A CHILD'S TEMPERATURE

In a child care facility; a child's temperature is often taken in the armpit (axillary) or in the child's mouth (orally), if the child is old enough to know not to bite down on the thermometer.

**How to take axillary temperatures**

- Place the tip of the thermometer in a dry armpit.
- Close the armpit by holding the elbow against the chest for four or five minutes, or until the thermometer beeps.
- After four or five minutes, or when the thermometer beeps, take the thermometer out and read the temperature.
- Fever is a temperature over 100.4º Fahrenheit.

**How to take oral temperatures**

- Be sure the child has not had a cold or hot drink in the last 30 minutes.
- Place the tip of the thermometer under one side of the tongue and toward the back.
- Have the child hold the thermometer in place with his lips and fingers. He should breathe through his nose, keeping mouth closed.
- Leave the thermometer in the mouth for three minutes, or until the thermometer beeps.
- After three minutes, or when thermometer beeps, take the thermometer out and read the temperature.
- Fever is a temperature over 100.4º Fahrenheit.

# DAILY ACTIVITIES OF THE SICK CHILD

- Mildly and moderately ill children who are attending a child care facility will have a slightly different routine to their day.

- They need to be monitored frequently for signs of illness. Some children will receive medication and a special diet, and they all need plenty of rest.

- Children often don't show signs of illness the way adults do. Unless their temperature is high, they are overly tired, or in a lot of pain they will remain active.

- Because of this, a program caring for ill children needs to provide a wide assortment of appropriate activities for the various age groups in care. Some ill children will be able to play with others, and some must remain isolated.

- Develop a daily schedule similar to healthy child care facilities, allowing time for health monitoring and extra rest. As in healthy child care, the day should consist of active and quiet play, planned activities and free choice, group interaction (when possible) and time for one-on-one interaction with the child care provider, meal and snack times, and rest times.

- Ill children may need a morning and an afternoon nap, and may not have outside play time. The decision about playing outside will be up to each individual facility and instructions from parents. The toys and equipment used should be sanitized and extra care must be taken to keep infants and toddlers from sharing toys.

- Music and books are an important part of each child's day. Playing calm music and reading or telling stories are very soothing activities for ill children. Preschoolers and school age children may enjoy a quiet board or card game.

- Paying attention to each child's "cues" may be the most important skill a child care provider can develop. Children will let you know what they are able to do.

# NUTRITION FOR THE SICK CHILD

**During an illness**

- Offer foods that are easily digested and tolerated.
    - Applesauce
    - Bagels
    - Bananas
    - Jell-O
    - Soup
    - Rice
    - Toast
    - Pasta
- For proper hydration, offer clear fluids that are not carbonated.
    - Clear broth
    - Juices
    - Gatorade
    - Oral electrolyte maintenance solution (i.e., Pedialyte)
    - Water
- The body is trying to heal itself, so during this period, “empty” calorie foods that are high in salt, sugar, or fats are not the best ones to offer the child.
- Always consult with the registered pharmacist about the nutrient/drug interactions associated with the prescription or over-the-counter medicine the child is being given. Milk products interfere with the pharmaceutical actions of many drugs. Many forms of sugars and starches can cause changes in the stool. Caffeine containing substances ma have a stimulating effect on the child inhibiting rest or causing loss of fluids.

# Chapter 9
# The Successful Caregiver


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# ROLE OF THE CHILD CARE HEALTH CONSULTANT IN CHILD CARE PROGRAMS

All child care programs should have access to a health consultant who can provide consultation and technical assistance. The child care health consultant is a health professional with expertise in child health and development who works with caregivers to recognize and promote the health and safety of staff, children, and families.

**Who is the Child Care Health Consultant?**

The child care health consultant can be a public health nurse, pediatric nurse, pediatrician, family physician, or health professional with expertise in:

- Child health
- Mental health
- Nutrition
- Health education
- Oral health
- Environmental health
- Emergency management
- Infectious diseases
- Issues relating to caring for children with special health care needs

**What are the qualifications of a Child Care Health Consultant?**

The child care health consultant should have knowledge and expertise in the following areas:

- Routines, conditions, and constraints for caregivers
- Pediatric health care and early brain development
- Community, state, and national resources and regulations
- Principles of consultation

- Working with diverse populations
- Oral, written, and electronic communication
- Communication with non-health-related personnel and local health authorities
- Techniques to teach health and safety to adults and children

**What does a Child Care Health Consultant do?**

The child care health consultant should be in regular contact with the child care program and be able to:

- Perform an assessment of the program focusing on health, safety, nutrition practices, and facility issues
- Assist in the development and implementation of written health policies
- Assist in linking children, families, and caregivers to community health resources including a medical home, immunizations, and health screenings
- Contribute to the professional development of caregivers
- Assist caregivers with the inclusion of children with special health care needs
- Create health care plans for children with special health care needs, in collaboration with health professionals in the child's medical home
- Delegate prescribed care to caregivers
- Assist the program in the event of a communicable disease outbreak

**Why does a Child Care Program need a Child Care Health Consultant?**

To assist in:

- Preventing infectious diseases in children, staff, and families
- Preventing injuries
- Promoting health by using
    - Written policies
    - Food safety practices
    - Sanitation procedures
    - Play equipment assessments

- Health record reviews
- Illness and injury records
- Education of staff and families

**Where can a Child Care Program find a Child Care Health Consultant?**

- Contact the Oklahoma State Department of Health, Child and Adolescent Health Division: (405) 271-4471

- Call the Child Care Warmline: (888) 574-5437

- Contact your local Child Care Resource and Referral Agency through the Oklahoma Child Care Resource & Referral Association, (888) 962-2772

# TAKING CARE OF YOURSELF

What a tremendous responsibility and awesome opportunity awaits you as a child care provider. You have the joy of living life through the eyes of precious little children. You will watch children grow from helpless infancy to more self-sufficient preschoolers, or even through the school-age years. You will be a part of their memories forever. In fact, it is while with you that many of their early milestones will be reached. Sounds great huh? Then why are many child care providers so exhausted?

It is extremely important that as a child care provider you make caring for yourself your number one job. If you don't think you are worth the effort, just ask any of your parents how valuable your being healthy and available is to them.

**How often do you feel?**

- Overwhelmed
- Frustrated
- Angry at family or others
- A lack of pleasure in things that usually bring a smile
- Irritable
- Exhausted or unable to sleep
- Not Organized

If you are experiencing any of these on a routine basis, you may have child care provider stress. Left unaddressed, these issues may lead to serious health problems and or burnout. What do you do?

**Actions you can take to protect yourself:**

- Make time for your annual physical/mammogram.
- Be sure that all physical causes are identified and addressed.
    - Could your lack of energy be due to a thyroid problem?
    - Could you be diabetic?
    - Could you have sleep apnea?

- All of these can lead to frustration, exhaustion, sleeplessness, or depression.
- It is important to exercise. It can change your mood! Even short walks help.
- Develop good eating habits.
- Develop a network of friends who are in child care as a support group.
- Enroll in a class on a subject **NOT** related to child care.
- Meditate, pray or attend a religious service of your choice.
- Go for a walk with a friend after work
- Get a pedicure and manicure.
- Go see a funny movie.
- **LAUGH EVERY DAY**, it will change your mood!
- Curl up on your couch with a blanket and your pet and read a great book.
- Go shopping and treat yourself to something special (not expensive).
- Make popcorn, toss M and Ms in the bowl, and watch a classic movie.
- Plan short "get away" weekends or vacations to reduce stress.
- Make time for your hobbies.
- Perhaps one of the MOST helpful ways to care for yourself is to ASK for help from a co-worker when a specific child interaction is becoming MORE than you can handle. Asking is NOT a sign of weakness, but of strength.

**How to prevent becoming ill or injured:**

- Stay current on YOUR immunizations
- Have you had your hepatitis immunizations?
- When was your last tetanus immunization?
- Do you get a yearly flu shot?
- Be sure to keep your skin moist and intact. Your skin is your first line of

defense against many illnesses. Be certain to keep any sores, cuts, or scrapes clean and COVERED.

- Review proper lifting techniques, these can save you from back pain and injury.

  - Lift comfortably. Choose a position that feels natural but is safe.
  - Avoid unnecessary bending.
  - Avoid reaching out. Handle heavy objects close to your body.
  - Remember to bend with your knees, not your back.

Do **NOT** work when you are ill. Have a back up plan in place. You are human and you will be ill sometimes. If you "just keep going" when you are ill, you run the risk of infecting the children in your care also. Remember you are very valuable to both the parents and children in your care; take CARE of yourself!

# TIPS FOR TALKING WITH FAMILIES

Communicating with parents on a regular basis is important. If there is 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:**

- Think through what the real problem is.
- What are the consequences of not doing anything?
- What are the consequences of talking to the family?
- What resources can you suggest the family turn to?
- Make copies of brochures of agencies that might help.
- Don't forget informal resources like relatives, neighbors, or the faith community.
- Choose an appropriate time:
  - The least stressful and hurried time of the day is best.
  - Ask if the parent or parents can stop by on their lunch hour, during naptime, 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 have a similar concern.
  - This gives the parent an opportunity to provide background information you may not know about.
  - This also gives the parent an opportunity to agree or disagree with your definition of the problem before you move on to discussing solutions.
- **Discuss the issue in terms of how it affects the child:**
  - Focus on your shared concern.

- 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 parents know you heard them and value their input.

- **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.
  - Always end your conversation with parents on a positive note.

# CULTURAL CONSIDERATIONS IN CHILD CARE

- Does your family celebrate birthdays with a piñata?
- Do you have an Easter ham or do you grill chicken?
- Do you live with your parents and grandparents in the same home?
- Is breastfeeding until two years old acceptable to you?
- What forms of discipline did you grow-up with? Did your Mom often say, "You are in trouble now! Just wait until your Father gets home…" relegating the task of discipline to him. Did your aunt have the same right to discipline you as your dad?

The answers to these questions help define your cultural preference. In child care, it is very important that you acknowledge the cultural differences represented in your facility. The different cultures in your center can create a beautiful patchwork quilt.

As a child care professional it is imperative that you seek to understand how a child's culture will impact your care. Let us examine how provider Lori handles this situation.

Lori welcomed 3-year-old Trey to her family child care home. Trey and his family recently moved here from another country. Trey entered the home and immediately removed his shoes. He then wandered from room to room as if looking for something. Several times during the day he stopped what he was doing and looked around as if waiting for special instructions.

At lunch, Lori served soft tacos and pudding, a favorite among her long-term children. Trey did not touch his taco, but did enjoy his pudding. At naptime, he kept moving his cot away from Melissa the girl next to him. Trey was very respectful, even saying yes sir to every request Lori had. He shared toys easily, but moved away when other children stood very close to him. Although he was able to toilet himself, he seemed incapable of redressing himself after toileting. During Katie's birthday party, her dad brought hamburger pizza and cake. Trey did not eat the pizza or the cake.

At the end of the day, he was quick to hug his mother and ready to go home. Lori sensed that he was not very comfortable in her home. She was delighted to have such a pleasant and respectful young child in her home and wanted to help him feel more at ease.

Lori quickly scheduled a parent meeting with Trey's parents. Lori shared her observations with the parents and asked for their input on how she could help Trey feel more comfortable. Trey's parents explained that they do not eat meat and offered to pack Trey a lunch from home. Trey's parents went on to explain that sweets such as cake were considered a real treat in their home and were reserved for weddings and celebrations of elders birthdays, rather than children's birthdays. Fruit is the preferred sweet in their home. The parents explained that Trey might have been looking for the family altars in Lori's home as he went from room to room. His parents also explained that he might have also been looking for grandparents or other elders in the home. In his home, boys did not sleep in the same room as girls, even for naptime.

Equipped with this new information, Lori was excited to be able to work with Trey's parents to make his child care experience a happy and positive one. She was pleased that Trey's parents offered to meet with the other parents during parent night and share their culture and answer any questions that others might have. Trey was happy to be asked to bring items from his home for show and tell. He brought a picture of his grandparents and a picture of his family's village.

Because language is the primary method of communication it is important to assess the words used in the child's home and remain consistent with this while they are in your care. For example: does the child "urinate", "pee", or "tinkle." If English is the second language in the home, try these suggestions to help with communication:

- Make a picture board and practice the correct word to use to express the need.
- Keep the message simple. Rather than, " Put your socks and shoes on. It is time to wash your hands and go outside for a picnic." Break it into small baby steps. "Put on your socks. Put on your shoes etc."
- Talk out loud about everything as you do it. For example: "Now I am going to get the green play dough out. Now I am making it flat." Be sure to use hand gestures as you talk, pointing to the green play dough.
- Sing lots of repetitive songs.
- Partner English speaking students with those who are learning.

Correct nutrition is how a child's brain and body grow. Food and mealtime have different meanings in different cultures. In some cultures, certain types of meat are not to be eaten during certain times, or even to be served or offered. Offering a mealtime prayer may be a priority in one family and not considered important in another. One family may feel that continuing to spoon feed a child when they are old enough to do it alone is not only appropriate, but also expected. Another family might see that as delaying a child's independence. When a family starts feeding solids to their infant, is also to be considered in light of their cultural norm.

In many countries it is the accepted norm for children, parents, grandparents, aunts, uncles and cousins to share the same home. All share in the training and discipline of the children. While respect for the elders is not only expected, it is required. Children are seen as prized belongings. How a child behaves both in the home and outside the home is considered a parent's measure of pride in rearing their children.

- As a professional child care provider, culture and how it impacts the care that you provide should always be an influence in your program. Factors to consider are:

  - perceptions of time and punctuality
  - acceptable personal space
  - eye-to-eye contact
  - personal hygiene
  - acceptable display of emotion
  - giving unsolicited advice
  - gender roles
  - formality in use of names and titles to show respect
  - appropriate physical touch
  - holiday celebrations
  - nutrition
  - personal achievement vs. good of the community

Learning about the child's nuclear family and culture will add many varied patterns to the patchwork quilt of care you provide.

# Appendices
# Resources, Sample Forms and Handouts


**Resources**

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| Warmline Phone Codes | p. 277 |
| County Health Departments | p. 280 |
| Health and Safety Resources for Children | p. 284 |
| Quality Inclusive Child Care Checklist | p. 287 |
| Website Guide for Developmental Resources | p. 289 |

**Sample Forms**

| | |
|---|---|
| Authorization for Medication Administration & Log | p. 291 |
| CCHP Health & Safety Checklist | p. 293 |
| Emergency Response Drill Log | p. 301 |
| Injury Report Form | p. 302 |
| Notice of Exposure to Communicable Disease | p. 304 |
| Special Health Care Plan | p. 305 |
| Symptom Record | p. 309 |

**Handouts**

| | |
|---|---|
| Carbon Monoxide Fact Sheet | p. 310 |
| Child Care Provider's Guide to Safe Sleep | p. 312 |
| Cleaning & Disinfecting | p. 315 |
| Diapering Procedures | p. 316 |
| Food Poisoning Fact Sheet | p. 318 |
| Morning Health Check | p. 320 |

**Handouts (cont.)**

| | |
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| MyPyramid Worksheet/Tips for Families | p. 321 |
| Nicotine Fact Sheet | p. 323 |
| Plant Smarts | p. 324 |
| Reportable Diseases/Conditions in Oklahoma | p. 326 |
| Never Shake a Baby | p. 327 |
| Toothbrushing & Storage | p. 330 |
| Wash Your Hands Properly | p. 332 |

# CHILD CARE WARMLINE

## 1-888-574-5437

The Warmline for Oklahoma Child Care Providers offers free telephone consultation to child care providers on numerous topics of concern. Consultants refer providers to appropriate services and resources within their communities.

*I'm concerned about a child's development.*

*How can I talk to the parents about my concerns?*

*This child is out of control. What can I do?*

*What can I do about a child biting other children?*

*How can I tell if a child has ringworm?*

Help for those puzzling questions. . .

Anyone who cares for children needs someone to talk to occasionally about those puzzling questions regarding behavior, child development, health, safety, working with parents. . .and more.

The Child Care Warmline is as close as a telephone and is available to help child care providers find solutions to the daily dilemmas of caring for children.

Trained professionals in child development, guidance, parent education, and health and safety are available to assist providers in finding the answers to questions and resources they need to provide quality care for children. Consultants are available Monday through Friday from 8:00 a.m. until 5:00 p.m. Messages left after hours will be answered as soon as a consultant is available.

Automated Warmline Library

Pre-recorded messages on a variety of topics related to child care, health, and development are available 24 hours a day. A list of topics is available at http://www.okdhs.org/programsandservices/cc/spinit/docs/warmline.htm

The Warmline is a service provided by Child Guidance Service, Oklahoma State Department of Health, and the Division of Child Care, Oklahoma Department of Human Services.

# WARMLINE PHONE CODES

| Behavior, Development, and Parenting Issues | | Infant Behavior and Development (cont.) | |
|---|---|---|---|
| | | | |
| 7715 | Bedwetting (Enuresis) | 7706 | 07-Month-Old Child |
| 1304 | Biting in the Toddler Years | 7707 | 08-Month-Old Child |
| 1305 | Biting: What to do When a Child Bites | 7708 | 09-Month-Old Child |
| 1306 | Biting: Strategies to Prevent Biting in Child Care | 7709 | 10-Month-Old Child |
| 4841 | Building Your Child's Self Esteem | 7710 | 11-Month-Old Child |
| 1310 | Children and Sleep: How much is Enough? | 7711 | 12-Month-Old Child |
| 1308 | Children's Fears | 7714 | Baby Teeth: Are They Important? |
| 6713 | Children's Insecurities | 4802 | Crying Baby |
| 7720 | Choosing Child Care | 4804 | Fathering an Infant |
| 4327 | Development Milestones: Birth to 3 Years | 4576 | Hiccups |
| 4310 | Development Milestones: 4 to 6 Years | 4807 | Mothering an Infant |
| 4843 | Discipline and Punishment | 7737 | Newborn Screening Tests |
| 7731 | Feet: What is Normal for Children? | 4937 | Sleep Apnea: Infants |
| 1301 | "Good" Byes: Helping Children Adjust to Child Care | 4809 | Sleep Patterns in Newborns |
| 4844 | Helping Siblings to Get Along | 7762 | Sudden Infant Death Syndrome |
| 7743 | New Baby Creates Jealousy | 7763 | Teething |
| 7744 | Nightmares and Night Terrors: Why do Children Have Them? | | |
| 7634 | Pigeon Toe (In-Toeing) | **Special Health Needs** | |
| 4845 | Separation Anxiety: Leaving Your Child with Caregiver | | |
| 7757 | Sleep Patterns in Children | 7712 | Alcohol-Affected or Drug Addicted Babies |
| 7758 | Sleeplessness | 6707 | Anxiety |
| 6769 | Sleepwalking | 4311 | Asthma in Children |
| 7759 | Speech Development in 0-2 Year Olds | 6780 | Attention Deficit Disorder: Children |
| 7760 | Speech Development in 2-5 Year Olds | 7713 | Autism |
| 1307 | Tantrums | 4591 | Cerebral Palsy |
| 7764 | Temper Tantrums | 7717 | Childhood Cancers |
| 7765 | Terrible Twos | 4503 | Common Vision Problems |
| 7766 | Thumb-Sucking | 4506 | Crossed Eyes/Outward Turning Eye/Lazy Eye |
| 1302 | Toddler Practicing Independence in Child Care | 4592 | Cystic Fibrosis |
| 1303 | Toilet Learning | 7724 | Diabetes in Children |
| 7745 | What Does "No" Mean to a Toddler? | 4593 | Down Syndrome |
| | | 7727 | Dyslexia |
| **Infant Behavior and Development** | | 4252 | Epilepsy |
| | | 6725 | Grief and Loss |
| 7701 | 02-Month-Old Child | 4686 | Hearing Loss in Children |
| 7702 | 03-Month-Old Child | 7742 | Muscular Dystrophy |
| 7703 | 04-Month-Old Child | 6969 | Overweight Child |
| 7704 | 05-Month-Old Child | 7751 | Premature Baby |
| 7705 | 06-Month-Old Child | 7753 | Reye's Sundrome |

| Special Health Needs (cont.) | | Common Childhood Health Issues & Infectious Diseases (cont.) | |
|---|---|---|---|
| | | 4331 | Colds |
| 4797 | Sexual Abuse and Children | 7721 | Croup |
| 7761 | Speech Problems in Children | 4452 | Ear Infection |
| 4846 | Suicide Warning Signs | 4332 | Eczema |
| 7767 | Tics and Tourette's Syndrome | 4722 | Fever Blisters and Cold Sores |
| | | 4735 | Fifth Disease |
| | | 4333 | Flu |
| **Symptoms of Illness** | | 4737 | Group A Streptococcus |
| | | 4739 | Hand-Foot-and-Mouth Disease |
| 5171 | Abdominal Cramps | 4155 | Hay Fever |
| 5502 | Concussion | 7733 | Head Lice |
| 5174 | Constipation | 4732 | Herpes Encephalitis |
| 6416 | Cough | 4612 | HIV/AIDS |
| 5403 | Dehydration | 4982 | Impetigo |
| 5175 | Diarrhea | 4334 | Infectious Mononucleosis |
| 6127 | Dizziness | 4806 | Jaundice |
| 7728 | Ears: Earache in Children | 4723 | Lice |
| 4453 | Ears: Earwax | 4724 | Lyme Disease |
| 4456 | Ears: Ruptured Eardrum | 7739 | Measles |
| 7173 | Fatigue | 7741 | Mumps |
| 4908 | Fever | 7748 | Pinkeye |
| 7732 | Fever: Treatment | 4734 | Pinworms |
| 4632 | Headaches: Migraine | 4935 | Pneumonia |
| 4633 | Headaches: Sinus | 4808 | Rashes |
| 5179 | Heartburn | 4803 | Rashes: Diaper |
| 4418 | Indigestion | 4159 | Rashes: Poison Ivy, Oak, and Sumac |
| 6731 | Insomnia | 4929 | Respiratory Syncytial Virus (RSV) |
| 6732 | Irritability | 4727 | Ringworm |
| 6431 | Loss of Appetite | 4740 | Roseola |
| 6438 | Lymph Nodes: Enlarged | 4728 | Rubella |
| 5182 | Nausea and Vomiting | 4729 | Salmonella Infection |
| 4913 | Nosebleed | 4736 | Scabies |
| 6154 | Palpitations | 4336 | Shingles |
| 5184 | Ringing in the Ear | 4720 | Skin Infection |
| 6107 | Shortness of Breath | 4157 | Skin: Allergies Contact Dermatitis, Eczema, Hives |
| 4457 | Sinus Problems | 4810 | Spitting Up |
| 6436 | Skin Lesions | 4730 | Tetanus |
| 6454 | Skin: Darkened | 4380 | Thrush |
| 6460 | Stools with Blood or Mucus | 4459 | Tonsilitis |
| 5185 | Swallowing Difficulty | 4731 | Tuberculosis (TB) |
| 6468 | Urination Problems | 4721 | Viral Hepatitis |
| 5186 | Wheezing | 7770 | Viral Infections |
| | | 4980 | Warts |
| **Common Childhood Health Issues & Infectious Diseases** | | 4708 | West Nile Virus |
| | | 7771 | Whooping Cough |
| 4211 | Anemia | | |
| 4931 | Asthma | | |
| 7716 | Chicken Pox | | |

| Care & Safety | | | Care & Safety (cont.) |
|---|---|---|---|
| | | | |
| 4151 | Allergic Shock (Anaphylaxis) | 7755 | Safety Seats for Children |
| 4902 | Bee Stings | 4920 | Splinters |
| 4901 | Bites: Animal and Human | 7561 | Sprains |
| 4926 | Bites: Spiders | 4245 | Strains |
| 4927 | Bites: Tick | 4921 | Sunburn |
| 7413 | Blisters | | |
| 7772 | Breathing Emergencies in Children | | |
| 7756 | Burns in Children | | |
| 4904 | Chemical Burns to the Skin | | |
| 4905 | Chemicals in the Eyes | | |
| 7718 | Childproofing Your Home | | |
| 7774 | Choking in Children | | |
| 4330 | Choking Prevention | | |
| 6108 | CPR: A Technique You Should Know | | |
| 4907 | Cuts and Scrapes: Shallow | | |
| 4375 | Dental Care for Infants | | |
| 4376 | Dental Care for Kids | | |
| 7726 | Drowning Alert | | |
| 4161 | Drug Allergy | | |
| 4916 | Electrical Shock | | |
| 7424 | Exercise: Are Your Children Getting Enough? | | |
| 4917 | Eye Injuries | | |
| 6934 | Feeding Your Child | | |
| 7611 | Finger Dislocation | | |
| 4154 | Food Allergies | | |
| 4918 | Food Poisoning | | |
| 4582 | Frostbite | | |
| 7535 | Hand Injuries | | |
| 7536 | Head Injuries | | |
| 7442 | Heat Stress | | |
| 7619 | Hip Dislocation: Childhood | | |
| 4911 | Home First Aid Supplies | | |
| 7840 | Home Safety Tips | | |
| 4872 | Household Chemical Safety Checklist | | |
| 7842 | Hydration: Getting Enough Water | | |
| 7736 | Immunizations: Children | | |
| 4156 | Insect Bites and Stings | | |
| 7445 | Kid Fitness | | |
| 6954 | Mealtimes | | |
| 7857 | Medication Safety | | |
| 4865 | Medicine: More is Not Better | | |
| 7740 | Medicines in Your Home: Can They Poison Your Child? | | |
| 4912 | Minor Burns and Scalds | | |
| 6959 | Nutrition for Children | | |
| 7749 | Poison Prevention | | |
| 4914 | Poisoning | | |
| 4867 | Poison-Proof Your House | | |
| 4928 | Puncture Wounds | | |
| 4922 | RICE: Rest, Ice, Compression, Elevation | | |

# County Health Departments

| City | County | Telephone |
|---|---|---|
| Ada | Pontotoc | (580) 332-2011 |
| Altus | Jackson | (580) 482-7308 |
| Alva | Woods | (580) 327-3192 |
| Anadarko | Caddo | (405) 247-2507 |
| Antlers | Pushmataha | (580) 298-6624 |
| Ardmore | Carter | (580) 223-9705 |
| Atoka | Atoka | (580) 889-2216 |
| Bartlesville | Washington | (918) 335-3005 |
| Beaver | Beaver | (580) 625-3693 |
| Beggs | Okmulgee | (918) 267-3606 |
| Blackwell | Kay | (580) 363-5520 |
| Blanchard | McClain | (405) 485-3319 |
| Bristow | Creek | (918) 367-3341 |
| Chandler | Lincoln | (405) 258-2640 |
| Checotah | McIntosh | (918) 473-5416 |
| Chickasha | Grady | (405) 224-2022 |
| Claremore | Rogers | (918) 341-3166 |
| Clayton | Pushmataha | (918) 569-7973 |
| Cleveland | Pawnee | (918)-358-2546 |
| Clinton | Custer | (580) 323-2100 |
| Coalgate | Coal | (580) 927-2367 |
| Coweta | Wagoner | (918) 486-2845 |
| Cushing | Payne | (918) 225-3377 |
| Drumright | Creek | (918) 352-9581 |

| City | County | Telephone |
|---|---|---|
| Duncan | Stephens | (580) 252-0270 |
| Durant | Bryan | (580) 924-4285 |
| El Reno | Canadian | (405) 262-0042 |
| Elk City | Beckham | (580) 225-1173 |
| Enid | Garfield | (580) 233-0650 |
| Eufaula | McIntosh | (918) 689-7774 |
| Fairview | Major | (580) 227-3362 |
| Frederick | Tillman | (580) 335-2163 |
| Guthrie | Logan | (405) 282-3485 |
| Guymon | Texas | (580) 338-8544 |
| Healdton | Carter | (580) 229-1291 |
| Henryetta | Okmulgee | (918) 652-8250 |
| Hobart | Kiowa | (580) 726-3316 |
| Holdenville | Hughes | (405) 379-3313 |
| Hollis | Harmon | (580) 688-3348 |
| Hugo | Choctaw | (580) 326-8821 |
| Idabel | McCurtain | (580) 286-6620 |
| Jay | Delaware | (918) 253-4511 |
| Kingfisher | Kingfisher | (405) 375-3008 |
| Lawton | Comanche | (580) 248-5890 |
| Lindsay | Garvin | (405) 756-2928 |
| Madill | Marshall | (580) 795-3705 |
| Mangum | Greer | (580) 782-5531 |
| Marietta | Love | (580) 276-2531 |
| McAlester | Pittsburg | (918) 423-1267 |
| Medford | Grant | (580) 395-2906 |
| Miami | Ottawa | (918) 540-2481 |

| City | County | Telephone |
|---|---|---|
| Moore | Cleveland | (405) 794-1591 |
| Muskogee | Muskogee | (918) 683-0321 |
| Norman | Cleveland | (405) 321-4048 |
| Okemah | Okfuskee | (918) 623-1800 |
| Oklahoma City | Oklahoma | (405) 427-8651 |
| Okmulgee | Okmulgee | (918) 756-1883 |
| Pauls Valley | Garvin | (405) 238-7346 |
| Pawnee | Pawnee | (918) 762-3643 |
| Perry | Noble | (580) 336-2257 |
| Ponca City | Kay | (580) 762-1641 |
| Poteau | LeFlore | (918) 647-8601 |
| Pryor | Mayes | (918) 825-4224 |
| Purcell | McClain | (405) 527-6541 |
| Sallisaw | Sequoyah | (918) 775-6201 |
| Sapulpa | Creek | (918) 224-5531 |
| Sayre | Beckham | (580) 928-5551 |
| Seminole | Seminole | (405) 382-4369 |
| Shawnee | Pottawatomie | (405) 273-2157 |
| Stigler | Haskell | (918) 967-3304 |
| Stillwater | Payne | (405) 372-8200 |
| Stilwell | Adair | (918) 696-7292 |
| Sulphur | Murray | (580) 622-3716 |
| Tahlequah | Cherokee | (918) 456-8826 |
| Talihina | LeFlore | (918) 567-2141 |
| Tishomingo | Johnston | (580) 371-2470 |
| Tulsa | Tulsa | (918) 582-9355 |
| Vinita | Craig | (918) 256-7531 |

| City | County | Telephone |
|---|---|---|
| Wagoner | Wagoner | (918) 485-3022 |
| Walters | Cotton | (580) 875-6121 |
| Watonga | Blaine | (580) 623-7977 |
| Waurika | Jefferson | (580) 228-2313 |
| Weatherford | Custer | (580) 323-2100 |
| Wewoka | Seminole | (405) 382-4369 |
| Wilburton | Latimer | (918) 465-5673 |
| Woodward | Woodward | (580) 256-6416 |
| Yukon | Canadian | (405) 354-4872 |

# HEALTH AND SAFETY RESOURCES FOR CHILDREN

| | |
|---|---|
| American Diabetes Association | (888) DIABETES<br>(405) 840-3881<br>www.diabetes.org |
| American Dietetic Association<br>Consumer Hotline | (800) 366-1655<br>www.eatright.org |
| American with Disabilities Act Information<br>Hotline (Department of Justice) | (800) 514-0301 (voice)<br>(800) 514-0383 (TDD)<br>www.usdoj.gov or www.ada.gov |
| American Heart Association | (800) 242-8721<br>(405) 942-2444 (OKC Area)<br>www.americanheart.org |
| American Lung Association | Oklahoma City (405) 748-4674<br>Tulsa (918) 747-3441<br>www.oklung.org or www.lungusa.org |
| American Red Cross | Oklahoma City (405) 228-9500<br>Tulsa (918) 831-1100<br>www.redcross.org<br>www.okc.redcross.org |
| Center for Early Childhood<br>Professional Development (CECPD) | (888) 446-7608<br>(405) 799-6383<br>www.cecpd.org |
| Center for Disease Control and Prevention | (800) 311-3435<br>www.cdc.gov |
| CHADD – Children & Adults with<br>Attention Deficit/Hyperactivity Disorder | (800) 233-4050<br>www.chadd.org |
| Child Abuse Hotline | (800) 522-3511 |
| Child & Family WebGuide – describes trustworthy websites on topics of interest to parents and professionals | www.cfw.tufts.edu/ |

| | |
|---|---|
| Consumer Product Safety Commission | (800) 638-CPSC (2772)<br>www.cpsc.gov |
| ECAO<br>Early Childhood Association of Oklahoma | (405) 607-4089<br>(866) 813-ECAO (3226)<br>www.ecaok.org |
| Emergency Medical Services for Children<br>Resource Center (First Care) | (405) 271-3307<br>www.emsc.ouhsc.edu |
| Epilepsy Association of Oklahoma | (405) 271-3232 |
| National Association of Family Child Care<br>(NAFCC) | (800) 359-3817<br>www.nafcc.org |
| National Association for the Education<br>of Young Children (NAEYC) | (800) 424-2460<br>www.naeyc.org |
| National Center on Shaken Baby Syndrome | (888) 273-0071<br>www.dontshake.com |
| National Child Care Information Center | (800) 616-2242<br>www.nccic.org |
| National Food Service Management Institute<br>Mealtime Memo for Child Care | (800) 321-3054<br>www.nfsmi.org |
| National Resource Center for Health and<br>Safety in Child Care | (800) 598-KIDS (5437)<br>nrc.uchsc.edu |
| Oklahoma Child Care Resource &<br>Referral Association | (888) 962-2772<br>www.oklahomachildcare.org |
| Oklahoma Child Care Warmline | (888) 574-5437 |
| Oklahoma Dept. of Human Services<br>Oklahoma Child Care Services | (405) 521-3561<br>(800) 347-2276<br>www.okdhs.org |
| Oklahoma Department of Public Safety | (405) 425-2424<br>www.dps.state.ok.us |
| Oklahoma Poison Control Center | (800) 222-1222<br>(405) 271-5062 (OKC Area)<br>www.oklahomapoison.org |

| | |
|---|---|
| Oklahoma Safety Council | (800) 580-7238<br>(405) 848-8626<br>www.oksafety.org |
| Safe Kids Oklahoma | (405) 271-5695<br>www.oksafekids.org |
| Safe Kids USA | www.usa.safekids.org |
| Smart Start Oklahoma | (405) 278-6978<br>www.smartstartok.org |
| SoonerCare (free health care for children) | (800) 522-0310<br>(405) 522-7171<br>www.okhca.org |
| SoonerStart (early intervention for children) | (800) 42-OASIS (426-2747 |
| **Oklahoma State Department of Health** | (405) 271-5600 |
| Child Care Warmline | (888) 574-5437 |
| Child Guidance Program | (405) 271-4477 |
| Child & Adolescent Health Division | (405) 271-4471 |
| Early Childhood/Health Child Care | (405) 271-4471 |
| Immunization Information | (405) 271-4073 |
| SIDS Program | (405) 271-4471 |
| Website | **www.health.ok.gov** |

# QUALITY INCLUSIVE CHILD CARE CHECKLIST

- ☐ Are families and children welcomed, and are children greeted in a loving, respected way? Are parents welcome at anytime during the day?
- ☐ Is the overall atmosphere bright, cheerful and child-focused, without being overwhelming?
- ☐ Do you notice caregivers/teachers really listening to children and families? Are caregiving and teaching practices responsive to differences in children's abilities, interests and experiences?
- ☐ Are the sounds of children predominantly happy? Does it appear that the adults and children enjoy being together?
- ☐ Is the physical environment safe, secure and free of barriers that limit or prevent access and mobility (e.g., ramps, outside play area, bathrooms)?
- ☐ Is there a fenced-in outdoor play area with a variety of safe equipment? Can the caregivers/teachers see the entire play yard at all times?
- ☐ Are learning materials and toys sufficient, safe, clean and within reach of all children? Are there enough for the number of children?
- ☐ Are there different areas for resting, quiet play and active play? Is there enough space for the children in all of these areas?
- ☐ Is there a daily balance of active and quiet activities (e.g., play time, story time, activity time and nap time)? Are the activities appropriate for each ability and age level?
- ☐ Are the majority of planned developmental activities individualized or in small groups?
- ☐ Do learning materials, books and pictures reflect diversity, including children with special needs?
- ☐ Do caregivers/teachers use a variety of instructional strategies to meet the individual needs of children?
- ☐ Do caregivers/teachers facilitate or enhance interactions between children with and without disabilities?

- ☐ Are children with disabilities included socially and engaged in meaningful activities throughout the day?
- ☐ Are children with disabilities given support and assistance when needed, and is it unobtrusive?
- ☐ Does the program accept children who are not yet walking or toilet-trained?
- ☐ Are therapeutic and/or support services such as OT, PT and Speech Therapy welcomed and provided on-site?
- ☐ Are parent's ideas welcomed? Are there ways for families to be involved in the program?
- ☐ Does communication between parents and staff seem open and ongoing? Are events and information shared with families regularly?
- ☐ Is the program licensed by the state? Is the program accredited or working towards national accreditation?

# WEBSITE GUIDE FOR DEVELOPMENTAL RESOURCES

**American Academy of Pediatrics** **www.aap.org/topics**

Health information categorized by developmental stages and by topic.

**Bright Futures Oral Health Toolbox** **www.mchoralhealth.org/Toolbox**

Oral health care information, including printable information and links to other resources.

**Center for Disease Control and Prevention Child Development** **www.cdc.gov/ncbddd/childdevelopment.htm**

An overview of child development and links to positive parenting tips for infants and children birth through eight years of age.

**Center for Disease Control and Prevention National Center on Birth Defects and Developmental Disabilities** **www.cdc.gov/ncbddd/**

Information related to the prevention of birth defects and links to specific information on birth defects, developmental disabilities, blood disorders and human development.

**Center for Disease Control and Prevention Act Early** **www.cdc.gov/ncbddd/autism/ActEarly/**

Information on development screening and typical developmental milestones for children from three months to five years of age.

**Center for Disease Control and Prevention Immunization Schedule** **www.cdc.gov/nip/recs/child-schedule.htm**

English and Spanish versions of the immunization schedule for children and adolescents, along with information on immunizations, recent changes and vaccinations for adults.

**Child Care Provider Warmline** **1-888-574-5437**

This toll free number provides telephone consultation for Oklahoma child care providers regarding children's health and development, learning and behavior, and family relationships. View the list of Warmline topics at:

**www.okdhs.org/programsandservices/cc/spinit/docs/Warmline.htm**

**Oklahoma State Department of Health**
**Child Guidance Program** **www.health.ok.gov/program/cgp/pub.html**

Publications in English and Spanish on children's development and behavior.

**Pathways Awareness Foundation** **www.pathwaysawareness.org**

Information about children's physical development with guidelines on what to do if you have concerns and a printable growth and development chart that allows you to track a child's physical, play and speech milestones.

**Zero to Three** **www.zerotothree.org**

Information on early brain and child development during the first 36 months of life.

# AUTHORIZATION FOR MEDICATION ADMINISTRATION

I hereby authorize designated agents of (name of facility)
_____
to administer the following medication to my child,
_____. I further agree to indemnify and hold harmless this facility, their agents, and servants against all claims as a result of any and all acts performed under this authority.

Parent/Guardian Name _____

Telephone _____

My child's health care provider is _____

Telephone _____

My child's condition is

_____

Purpose of medication is
_____

Time of administration _____

Name of medication _____

Duration of administration _____

Method of administration _____

Possible side effects
_____

In case of emergency, contact
_____

Telephone_____

Today's Date _____

Monthly Medication Record on back to be completed by person administering medication.

# Monthly Medication Log

Name of Child

| Dates to administer | Dosage amount | Time of administration | Staff signature and time given | Staff signature and second time given (if required) | Parent initial to acknowledge administration |
|---|---|---|---|---|---|
| Monday Date: | | | | | |
| Tuesday Date: | | | | | |
| Wednesday Date: | | | | | |
| Thursday Date: | | | | | |
| Friday Date: | | | | | |
| Monday Date: | | | | | |
| Tuesday Date: | | | | | |
| Wednesday Date: | | | | | |
| Thursday Date: | | | | | |
| Friday Date: | | | | | |
| Monday Date: | | | | | |
| Tuesday Date: | | | | | |
| Wednesday Date: | | | | | |
| Thursday Date: | | | | | |
| Friday Date: | | | | | |
| Monday Date: | | | | | |
| Tuesday Date: | | | | | |
| Wednesday Date: | | | | | |
| Thursday Date: | | | | | |
| Friday Date: | | | | | |

Any additional comments and/or observation should be recorded with staff's initials.

Completed form and corresponding documentation is to be kept on-site in the child's file.

# CCHP Health and Safety Checklist – Revised

*Developed by the California Childcare Health Program, administered by University of California, San Francisco (UCSF) School of Nursing (www.ucsfchildcarehealth.org). 2005.*

CALIFORNIA CCHP CHILDCARE HEALTH PROGRAM

Program Name / ID #: _____

Classroom Name / ID #: _____

Date: _____

Observer: _____

Time Begin: _____AM/PM

Time End: _____AM/PM

**CODES**

C Completely Meets Standard

NC Does Not Completely Meet Standard

N/A Not Applicable

Adopted and revised to Oklahoma licensing standards for Oklahoma Child Care Resource and Referral Association's Child Care Health Consultant HSEP Project. 2006

**INDOOR:**

| **Emergency Prevention/Poisons** | **C** | **NC** | **N/A** | **Notes** |
|---|---|---|---|---|
| 1. Emergency telephone numbers are posted for emergency services (for example, 911, poison control, fire department, police and children's protective services) near all program phones. | | | | |
| 2. Emergency procedures are posted for fire and earthquakes, and other regional natural disasters (tornados, floods, hurricanes) in each classroom. | | | | |
| 3. If natural disasters occur in a region, a 48-hour supply of food and water is stored for each child and staff member. | | | | |
| 4. An evacuation map is posted in each classroom. | | | | |
| 5. There is a smoke detector system, alarm or sprinklers in working order in each room or place where children spend time. | | | | |
| 6. Water that may be in direct contact with children is no more than 120° F. | | | | |
| 7. All heating units/fireplaces in children's reach are covered with barriers. | | | | |
| 8. All electrical outlets in children's reach are covered. | | | | |
| 9. Earthquake/Tornado safety: There are no heavy objects on open shelves and/or cabinets over 3 feet (for example, prevent falling objects). | | | | |
| 10. Earthquake/Tornado safety: All tall furniture over 4 feet (for example, cubbies, shelves) are bolted to the wall or floor. | | | | |
| 11. First Aid: Each classroom and area where children spend time has at least one fully equipped, readily available first aid kit. | | | | |
| 12. First Aid: The program has a separate fully equipped first aid kit for outdoor play area and all field trips. | | | | |
| 13. Poisons: Cleaning agents are labeled and stored (except bleach solution) in their original containers. | | | | |
| 14. Poisons: Cleaning agents are kept separate from food in cabinets and out of children's reach. | | | | |
| 15. Air quality: Temperature is between 65° F and 80° F at all times | | | | |
| 16. Air quality: There are no bad odors or fumes (for example, tobacco, mildew, urine/excrement, chemicals, air fresheners). | | | | |

Adopted and revised to Oklahoma licensing standards for Oklahoma Child Care Resource and Referral Association's Child Care Health Consultant HSEP Project. 2006

| Staff and Children's Possessions | C | NC | N/A | Notes |
|---|---|---|---|---|
| 17. Children's personal belongings (including clothing and bedding) are stored so they do not touch others' belongings. | | | | |
| 18. Adult purses/backpacks are out of reach of children. | | | | |

**Special Needs**

**Medications: Are there children's medications at the program?**

_____ Yes—continue with question #s 19 – 22.

_____ No—skip to question # 23.

| | | | | |
|---|---|---|---|---|
| 19. Medications are labeled with the child's name and are prescribed medications only. | | | | |
| 20. Medications are stored out-of-reach of children and they are in their original and childproof container. | | | | |
| 21. Medications are labeled with a date that shows it is not expired. | | | | |
| 22. Medications are labeled with the administration instructions and are refrigerated (if needed). | | | | |
| 23. The names of children with special dietary needs and a description of their needs (including specific food allergies) are posted in food *preparation* area(s). | | | | |
| 24. The names of children with special dietary needs and a description of their needs (including specific food allergies) are posted in the child's classroom and separate eating areas (if applicable). | | | | |

**Handwashing**

| | | | | |
|---|---|---|---|---|
| 25. Proper handwashing procedures are posted at all handwashing sinks, including food preparation and art sinks. | | | | |
| 26. Children's handwashing sink(s) are at child's level or accessible by a safety step. | | | | |
| 27. Staff wash their hands with liquid or foam soap and running water after each toileting/diapering of children | | | | |
| 28. Staff wash their hands with liquid or foam soap and running water before food preparation and/or service. | | | | |
| 29. Children wash their hands, or have their hands washed, with liquid or foam soap and running water after each toileting/diapering.<br>Total # of children observed after toileting/diapering_____<br># of children observed washing correctly_____ | | | | |

Adopted and revised to Oklahoma licensing standards for Oklahoma Child Care Resource and Referral Association's Child Care Health Consultant HSEP Project. 2006

| | C | NC | N/A | Notes |
|---|---|---|---|---|
| 30. All children who feed themselves wash their hands, or have their hands washed, with liquid or foam soap and running water before eating.<br>Total # of children observed before eating_____<br># of children observed washing correctly_____ | | | | |
| 31. All children wash their hands, or have their hands washed, with liquid or foam soap and running water after eating.<br>Total # of children observed after eating_____<br># of children observed washing correctly_____ | | | | |

## Food Preparation/Eating/Sanitation

| | | | | |
|---|---|---|---|---|
| 32. No perishables, including food brought in by children (for example, meat, fish, poultry, milk, bottles of formula/breast milk, eggs) are left out of the refrigerator for more than one hour. | | | | |
| 33. Food preparation areas are separate from the eating and play areas. | | | | |
| 34. Food preparation and eating areas, including counters, tabletops and floors, are cleaned/swept before and after food preparation and meals. | | | | |
| 35. Food preparation areas are separate from the toilet, bathroom and diaper-changing areas. | | | | |
| 36. Refrigerators have a thermometer and are equal to or less than 41° F. | | | | |
| 37. Children under 2 years old do not have food that causes choking, even if brought from home (for example, nuts, popcorn, candy, whole grapes, hot dog rounds, chunks of meat, spoonfuls of peanut butter, carrots). | | | | |
| 38. A current weekly menu of all food and beverages served in the program is posted in every classroom and the parent area and/or board. | | | | |
| 39. There is a designated area (for example, sink) or container, out of children's reach, for mouthed or contaminated toys. | | | | |

## Oral Health

| | | | | |
|---|---|---|---|---|
| 40. All children (over 35 months of age) brush their own teeth or have their teeth brushed at least once a day. | | | | |
| 41. Toothbrushes are labeled with the child's name and stored safely without touching other toothbrushes. | | | | |

**Outdoor**

| | | | | |
|---|---|---|---|---|
| Number of adults _____Number of children _____<br>Outdoor staff to child ratios (# adults: # children)_____ | | | | |

Adopted and revised to Oklahoma licensing standards for Oklahoma Child Care Resource and Referral Association's Child Care Health Consultant HSEP Project. 2006

| 42. Adult staff are present in all outdoor areas and provide direct supervision. | C | NC | N/A | Notes |
|---|---|---|---|---|
| 43. All children are always visible by an adult staff member while outside. | | | | |
| 44. Outdoor areas are maintained and are clean and safe; no trash, broken equipment, sharp objects, splinters, glass, animal excrement present. | | | | |
| 45. Helmets are worn by all children when riding bicycles, tricycles or other riding toys/equipment. | | | | |
| 46. Outdoor stationary playground equipment is stable and set in secure concrete settings and equipment does not wobble or tip when shaken. | | | | |
| 47. All pieces of outdoor playground equipment over 9 or more inches high have shock-absorbing surfaces underneath them such as; loose fine sand, woodchips, mulch or approved rubber mats | | | | |
| 48. Shock-absorbing surfaces (fine sand, woodchips, mulch or approved mats) under outdoor playground equipment extend at least 6 feet beyond the perimeter of the equipment. | | | | |
| 49. All fixed outdoor playground equipment has a minimum of 6 feet clearance space from walkways, buildings and other structures that are not used as part of play activities. | | | | |
| 50. The outdoor play area is enclosed with a fence or natural barrier that allows observation of children. | | | | |
| 51. Outdoor fences/barriers have at least two exits. | | | | |
| 52. Outdoor fences/barriers have self-closing gates with self-latching mechanisms that cannot be opened by children. | | | | |
| 53. Openings on outdoor playground equipment, fences and handrails are either less than $3^{1}/_{2}$ inches or greater than 9 inches wide. | | | | |

**Indoor**

Number of adults_____ Number of children _____

Indoor staff to child ratios (# adults: # children)_____

| | | | | |
|---|---|---|---|---|
| 54. Indoor climbing equipment is over approved mats that extend at least 6 feet from the structure. | | | | |
| 55. Indoor climbing equipment is a maximum height (for example, 3 feet for 3 year olds, 4 feet for 4 year olds, 5 feet for 5 year olds). | | | | |

Adopted and revised to Oklahoma licensing standards for Oklahoma Child Care Resource and Referral Association's Child Care Health Consultant HSEP Project. 2006

| **IT General**<br><br>This section is to be completed by programs that have children 0-35 months. If the program does not have children of this age, please note on the CCHP H&C Checklist and skip to the Diapering section. | **C** | **NC** | **N/A** | **Notes** |
|---|---|---|---|---|
| 56. Toys and objects have diameters equal to or greater than $1^{1}/_{4}$ inches and lengths equal to or greater than $2^{1}/_{4}$ inches. | | | | |
| 57. Staff observe proper body mechanics when lifting and picking up children and heavy loads (for example, bend at knees, load close to body, no twisting, push don't pull, get help for heavy loads). | | | | |

**Diapering**

This section is to be completed on children who use diapers or pull-ups. If the program does not have children who are in diapers or pull-ups, please note this on the CCHP H & S Checklist and skip to the IT Food Preparation/Eating section.

| | | | | |
|---|---|---|---|---|
| 58. A complete and accurate diaper-changing protocol is posted in diaper-changing area(s). | | | | |
| 59. Diapering protocol: A clean, disposable non-absorbent liner is used on the diaper-changing surface with each diapering. | | | | |
| 60. Diapering protocol: Soiled diapers are removed without contaminating the diaper-changing surface, child and provider. | | | | |
| 61. Diapering protocol: Soiled clothes are placed in a plastic bag after changing and stored in the child's cubby for parent pick-up. | | | | |
| 62. Diapering protocol: Soiled diapers are disposed of in a covered, plastic-lined receptacle operated by a foot pedal. | | | | |
| 63. Diapering protocol: Staff always keep one hand on the child during diapering. | | | | |
| 64. Disposable gloves are available in the diaper-changing area(s). | | | | |
| 65. Diaper-changing surfaces are at adult height, in good repair and sturdy. | | | | |
| 66. Diaper-changing surfaces are water-resistant, non-absorbent and smooth. | | | | |
| 67. Diaper-changing surfaces are cleaned and sanitized after each use. | | | | |
| 68. Children under 36 months, who are not able to do so themselves, have their hands washed by a staff person with liquid or foam soap and running water (for infants with no head control a moistened towel with soap may be substituted) after diapering/toileting. | | | | |
| 69. Children who are able to do so themselves, wash their own hands with liquid or foam soap and running water after diapering/toileting. | | | | |
| 70. Staff wash their own hands with liquid or foam soap and running water after each diapering/toileting of a child. | | | | |

Adopted and revised to Oklahoma licensing standards for Oklahoma Child Care Resource and Referral Association's Child Care Health Consultant HSEP Project. 2006

| IT Food Preparation/Eating<br><br>This section is to be completed by programs that have children 0-35 months. If the program does not have children of this age, please note on the CCHP H&C Checklist and skip to the Sleeping/Napping section. | C | NC | N/A | Notes |
|---|---|---|---|---|
| 71. Bottles with formula in the refrigerator are labeled with the individual child's name and dated within two days of the observation visit. | | | | |
| 72. Breast milk in the refrigerator is labeled with the individual child's name and dated within two days of the observation visit. | | | | |
| 73. Breast milk in the freezer is labeled with the individual child's name and dated within three months of the observation visit. | | | | |
| 74. Breast milk is thawed under running cold water or in the refrigerator, not heated in the microwave or in boiling water. | | | | |
| 75. Infants too young to sit up are held by an adult while being fed, and infants able to sit up and toddlers eat sitting up. | | | | |
| 76. Oral Health: Children under 36 months have their gums and/or teeth wiped with either a disposable cloth or gauze, or brushed at least once a day. | | | | |
| **Sleeping/Napping**<br><br>All cribs: Does the program have cribs?<br>_____Yes—continue with question # 78.<br>_____No—end the CCHP H & S Checklist here. | | | | |
| 77. Cribs are made of wood, metal or plastic and have mattresses that fit (for example, no more than two fingers can fit between the mattress and the crib). | | | | |
| 78. Cribs have secured latching devices and slats spaced no more than $2\frac{3}{8}$ inches apart. | | | | |
| 79. Cribs do not have corner post extensions over $\frac{1}{16}$ of an inch and do not have cutouts in the head or footboards. | | | | |
| 80. All infants under 12 months are put to sleep on their backs. | | | | |
| 81. No soft bedding is accessible to children under 12 months in their sleeping area(s). | | | | |

Adopted and revised to Oklahoma licensing standards for Oklahoma Child Care Resource and Referral Association's Child Care Health Consultant HSEP Project. 2006

| | | | | |
|---|---|---|---|---|
| 82. All cribs, cots, mats or other sleeping places are at least 36" apart, unless separated by a solid barrier. | | | | |

## Total and Average Score

| | # Completely Met | # of Items Scored | Average Score |
|---|---|---|---|
| **Emergency Prevention/Poisons** | _____ | _____ | _____ |
| **Staff and Children's Possessions** | _____ | _____ | _____ |
| **Special Needs/Medications** | _____ | _____ | _____ |
| **Handwashing** | _____ | _____ | _____ |
| **Food Preparation/Eating/Sanitation** | _____ | _____ | _____ |
| **Oral Health** | _____ | _____ | _____ |
| **Outdoor Equipment** | _____ | _____ | _____ |
| **Indoor Equipment** | _____ | _____ | _____ |
| **Infant/Toddler General** | _____ | _____ | _____ |
| **Diapering** | _____ | _____ | _____ |
| **I/T Food Preparation/Eating** | _____ | _____ | _____ |
| **Sleeping/Napping** | _____ | _____ | _____ |
| **TOTAL** | _____ | _____ | _____ |

Adopted and revised to Oklahoma licensing standards for Oklahoma Child Care Resource and Referral Association's Child Care Health Consultant HSEP Project. 2006

Name of Child Care Facility: _____

| DATE | TIME | FIRE | TORNADO | OFF-SITE EVACUATION | LOCATION | NAME/SIGNATURE OF PERSON OBSERVING DRILL |
|---|---|---|---|---|---|---|
| | | | | | | |
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**Emergency Response Drill Log**

# INJURY REPORT FORM

Fill in all blanks and boxes that apply

Name of Program: _____Phone: _____

Address of Facility: _____

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

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

Name of Legal Guardian/Parent Notified: _____

Notified by: _____

Time Notified: _____:_____ am/pm

EMS (911) or other medical professional □ Not notified □ Notified

Time Notified: _____:_____ am/pm

Location where incident occurred: □ playground □ classroom □ bathroom □ hall □ kitchen □ doorway □ large muscle room or gym □ office □ dining room □ unknown □ other (specify)

_____

Equipment/product involved: □ climber □ slide □ swing □ playground surface □ sandbox □ trike/bike □ hand toy
(specify):_____

□ other equipment (specify):

_____

Cause of injury: (describe)

_____

□ fall to surface; estimated height of fall _____ feet;
type of surface: _____
□ fall from running or tripping □ bitten by child □ motor vehicle □ hit or pushed by child □ injured
by object
□ eating or choking □ insect sting/bite □ animal bite □ injury from exposure to cold □ other
(specify):

_____

_____

Parts of body injured: ☐ eye ☐ ear ☐ nose ☐ mouth ☐ tooth ☐ other part of face ☐ other part of head ☐ neck arm/wrist/hand ☐ leg/ankle/foot ☐ trunk other (specify_____

Type of injury: ☐ cut ☐ bruise or swelling ☐ puncture ☐ scrape ☐ broken bone or dislocation ☐ sprain ☐ crushing injury ☐ burn ☐ loss of consciousness ☐ unknown ☐ other (specify):
_____

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

_____

Treatment provided by:_____

☐ no doctor's or dentist's treatment required
☐ treated as an outpatient (e.g., office or emergency room)
☐ hospitalized (overnight) # of days: _____

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

Corrective action needed to prevent reoccurrence: _____

Name of official/agency notified: _____ Date:_____

Signature of staff member: _____ Date:_____

Signature of Legal Guardian/Parent: _____ Date:_____

copies: 1) child's folder 2) parent 3) injury log

# Notice of Exposure to Communicable Disease

Name of Child Care Program_____

Address of Child Care Program_____

Telephone Number of Child Care Program_____

Date _____

**Dear Parent or Legal Guardian:**

A child in our program has or is suspected of having: _____

**Information About this Disease**

This disease is spread by: _____

The symptoms are: _____

_____

The disease can be prevented by _____

_____

What the program is doing to reduce the spread: _____

_____

What you can do at home to reduce the spread: _____

_____

_____

If your child has any symptoms of this disease, call your health care provider to find out what to do and be sure to tell them about this notice. If you do not have a regular health care provider to care for your child, contact your health department for instructions on how to find one, or ask staff here for a referral. If you have any questions, please contact:

_____ at _____
(Caregiver's Name) (Telephone Number)

# Special Health Care Plan

The special health care plan provides information on appropriately accommodating the special health concerns and needs of this child while in child care.

**Name of Child:** _____ Date: _____

**Facility Name:** _____

**Description of condition(s):** (include description of difficulties associated with each condition)

_____
_____
_____
_____
_____
_____
_____

**Team Member Names and Titles** (parents of the child are to be included)
Care Coordinator (responsible for developing and administering the Special Health Care Plan):

_____
_____
_____
_____
_____

If training is necessary, then all team members will be trained.

☐ Individualized Family Service Plan (**IFSP)** attached

☐ Individualized Education Plan (**IEP)** attached

| **Outside Professionals Involved** | | **Telephone** |
|---|---|---|
| Health Care Provider (MD, NP, etc.): | _____ | _____ |
| Speech & Language Therapist: | _____ | _____ |
| Occupational Therapist: | _____ | _____ |
| Physical Therapist: | _____ | _____ |
| Other: | _____ | _____ |

**Communication**

How the team will communicate (notes, communication log, phone calls, meetings, etc.):

_____

_____

How often will team communication occur: ☐ Daily ☐ Weekly ☐ Monthly

☐ Bi-Monthly ☐ Other

**Specific Medical Information**

Medical documentation and information provided and attached: ☐ Yes ☐ No

Medication to be administered: ☐ Yes ☐ No

☐ Medication Administration Form completed by health care provider and parents are in child's file on site (including: type of medication, method, amount, time schedule, potential side effects, etc.)

Any known allergies to foods and/or medications:

_____

Specific health-related needs: _____

_____

_____

_____

_____

Planned strategies to support the child's needs and any safety issues while in child care:
(diapering/toileting, outdoor play, circle time, nap/sleeping, etc.) _____

_____

_____

_____

_____

_____

_____

Plan for absences of personnel trained and responsible for health-related procedures(s):

_____

_____

Other (i.e., transportation, field trips, etc.): _____

_____

**Special Staff Training Needs**

Training monitored by: _____

1) Type (be specific): _____

Training done by: _____Date of Training: _____

2) Type (be specific):_____

Training done by: _____Date of Training: _____

3) Type (be specific): _____

Training done by: _____Date of Training _____

**Equipment/Positioning**

Physical Therapist (PT) and/or Occupational Therapist (OT) consult provided: ☐ Yes ☐ No ☐ Not Needed

Special equipment needed/to be used: _____
_____

Positioning requirements (attach additional documentation as necessary): _____
_____

Equipment care/maintenance notes: _____

**Nutrition and Feeding Needs**

☐ Nutrition and Feeding Care Plan completed by team is in child's file on-site.

**Behavior Changes** (be specific when listing changes in behavior that arise as a result of the health-related condition/concerns)

_____
_____
_____

**Additional Information** (include any unusual episodes that might arise while in care and how the situation should be handled)

_____
_____
_____

**Emergency Procedure**

☐ Special emergency and/or medical procedure required (additional documentation attached)

Emergency instructions: _____
_____
_____

Emergency contact: _____ Telephone: _____

**Follow-up: Updates/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: _____

# Symptom Record

Child's Name: _____

Date: _____ Symptoms: _____
_____
_____

When did symptoms begin, how often are they occurring, how severe do they seem?
_____
_____
_____

Any change in child's behavior? _____
_____

Child's temperature: _____ Time taken: _____

How much and what type of food and fluid did the child take in the past 12 hours?
_____
_____

How many and how typical/normal was urine and bowel movement in past 12 hours?
_____

Exposure to medication, animals, insects, soaps, new foods: _____
_____

Exposure to others who were sick and what sickness: _____
_____

Child's other problems that might affect this illness: (asthma, anemia, diabetes, allergy, emotional trauma) _____

What has been done so far? _____
_____

Advice from the child's health care provider: _____
_____

Name of person completing this form: _____

POISON Help™
1-800-222-1222

# Carbon Monoxide Fact Sheet

**What is carbon monoxide?**
Carbon monoxide (CO) is a very dangerous gas that people cannot see, taste or smell. It is made from incomplete burning of materials such as gasoline, charcoal and wood.

**Why is carbon monoxide so dangerous?**
Too much CO in your blood will kill you. When a person breathes CO, it goes into the organs instead of oxygen. People literally suffocate from the inside out. Hundreds of people die each year from breathing CO.

**Where does CO come from?**

- Kerosene or propane
- Space heaters
- Furnaces
- Gas oven or range top
- Gas water heater
- Gas clothes dryer
- Gasoline-powered engines
- Charcoal grills
- Fireplace/chimney

**What are the symptoms of CO poisoning?**
CO is sometimes called "The Great Imitator." This is because the minor symptoms are like the flu. It is sometimes hard to tell the difference between minor CO symptoms and the flu. This is one of the reasons CO detectors are so important.

**Minor Symptoms**
Headache
Nausea
Vomiting
Irritability
Chest pain in heart patients
Blurred vision

**Moderate Symptoms**
Minor Symptoms **plus**
Drowsiness
Weakness
Dizziness
Fainting
Severe headache
Difficulty thinking

**Severe Symptoms**
Moderate Symptoms **plus**
Increased heart rate
Blackout spells
Permanent brain damage
Coma
Convulsions/seizure
DEATH

A person does not always notice minor symptoms. In just one night, a person can have severe symptoms or even die from CO poisoning. This is why it is very important to have CO detectors properly installed in your home.

**When would I need to see a physician?**

- Any person exposed to CO and has moderate or severe symptoms (see above) should see a physician right away.
- Infants and elderly adults who have been exposed to CO should see a doctor, even if they have no symptoms.

- People who have heart problems should see a doctor if they have been exposed to CO.
- Pregnant women should see a doctor right away if exposed to CO. The fetus can suffer harm even if the woman has no symptoms.

**How can I protect myself from CO poisoning?**

- Place a CO detector near the sleeping area.
- Never use oven or gas ranges for heating purposes.
- All fuel burning appliances, furnaces, venting and chimney systems should be checked annually by a professional. CO detectors are not a substitute for yearly checks.
- Never use fuel-burning appliances, like a barbeque grill, in a confined area such as the garage or basement.
- Never burn charcoal inside your home, cabin, recreation vehicle or tent.
- Never leave the car running in the garage. Car exhaust contains CO. It can enter the home – even if the garage door is up.

**Where do I put a CO detector?**

All homes should have a CO detector near the sleeping areas. Other CO detectors should be put on each level of the house and near living areas. A CO detector should not be placed within 15 inches of heating or cooking appliances or in a humid area, such as the bathroom. Unlike smoke alarms, CO detectors can be placed at any height.

**What do I do if a carbon monoxide detector sounds?**

- Everyone should leave the house and get outside right away.
- Go to a doctor right away if anyone has had moderate or severe symptoms, has a history of heart problems, is pregnant, or if an infant has been exposed.
- Call your local gas company, fire department or appliance repair shop to come and find the source of the CO.
- DO NOT GO BACK INSIDE until the CO leak has been found and fixed.

**Oklahoma Poison Control Center**
**1-800-222-1222**
**OKC Area (405) 271-5454**
**www.oklahomapoison.org**

# A CHILD CARE PROVIDER'S GUIDE TO SAFE SLEEP

About 20% of Sudden Infant Death Syndrome (SIDS) deaths occur while an infant is being cared for by someone other than a parent. Many of these deaths occur when infants who are used to sleeping on their backs at home are then put to sleep on their tummies by another caregiver. This is sometimes referred to as "unaccustomed tummy sleeping".

**Who is at risk for SIDS?**

- SIDS is the leading cause of death for over 2,000 babies annually in the United States.
- It is the leading cause of death between 1 month and 12 months of age.
- It is most common among infants that are 2 – 4 months old.
- It is more common during the winter months.
- It is more common in male babies.

Because we don't know what causes SIDS, Safe Sleep Practices should be used to reduce the risk of SIDS in every infant under the age of one year.

**What can child care providers do?**

- Create and use a safe sleep policy. *Reducing the Risk of Sudden Infant Death Syndrome, Applicable Standards from Caring for Our Children National Health and Safety Performance Standards: Guidelines for Out of Home Child Care Programs* outlines what should be included in the safe sleep policy.
  Visit http://nrc.uchsc.edu/SPINOFF/SIDS/SIDS.htm to download a free copy.
- Practice SIDS reduction in your program by using the *Caring for Our Children* standards.
- Talk with a child care health consultant about health and safety in child care.
- Talk with families about infant sleep positioning.
- Don't smoke around babies, especially in the room where they sleep.
- Be able to respond to an infant medical emergency.
- Be aware of bereavement/grief resources.

**A Safe Sleep Policy Should Include the Following:**

- Healthy babies will always be placed on their backs to sleep. Side sleeping is not as safe as back sleeping and is not acceptable.
- A physician's note will be required for non-back sleepers, stating why the baby should not use the back-sleeping position.
- Safety-approved cribs with firm mattresses and a tight-fitting sheet will be used for all infants.
- Cribs will be kept free of toys, stuffed animals, bumper pads and extra bedding.
- If a blanket is used it will be only one thin blanket. Baby will be placed with feet at the foot of the crib. The blanket will come no higher than the infant's chest and be tucked in along the sides and foot of the mattress.
- Only one infant is assigned to each individual crib.
- Sleeping babies are visually checked on often.
- The room where infants sleep is maintained at a comfortable temperature.
- No smoking is allowed in the child care facility.
- Child care providers who smoke must do so outside, with an overcoat on. The overcoat is removed before entering the children's room.
- There will be supervised "tummy time" daily for babies when they are awake. This will help the babies strengthen their muscles and develop normally.
- Staff will receive training on **Sleep Safety** and **Sleep Safety Policies**, and it will be reviewed often.

If you need assistance creating your Safe Sleep Policies, contact a local child care health consultant to assist you in creating a policy that fits your child care facility.

**Tummy to Play and Back to Sleep**

Tummy time is playtime when infants are awake and placed on their tummies while someone is watching them. Have as much tummy time as possible to allow infants to develop normally. Limit time spent in freestanding swings, bouncy chairs, and car seats. These items all put added pressure on the back of the baby's head.

**Resources**

American Academy of Pediatrics
www.aappolicy.org

National Institute for Child and Human Development Back to Sleep Campaign
Order free educational materials from the Back to Sleep Campaign at
www.nichd.nih.gov/sids/sids.cfm

First Candle/SIDS Alliance
www.sidsalliance.org/

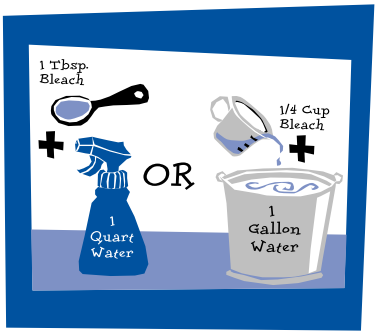
National SIDS and Infant Death Resource Center
www.sidscenter.org/

Association of SIDS and Infant Mortality Programs
www.asip1.org/

CJ Foundation for SIDS
www.cjsids.com/

STOP DISEASE

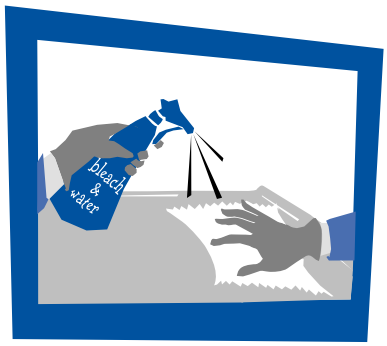
# CLEANING AND DISINFECTING



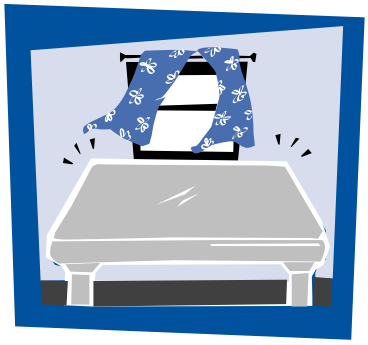

- Make a fresh bleach solution every day using:
  - 1 tablespoon bleach in 1 quart water

    -OR-
  - 1/4 cup bleach in 1 gallon water.


- Clean off any visible soil with soap and water.




- Disinfect by spraying with bleach solution. Wipe disinfectant over the surface with a paper towel. Leave glistening wet—do not dry off.



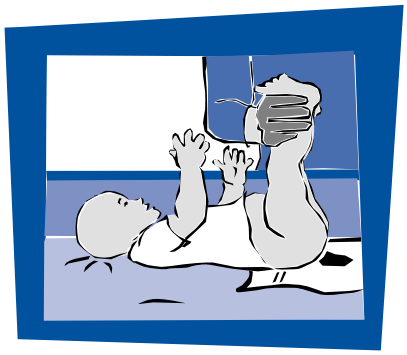
- Allow to air dry for 2 minutes.

STOP DISEASE

# DIAPERING PROCEDURES

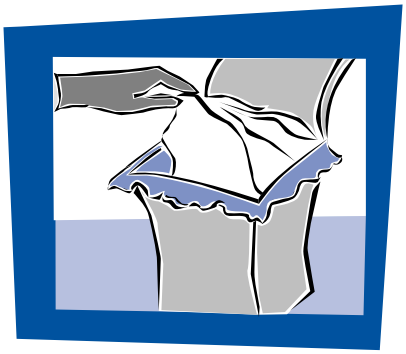
**1. Organize needed supplies within reach.**

- Wash your hands and gather what you need.
- Place a disposable cover on the diapering surface.



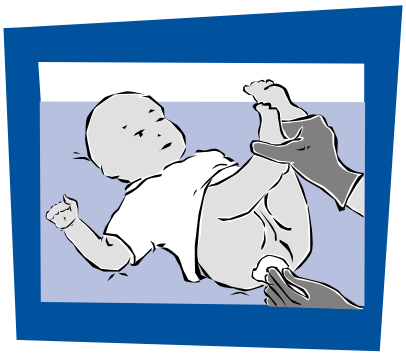
**2. Avoid contact with soiled items.**

- If using gloves, put them on now.
- Using only your hands, pick up the child.
- Provide steps for older children.
- Lay the child on the paper towel.
- Never leave the child unattended.



**3. Remove the soiled diaper.**

- Remove soiled diaper and soiled clothes.
- Fold the soiled surface inward.
- Put disposable diapers in a covered, plastic-lined trash can.
- Put soiled, reusable diaper and/or soiled clothes without rinsing in a plastic bag for parents.



**4. Clean the child's diaper area.**

- Use disposable wipes to clean and dry the child's bottom.
- If the child needs a more thorough washing, use soap, running water, and paper towels.
- Remove the disposable covering from beneath the child and discard it into a covered plastic-lined trash can.
- If you are wearing gloves, remove and dispose of them now into a covered, plastic-lined trash can.

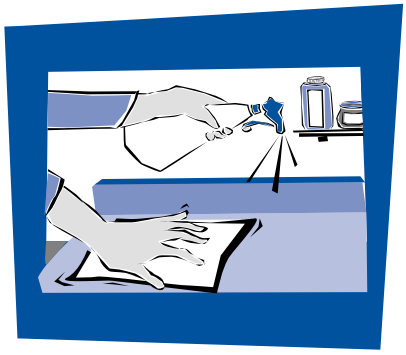
STOP DISEASE

# DIAPERING PROCEDURES

**5. Put on a clean diaper and dress the child.**

- Use a facial or toilet tissue to apply any necessary creams or ointments.
- Note and plan to report any skin problems such as redness.
- Slide a fresh diaper under the child, then adjust and fasten it. If pins are used, place your hand between the child and the diaper when inserting the pin.

**6. Wash the child's hands and return the child to a supervised area.**



**7. Clean and sanitize the diaper changing surface.**

- Clean and disinfect the diapering area, all equipment or supplies that were touched, and soiled crib or cot, if needed.


**8. Wash your own hands thoroughly.**

# Food Poisoning Fact Sheet

**What is food poisoning?**
Common foods may sometimes be poisoned by bacteria (germs). These germs cannot be seen by the human eye alone. Under certain circumstances, these germs can cause food poisoning. Poisonous foods may not smell or taste bad. Although most food poisoning will usually go away in 24 hours – some forms can be fatal.

**What are symptoms of food poisoning?**
Many different bacteria can cause food poisoning. Most of the symptoms caused by food poisoning are the same as those caused by stomach viruses. It is impossible to know the difference between food poisoning and a stomach virus without a stool culture. Some of the most common bacteria that cause food poisoning are salmonella, C. perfringens, staphylococcus and E. Coli. Symptoms can include: headache, fatigue, nausea, vomiting, diarrhea, dehydration, fever and abdominal pain. Food poisoning can also cause death, especially in high-risk groups such as the elderly, infants or individuals with an immune deficiency.

C. Botulinum is another bacteria that can cause food poisoning. Botulism is more common in improperly prepared home canned foods such as green beans. It is more rare, but often fatal. Symptoms include double vision, inability to move, trouble talking, difficulty swallowing, drooping eyelids, dry/sore throat.

**What food can cause food poisoning?**
The most common sources of poisoned food are meats, chicken, dairy products (milk, cheese, eggs, mayonnaise), home canned food (botulism), pure raw honey (infant botulism). Infants under one year old should not eat honey. Fish and shellfish can also cause food poisoning. Symptoms and treatment are different.

**What do I do if I think I or someone else might have food poisoning?**
Call the Oklahoma Poison Control Center. The Oklahoma Poison Control Center can help provide more information about when to see a doctor. The main concern is usually from dehydration or body fluid loss from vomiting and diarrhea. It is very easy for a child to become dehydrated. If food poisoning is suspected, it is important to drink plenty of fluids, especially water. Do not take anything to stop the vomiting or diarrhea unless recommended by a doctor. Medications for these symptoms can actually prolong them.

**When do I see a doctor?**
If you see blood in the vomit or stool, high fever (101° F), inability to keep fluids down and symptoms that last longer than a day, you should see a doctor. Parents of pediatric patients with fever and vomiting should contact their physician. Severity of symptoms varies with age and health. Elderly people and young infants with the same symptoms as healthy young adults can actually be much sicker.

**How do I avoid food poisoning?**
Food safety can help you prevent food poisoning.

**Shopping**

- Buy meats that are cold and tightly wrapped. Check eggs – do not buy cartons with cracked or broken eggs.
- Avoid cans with bulges, leaks or dents. Make sure lids and seals are not broken. If a product looks or smells bad – DO NOT taste it.
- Put refrigerated/frozen foods in your grocery cart last so they do not warm up while you shop.
- Keep meat and chicken away from other foods in your cart. Place these foods in plastic bags to keep juices from leaking out.
- If you travel more than one hour to get home – bring a cooler for food that could spoil. Make the store the last stop before heading home.

**Storing**

- Set your refrigerator at 40° F or colder, and your freezer at 0° F or colder.
- Put meat, chicken and dairy products in the refrigerator right away after returning from the grocery store.
- If you are not going to use meats within a few days, place them in the freezer. Wrap meats tightly in aluminum foil or freezer wrap.
- Use fresh or thawed meats as soon as possible.
-

**Preparing**

- Defrost foods in the refrigerator. If you must thaw in a hurry, do so in a watertight plastic bag and put in cool water. Never thaw food uncovered on a kitchen counter at room temperature. Cook food right away after thawing.
- Keep hands, utensils, cutting boards and sinks clean. Bacteria are easily spread by contaminated surfaces.
- Clean cutting boards often with a bleach solution. Mix 2 teaspoons of household bleach and 1 quart of warm water. Make sure to label the container. Use the mixture to clean the boards, then rinse them under cool running water. Plastic cutting boards are the best for meats. Do not use the same board to cut bread, produce or cooked meats.
- Always wash hands well with soapy water before, during and after preparing foods.
- Do not place foods on the same plate or surface that held raw meat or chicken. Wash the surface and utensils that have touched meat or chicken before using them to prepare other foods.
- Thoroughly cook meat, chicken and fish.
-

**Serving**

- Never leave cooked foods at room temperature for longer than two hours; if the room is warm, no longer than one hour.
- Put leftovers in the refrigerator right away. Do not wait for foods to cool down first.
- To re-heat leftovers, cover and heat to 165 F. Use leftovers within 3-4 days.

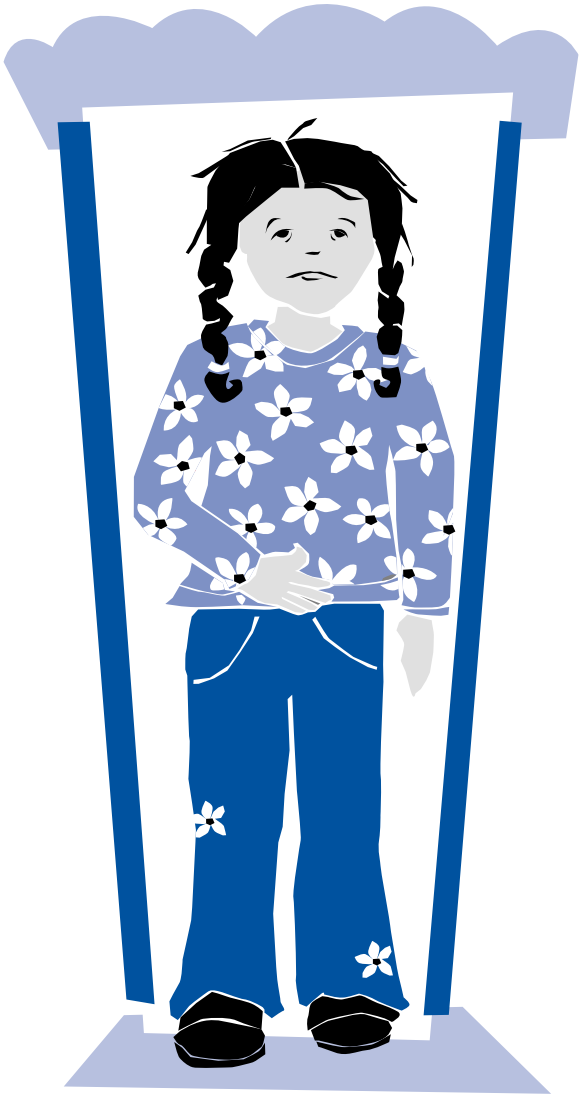
If you suspect food is spoiled -
DO NOT taste or eat it!
When in doubt, throw it out!

6/2007

**For questions or for more information, please call the**
**Oklahoma Poison Control Center**
**1-800-222-1222 or**
**OKC Area (405) 271-5454**

STOP DISEASE

# MORNING HEALTH CHECK



## Signs to Observe:

- General mood and changes in behavior
- Fever or elevated body temperature
- Skin rashes, unusual spots, swelling or bruises
- Complaints of pain and not feeling well
- Signs/symptoms of disease (severe coughing, sneezing, breathing difficulties, discharge from nose, ears or eyes, diarrhea, vomiting etc.)
- Reported illness in child or family members

## Use all of your senses . . .

- **LOOK** - for signs
- **LISTEN** - for complaints
- **FEEL** - for fever
- **SMELL** - for unusual odor

California Childcare Health Program
www.ucsfchildcarehealth.org

Rev. 01/03

# MyPyramid Worksheet

Name: _____

MyPyramid FOR KIDS

## Check how you did yesterday and set a goal to aim for tomorrow

| Write In Your Choices From Yesterday | Food and Activity | Tip | Goal (Based On a 1800 Calorie Pattern) | List Each Food Choice In Its Food Group* | Estimate Your Total |
|---|---|---|---|---|---|
| Breakfast: | **Grains** | Make at least half your grains whole grains. | **6 ounce equivalents** (1 ounce equivalent is about 1 slice bread, 1 cup dry cereal, or ½ cup cooked rice, pasta, or cereal) | | _____ ounce equivalents |
| Lunch: | **Vegetables** | Color your plate with all kinds of great tasting veggies. | **2½ cups** (Choose from dark green, orange, starchy, dry beans and peas, or other veggies). | | _____ cups |
| Snack: | **Fruits** | Make most choices fruit, not juice. | **1½ cups** | | _____ cups |
| Dinner: | **Milk** | Choose fat-free or lowfat most often. | **3 cups** (1 cup yogurt or 1½ ounces cheese = 1 cup milk) | | _____ cups |
| Physical activity: | **Meat and Beans** | Choose lean meat and chicken or turkey. Vary your choices—more fish, beans, peas, nuts, and seeds. | **5 ounce equivalents** (1 ounce equivalent is 1 ounce meat, chicken or turkey, or fish, 1 egg, 1 T. peanut butter, ½ ounce nuts, or ¼ cup dry beans) | | _____ ounce equivalents |
| | **Physical Activity** | Build more physical activity into your daily routine at home and school. | At least **60 minutes** of moderate to vigorous activity a day or most days. | | _____ minutes |

How did you do yesterday? ☐ Great ☐ So-So ☐ Not So Great

My food goal for tomorrow is: _____

My activity goal for tomorrow is: _____

* Some foods don't fit into any group. These "extras" may be mainly fat or sugar—limit your intake of these.

# Tips for Families

## Eat Right

1 **Make half your grains whole.** Choose whole-grain foods, such as whole-wheat bread, oatmeal, brown rice, and lowfat popcorn, more often.

2 **Vary your veggies.** Go dark green and orange with your vegetables—eat spinach, broccoli, carrots, and sweet potatoes.

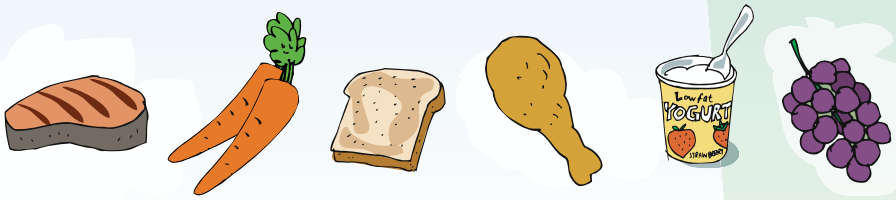
3 **Focus on fruits.** Eat them at meals, and at snack time, too. Choose fresh, frozen, canned, or dried, and go easy on the fruit juice.

4 **Get your calcium-rich foods.** To build strong bones serve lowfat and fat-free milk and other milk products several times a day.

5 **Go lean with protein.** Eat lean or lowfat meat, chicken, turkey, and fish. Also, change your tune with more dry beans and peas. Add chick peas, nuts, or seeds to a salad; pinto beans to a burrito; or kidney beans to soup.

6 **Change your oil.** We all need oil. Get yours from fish, nuts, and liquid oils such as corn, soybean, canola, and olive oil.

7 **Don't sugarcoat it.** Choose foods and beverages that do not have sugar and caloric sweeteners as one of the first ingredients. Added sugars contribute calories with few, if any, nutrients.




## Exercise

1 **Set a good example.** Be active and get your family to join you. Have fun together. Play with the kids or pets. Go for a walk, tumble in the leaves, or play catch.

2 **Take the President's Challenge as a family.** Track your individual physical activities together and earn awards for active lifestyles at *www.presidentschallenge.org*.

3 **Establish a routine.** Set aside time each day as activity time—walk, jog, skate, cycle, or swim. Adults need at least 30 minutes of physical activity most days of the week; children 60 minutes everyday or most days.

4 **Have an activity party.** Make the next birthday party centered on physical activity. Try backyard Olympics, or relay races. Have a bowling or skating party.

5 **Set up a home gym.** Use household items, such as canned foods, as weights. Stairs can substitute for stair machines.

6 **Move it!** Instead of sitting through TV commercials, get up and move. When you talk on the phone, lift weights or walk around. Remember to limit TV watching and computer time.

7 **Give activity gifts.** Give gifts that encourage physical activity—active games or sporting equipment.

**Have fun!**

# Nicotine Fact Sheet

Nicotine is found in cigars, cigarettes, cigarette butts, chewing tobacco (including spit from chewing tobacco) and nicotine gum or patches. Nicotine is a poison. Symptoms have been seen in children who have chewed as little as one-half piece of nicotine gum or bitten into one nicotine patch. Eating one or more cigarettes, three or more cigarette butts or more than one pinch of snuff is considered potentially toxic or poisonous to children. Infants are especially sensitive to nicotine.

Symptoms usually begin within 30 to 90 minutes. If in liquid form (for example, the spit from a chewing tobacco user) or gum form, symptoms may appear as soon as 15 to 30 minutes.

Dizziness, nausea or vomiting, stomach pain, weakness and increased drooling are symptoms of nicotine poisoning. Children can suffer abnormal blood pressure or heartbeat, slowed or interrupted breathing, general sluggishness, seizures and coma. Cats and dogs will show the same effects as children when exposed.

If you suspect nicotine poisoning:

- Do not wait for symptoms to appear
- Do not make the person throw up or vomit
- Do not give the person anything to eat or drink
- Call the Oklahoma Poison Control Center right away

4/2005

**For other questions or for more information, please call the Oklahoma Poison Control Center**

**1-800-222-1222**

**OKC Area (405) 271-5454**

**www.oklahomapoison.org**

# Plant Smarts

POISON HELP 1-800-222-1222

- Plants are everywhere. Young children are attracted to their lush leaves and bright berries. Some plants can be dangerous, even deadly. If you suspect a poisoning, call the poison center right away; do not wait for symptoms to appear. Poisonous plants, household cleaners and medicines are the three most common causes of accidental poisoning in children less than five years of age. Most serious poisonings involve adults who mistake a plant to be safe to eat, or for use in making tea.

## Plant Safety/Poison Prevention

- Keep plants, seeds, berries and bulbs stored safely away from children and pets. Stems, berries and leaves can be a choking hazard for children.
- Know the plants in your area, home and yard. Your local greenhouse, nursery or florist may be able to help identify plants. Label potted plants.
- Teach your children at an early age to keep plants, berries, flowers or mushrooms out of their mouths.
- Do not eat wild plants. Heating and cooking do not always destroy plant poisons.
- Remove all mushrooms from your yard.
- Do not allow children to suck on flowers or to make "tea" with plants and flowers.
- Never chew on jewelry made from seeds or beans.
- Do not make "hot dog roasting" sticks or toys from unknown bushes.
- Avoid smoke from burning plants unless you know their exact identification.
- Be especially cautious after spraying the yard or flowerbeds with a pesticide.

## First Aid for Plants

POISON HELP 1-800-222-1222

If exposed to a poisonous plant, follow these steps:

**Mouth**

- Remove any portion of the plant, berry or mushroom.
- Save a piece of the mushroom or plant in a brown paper bag for later identification.
- Wash out mouth with water or wipe with wet cloth. Check for any irritation, swelling or discoloration. Offer the patient a sip of water if they are not choking or coughing.
- Call the poison center. Bring the patient and plant to the phone. You will need at least a 10 inch sample of the plant including stem, leaves, fruit or seeds, and any flowers.

**Skin**

- A few plants may cause irritation, itching, and/or rash to the skin. To prevent further irritation, remove contaminated clothing and wash skin well with soap and water.
- Call the poison center. Bring the patient and plant to the phone.

**Eyes**

- Wash hands with soap and water to avoid irritation to the eye.
- Gently rinse eye with lukewarm tap water for 15 minutes.
- Call the poison center. Bring the patient and plant to the phone.

## List of Poisonous Plants in Oklahoma*

- Azaleas, Laurels, Rhododendron
- Black Locust
- Betel palm
- Caladium, Dumbcane, Elephant Ear
- English Ivy
- Golden Chain Tree
- Holly
- Hyacinth, Narcissus, Daffodil, Crocus
- Iris
- Kentucky Coffee Bean
- Larkspur, Delphinium
- Lobelia
- Lupina, Blue Bonnets
- Mistletoe
- Morning glory
- Periwinkle
- Poison Ivy
- Pokeweed, Pokeberry
- Potato, Tomato (leaves are toxic)
- Silver nightshade, Jerusalem Cherry
- Wisteria
- Yew

**MOST DANGEROUS**

- **Castor Bean, Jequirty pea**
- **Death Camus, Zigadenus**
- **Foxglove. Lilly of the Valley**
- **Henbane**
- **Jimson Weed, Angel Trumpet**
- **Monk's-hood, Wolfsbane**
- **Mushrooms -** Wild mushrooms should NEVER be ingested. One or two bites of poisonous types can be fatal.
- **Oleander**
- **Poison Hemlock**
- **Skunk cabbage, Corn Lily**
- **Water Hemlock**

*This list is designed to help you identify Oklahoma's poisonous plants. It is not intended to be all-inclusive.

## Did you know…?

- Plants that are safe for animals or birds can be poisonous to humans. If you see a plant or berry being eaten by an animal, this does not mean the plant is safe for people to eat. Birds safely eat poke and mistletoe berries, but these berries can be dangerous if consumed by people.
- The fluid from a poison ivy rash cannot give a poison ivy rash to another person. Only the plant's oil can cause this reaction in susceptible people. If you touch poison ivy, wash the area as soon as possible with soap and water. Also, wash anything else which may have been in contact, such as clothing, animals or camping gear.
- Poinsettia - Although previously thought a poisonous plant, recent studies have shown that the poinsettias may cause vomiting, but are not fatal.
- Pokeberries cannot be made safe for pies.

## Common Non-poisonous Plants*

Symptoms from eating or handling these plants are unlikely to occur. Plants that are not poisonous can be harmful if sprayed with pesticides. Remember, a plant leaf can easily block a child's airway.

| | |
|---|---|
| African Violet | Bamboo |
| Begonia (Pellionia sp.) | Boston Fern |
| Corn plant | Dandelion |
| Dracaena | Gloxinia |
| Hen-and-Chick | Impatiens |
| Jade Plant | Kalanchoe |
| Pansy | Petunia |
| Prayer Plant | Rose |
| Spider Plant | Swedish Ivy |
| Wandering Jew | Yucca |

*This list is not intended to be all-inclusive.

**Oklahoma Poison Control Center**
**1-800-222-1222**
**www.oklahomapoison.org**

Communicable Disease Division
Oklahoma State Department of Health

# REPORTABLE DISEASES/CONDITIONS IN OKLAHOMA

## The following diseases are to be reported to the OSDH by telephone, FAX, or PHIDDO immediately upon suspicion, diagnosis, or positive test.

Anthrax
Bioterrorism-suspected disease
Botulism
Brucellosis
Diphtheria
*H. influenzae* invasive disease
Hepatitis A (Anti-HAV-IgM +)
Measles (Rubeola)
Meningococcal invasive disease
Outbreaks of apparent infectious disease
Plague
Poliomyelitis
Rabies
Smallpox
Tularemia
Typhoid fever
Viral hemorrhagic fever

## The following diseases are to be reported to the OSDH within one business day

Acid Fast Bacillus (AFB) positive smear
AIDS (Acquired Immunodeficiency Syndrome)
Arboviral Infections
Campylobacteriosis
Congenital rubella syndrome
Cryptosporidiosis
Cyclosporiasis
Dengue Fever
*E. coli* O157,*E. coli* 0157: H7 or a shiga-like toxin producing *E. coli* (EHEC)
Ehrlichiosis
Encephalitis
Giardiasis
Hantavirus Pulmonary Syndrome
Hemolytic Uremic Syndrome, postdiarrheal
Hepatitis B (acute or chronic, HBsAg+ and/or anti-HBc IgM+)
Hepatitis C (confirmed by RIBA or PCR only)
Hepatitis, acute unspecified
Human Immunodeficiency Virus (HIV) infection
Legionellosis
Leprosy
Leptospirosis
Listeriosis
Lyme Disease
Malaria
Mumps
Pertussis
Psittacosis
Rocky Mountain Spotted Fever
Rubella
Salmonellosis
Shigellosis
*Streptococcus*, group A, invasive disease
*Streptococcus pneumoniae* invasive disease
Syphilis
Tetanus
Trichinosis
Tuberculosis
Unusual syndrome, or uncommon disease
*Vibrio* spp. infections including cholera
Yellow Fever

## The following diseases are to be reported to the OSDH within one month

CD4 Cell Count <500
*Chlamydia* infections
Creutzfeldt-Jakob Disease
Gonorrhea
Pelvic Inflammatory Disease

## Isolates of the following organisms must be sent to the OSDH Public Health Laboratory:

**P.O. Box 24106 OKC, OK 73124**

(1) *Bacillus anthracis*
(2) *Brucella* spp.
(3) *Campylobacter* spp.
(4) *E. coli* O157, O157:H7, or a shiga-like toxin producing *E. coli* (EHEC)
(5) *Francisella tularensis*
(6) *H. influenzae* (sterile site isolates only)
(7) *Listeria* (sterile site isolates only)
(8) *Mycobacterium tuberculosis*
(9) *N. meningitidis* (sterile site isolates only)
(10) *Plasmodium* spp.
(11) *Salmonella* spp.
(12) *Shigella* spp.
(13) *Vibrio* spp.
(14) *Yersinia* spp.

**Clinical specimens for Botulism testing must be sent to the OSDH Public Health Lab**

| HIV/STD Service | Communicable Disease Division | Immunization Division |
|---|---|---|
| (405) 271-4636 | (405) 271-4060 | (405) 271-4073 |
| FAX (405) 271-1187 | FAX (405) 271-6680 | FAX (405) 271-6133 |
| | FAX (800) 898-6734 | |

**FAX machines are located in locked offices and are monitored to ensure the confidentiality of disease reports.**

**(Revised 10/05)**

# NEVER SHAKE A BABY

**When an infant cries, he or she is trying to tell you something. If a baby is crying and won't stop, check to see if he/she:**

- has a rash, clothing pinching, or is teething?
- is cold or hot?
- has a fever?
- is in pain or sick?
- needs a diaper change?
- needs to be fed or burped?
- needs to suck? (Offer a pacifier or guide the baby's fingers to his/her mouth.)
- wants to be held close and cuddled?

**Safe ways to calm a baby:**

- sing or play soft music
- hold him/her against your chest, pat on the back gently, and walk around or rock back and forth
- hold the baby's arms close to his/her body; swaddling or wrapping comforts some babies
- take baby for a ride in the stroller
- feed the baby slowly
- burp the baby often
- maintain calming movements for about 5 minutes at a time

**Remember**: Never, never, never shake a baby!

**If you find you cannot calmly care for a baby, or if you are tempted to shake a baby:**

- **STOP! THINK!** Why do you feel so upset?
- ask another caregiver for help
- leave the baby in a safe place and go into another room where you can't hear the crying for a few minutes
- remind yourself, "babies need to cry"
- take 10 deep breaths
- play relaxing music
- exercise
- call a friend or caregiver for support

**What is Shaken Baby Syndrome?**

The term "shaken baby syndrome" is used for the internal head injuries a baby or young child sustains from being violently shaken. Babies and young children have very weak neck muscles to control their heavy heads. If shaken, the fragile brain is slammed up against the skull of the child causing severe bleeding, bruising and swelling in the brain. Early symptoms can include extreme irritability, vomiting, excessive sleepiness, difficulty breathing, feeding changes, seizures and stiffness.

**How can Shaken Baby Syndrome be prevented?**

- Never shake a child, especially under the age of six. **FOR ANY REASON!**
- Always provide support for the baby's head when holding, playing with or transporting him or her.
- Learn what to do if the baby will not stop crying. Remember that all babies cry, some a lot, during the first few months of life.
- Make sure that everyone who cares for the child (including baby-sitters, childcare providers, and relatives) knows the dangers of shaking babies and young children.
- Play gently with babies.

**What if a baby is shaken?**

Call 911! Get the baby to the emergency room immediately!. . .even if you feel embarrassed or guilty. Quick medical attention can prevent future problems and may even save a child's life!

**Remember: Children are being hurt. . . sometimes permanently . . . by adults who do not know the dangers of shaking.**

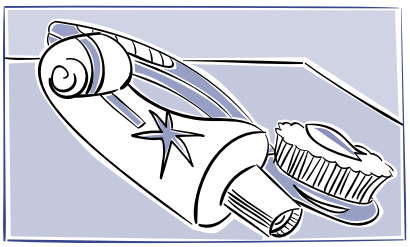
**Contact Information:**

Prevent Child Abuse Oklahoma
437 N.W. 12th Street
Oklahoma City, OK 73103

Phone: (405) 232-2500
1-800-CHILDREN

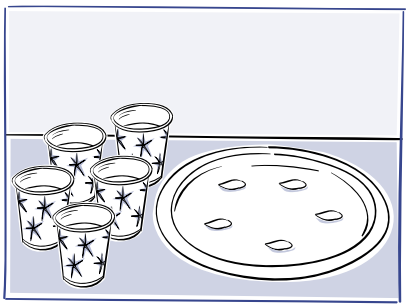
STOP DENTAL DISEASE

# TOOTHBRUSHING



For children 1 year or older:

- Use a soft bristled child-sized toothbrush.
- Use a tiny speck of fluoride toothpaste—about the size of a grain of rice is plenty!

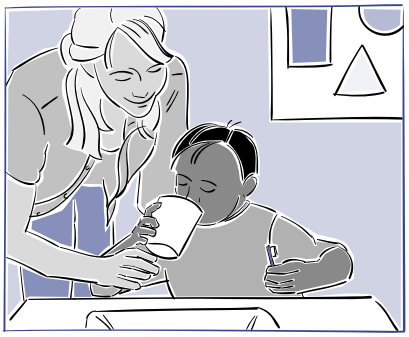


Don't share the toothpaste tube! Instead:

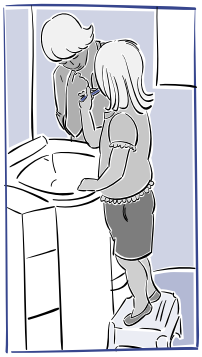
- Dole out toothpaste on a small slip of disposable wax paper (one per child).
- Place dabs of toothpaste along the edges of a paper plate. Each child "picks up" a bit of toothpaste with toothbrush.
- Give each child a small paper cup with a dab of toothpaste along the rim. Each child uses his own cup after brushing for rinsing.

Brush all tooth surfaces gently and thoroughly:

- Start with the tops and sides of all teeth.
- Don't forget the edge of the gum at the base of the tooth where plaque can accumulate.



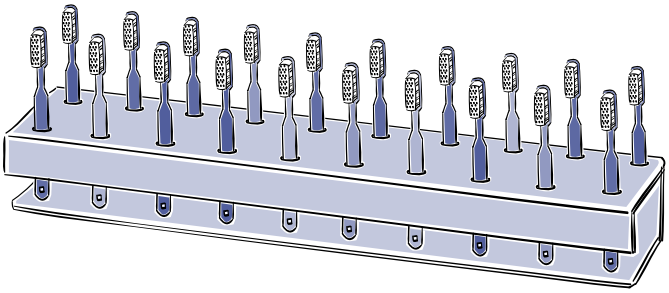
Assist the child with rinsing the mouth.



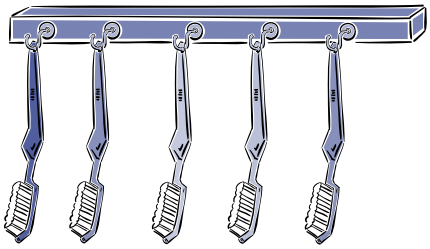
Children need assistance and supervision with tooth brushing until at least age 8 or older!

STOP DENTAL DISEASE

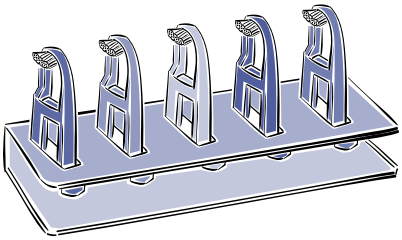
# TOOTHBRUSH STORAGE



Store toothbrushes in open air, so bristles will dry out.



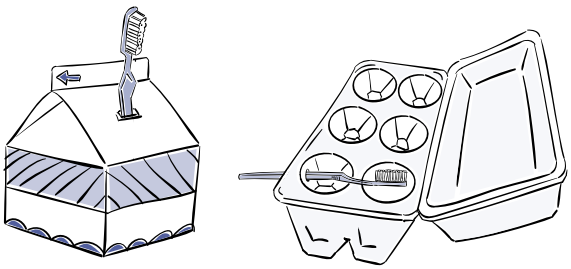
Suspend toothbrushes so that bristles do not touch each other.



Space them so that toothbrush bristles do not touch or drip on each other.

Change brushes every 3 months or when worn.

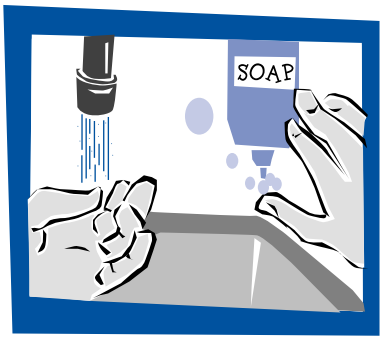
Label toothbrushes and storage rack with children's names.



Use a commercial storage rack or make your own.

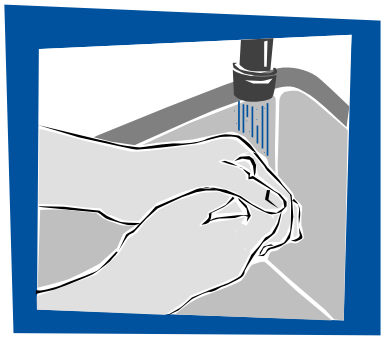
STOP DISEASE

# WASH YOUR HANDS PROPERLY




1. Wet hands and apply soap. Use warm running water; liquid soap is best.

2. Rub hands together vigorously for at least 10 seconds, scrubbing all surfaces.



3. Rinse hands well under running water until all the soil and soap are gone.


4. Dry hands with a fresh paper towel.

5. Turn off water with a paper towel—not with your clean hands.

6. Discard the used paper towels in a lined, foot-pedal canister.

**Good Health Handbook Survey**

A committee to revise the Good Health Handbook was formed that included representatives from the Oklahoma State Department of Health, Oklahoma Department of Human Services, Oklahoma Child Care Resource and Referral Association and the University of Oklahoma Health Sciences Center.

This resource is intended to be user-friendly and relevant to anyone caring for children. We would appreciate your input on these revisions and hope that you will take the time to fill out the attached survey.

Feel free to provide written comments along with the corresponding page number of the area you are addressing.

All surveys will be reviewed and future revisions will be made based on feedback and the latest research. No identifying information will by used. Thank you for your assistance.

Job Title: _____

Type of Program:

☐ Child Care Center ☐ Child Care Home ☐ School

☐ Pre-Kindergarten ☐ Kindergarten ☐ Head Start

☐ Other (describe) _____

1. Are the resources in the Good Health Handbook helpful?

YES ☐ SOMEWHAT ☐ NO ☐

Comments:

2. Have you utilized the Good Health Handbook to provide information to parents?

YES ☐ NO ☐

Comments:

3. Have you gained new knowledge that has helped in caring for children through your use of the Good Health Handbook?

YES ☐ SOMEWHAT: ☐ NO ☐

Comments:

4. Have you utilized the Good Health Handbook to help you access additional resources for children's health and safety?

YES ☐ NO ☐

Comments:

5. What additional information or resources would be helpful to include?

6. Please provide any additional comments in the space below:

a. Chapter or Topic
b. Page Number
c. Specific Comment:

(Feel free to attach additional pages if needed)

Please fax this form to:
Child and Adolescent Health, Early Childhood Coordinator (405) 271-9202
Or mail to:
Oklahoma State Department of Health
Child and Adolescent Health Division, Room 903
Early Childhood Coordinator
1000 N.E. 10th Street
Oklahoma City, Oklahoma 73117-1299

You may call the Child and Adolescent Health Division with questions: (405) 271-4471.