ACCESSING VOLUME 3 AND VOLUME 4

OKHS Volume 3: E-Reference gives you detailed information about the health and safety subjects introduced in OKHS volumes 1 and 2. OKHS Volume 4 is an appendix to volume 3 that contains documents and forms to download and print.

TO ACCESS ONE OR BOTH OF THESE DOCUMENTS

Scan this quick response (QR) code with your smartphone, tablet or other handheld device to download the Volume 3, E-Reference, and Volume 4, Appendix to the E-Reference as either an interactive PDF or E-book

OR

Go to the following website:

http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HealthChildcare/Pages/OKHS.aspx

Sign up for the OKHS Training Session — You will learn up-to-date information about:

- Promoting children’s health;
- Preventing common childhood illnesses and injuries.

For trainings in your area, contact your local Child Care Resource & Referral office or visit the training calendar at http://www.oregonchildcaretraining.org.

Oregon Kids, Healthy and Safe is a joint project among the following partners:
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WHAT IS THE PURPOSE OF THE E-REFERENCE?

Finding good quality care for their children is essential for hundreds of thousands of Oregon families. The number of families with children in early care and education has grown dramatically in the past 25 years. Families use a variety of early care and education providers: centers, family homes, Head Start, preschool, family and friends. Parents care about their children’s health and safety in early care and education. To meet these health and safety needs, early care and education providers want easy-to-use information.

The Oregon Kids: Healthy and Safe (OKHS) project’s goal is to ensure health and safety in early care and education; it is for early care and education providers and includes:

- Volume 1 – Workbook;
- Volume 2 – Quick Reference;
- Volume 3 – E-Reference;
- Volume 4 – Appendix.

Each early care and education provider participating in the OKHS training will receive a copy of Volume 1: Workbook and Volume 2: Quick Reference. The OKHS training is offered to early care and education providers statewide. Credit hours can help meet the Oregon child care licensing training requirement. Check with your local Child Care Resource & Referral agency for training information.

OKHS volumes 1 and 2 are learning tools for training participants. You and your staff can use OKHS for quick answers to your health and safety questions.

Oregon Kids: Healthy and Safe Volume 3: E-Reference is:

- A resource book to be used by trainers in conducting health and safety training with early care and education providers;
- A reference book to be used by early care and education providers while caring for children;
• A collection of information on early care and education best practices that can be used by licensing staff for provider handouts;
• A tool for in-house staff training in centers and in-home early care and education businesses;
• An early care and education tool for parents.

You will find hotlinks to resources within and outside the volumes. This will guide you to more information about early care and education health and safety topics.

The E-Reference is available at http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HealthChildcare/Pages/OKHS.aspx.

After you use the E-Reference, please provide feedback about your experience. What part of the E-Reference is most helpful? What can be improved?

We will use your suggestions and comments to update the E-Reference. Contact the Oregon Health Authority’s Public Health Division, Office of Family Health at 971-673-0252 or email your comments to healthychildcare@state.or.us.

HOW IS THE E-REFERENCE ORGANIZED?

The E-Reference has four chapters:

A. Introduction;
B. Promoting healthy growth and development;
C. Preventing and responding to illness;
D. Preventing and responding to injuries and poisoning.

Each chapter’s table of contents gives you a list of that chapter’s main topics. At the end of each chapter, you will find a list of more resources and links to useful forms or documents. You will find many links throughout the E-Reference that will take you directly to further information about the topics you are researching.

HOW DO I KNOW THE DIFFERENCE BETWEEN A BEST PRACTICE AND A STATE EARLY CARE AND EDUCATION REGULATION?

This E-Reference presents a collection of best practices. It is not a substitute for, or guide to, state early care and education regulations. All best practices are consistent with the minimum regulatory requirements. In some cases, best practices exceed regulatory requirements. “Caring for our
Children, National Health and Safety Performance Standards Guidelines" is the major resource for best practices presented in this E-Reference.

This E-Reference identifies some of the most important health and safety regulations governing early care and education and contained in the Oregon Administrative Rules (OAR) administered by the Oregon Department of Employment Child Care Division (CCD) and the Oregon Health Authority (OHA). Regulations govern early care and education centers, certified family early care and education homes (formerly group homes) and registered family early care and education homes.

For the Oregon Administrative Rules (OARs) related to early care and education, go to [http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_414/414_tofc.html](http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_414/414_tofc.html).


For questions about a specific rule, call your licensing specialist noted on your license (certified facilities) or 1-800-556-6616 (registered facilities).

Watch for the following symbols throughout the text. The first two symbols alert you to specific regulations. The third symbol notes best practices for care to children with special needs. The fourth symbol notes a medical emergency requiring your immediate action.

- This symbol indicates an Oregon Employment Department Child Care Division (CCD) rule. In some instances, the symbol indicates a regulation for one type of facility. In other instances, a rule is relevant to two or all three types of facilities. Refer to your individual rule book to determine if the icon relates to the type of care you provide.

- This symbol indicates a restrictable disease defined in an administrative rule, or a medical condition that meets the restriction criteria and requires the child be excluded from early care and education to seek medical attention. When you see this symbol, be sure to see [OKHS Volume 4: Appendix, Chapter C, “Links to Information on Specific Illnesses”](#) to read the description of the disease and what to do.

- This symbol is used throughout the E-Reference to alert you to best practices in caring for children with special needs.

- When you see this symbol, you need to assess the situation and then either call 911 or seek immediate medical attention.
A positive relationship between the family and the early care and education provider is an important part of quality early care and education. This relationship needs to be nurtured on a regular basis, beginning with the first contact with the family.

Families and early care and education providers share a common interest in supporting a healthy, safe, culturally and developmentally appropriate environment for their children. Families and providers are partners and need to play mutually supportive roles. One way early care and education providers can demonstrate their respect for families is by using the term “family” to acknowledge the variety of people that may play a parenting role in a family. In the E-Reference, the term “family” includes biological parents, adoptive parents, foster parents, grandparents, stepparents, same-sex parents or other adults or relatives.

Culture is a basic building block of identity. Through culture, children gain a sense of who they are, a feeling of belonging, and a sense of what issues are important within their group. Traditionally, the child’s family and cultural community have been responsible for teaching values, expectations and ways of doing things. In today’s society, this role is often shared with professional early care and education providers, whose cultures may be different from the child’s.

Consistency of care between the child’s home and early care and education becomes even more critical when a child is cared for in a culture that is different from his or her own. It is ideal for the early care and education experience and the culture of the child’s home to complement one another.

As a provider, it is very important to be aware of cultural differences in child-rearing practices. Some of these differences may include:

- Language learning;
- Feeding;
- Napping;
- Toilet training;
To be culturally responsive, a provider may use the “3 A’s”:

- **Acknowledge** — Recognize there may be differences based on cultural beliefs;
- **Ask** — Talk to the family and ask for information about child-rearing values;
- **Adapt** — Be open to new ideas. Learn about the family’s culture and share yours with them. Negotiate and compromise.

By putting these steps into practice, providers can gain the knowledge necessary to support the growth and development of all children in care.

In addition to unique cultural backgrounds, families have different skills, strengths, needs, concerns, feelings and expectations. The rapport you establish in the early days of your relationship is very important.

To promote communication and information sharing with families, providers are encouraged to:

- Informally share daily information with parents about their child’s needs and activities.
- Have regular parent conferences to review the child’s development and adjustment to care.

**BEGINNING THE FAMILY-PROVIDER PARTNERSHIP**

The family-provider partnership begins with the first telephone contact. Encourage families to visit and ask questions about your program. Provide them with a packet of information describing your program’s policies — from fees and hours to education and discipline. Be sure that your forms and materials respect families’ racial, ethnic, cultural, religious, social and economic
diversity. Look for community resources that can help you understand and honor family values, customs and choices. Seek help in communicating with families with different cultural and language backgrounds. Look for ways to include children with special needs.

Provide families with written information about:

- **Time responsibilities**
  - Arrival and departure times and procedures;
  - Family involvement opportunities and expectations;
  - Open door visiting policy;
  - Holiday and vacation scheduling.

- **Fee arrangements and schedule**
  - Amount and payment schedules;
  - Late charges;
  - Holiday and vacation rates.

- **Daily communication and information exchange**
  - Verbal and written;
  - When and how concerns are shared.

- **Policies**
  - Health and illness policies, including medications;
  - Behavior and discipline policies;
  - Sanitation and hygiene;
  - Facility maintenance policies;
  - Toilet training;
  - Food handling and feeding;
  - Sleeping;
  - Emergency plan;
  - Transportation and field trips.
• **Obtaining information and authorizations from families**

  Get health and behavior information, including any current health or behavior concerns such as challenging behavior, special diets or allergies. Please refer to *OKHS Volume 4: Appendix, Chapter A, “Child Enrollment and Authorization form.”*

  Secure written information and signed consent for medications or treatments needed while the child is in care. See “*Medication administration*” in the General resources section of Chapter C. The American Academy of Pediatrics developed the Medication Administration Packet. The packet includes forms for authorization to give medication, receive medication, and document which medications are given.

**CONTINUING TO BUILD THE RELATIONSHIP**

Encourage the family to spend time in your center or home. This helps the child adjust to a new place. It also helps the family to get to know you and your program.

Raise any concerns with families early. If a child’s behavior is changing in a negative way, don’t be afraid to discuss it with the family. Talk about ways you have found that work to encourage positive behaviors. If there is a health concern, be open and straightforward in discussing it.

Good communication also helps families raise concerns. For example, if your illness policy is different than the family’s doctor’s advice, misunderstandings may occur if the family doesn’t feel free to ask about the difference. At such times, you may find it helpful to call upon an outside resource — a public health nurse, health consultant, child development specialist or other expert — for input. You might decide that you need to change your policy. Listen carefully if families have criticisms about a policy. Involve parents as equal partners to find solutions.

The family-provider partnership is important for your morale, as well as for the well-being of the children. If you nurture this relationship as carefully as you would a garden, it will reap great rewards.

Source: Adapted from the Child Care Health Handbook, Child Care Health Program, Public Health, Seattle and King County, 2001.
Children come to early care and education with all types of abilities and needs. Even though children are very diverse in the care they need, all children are children first. They are more alike than different.

The term “children with special needs” typically means children who have disabilities, emotional or behavioral disorders or special health care needs. Some, but not all, of these children may require accommodations or supports not typically needed by other children the same age. This section will offer information on caring for children with special needs, including support for making accommodations when they are needed.

There are many benefits to including children with diverse abilities and needs in your early care and education setting. You can find more information on these benefits and other ideas about inclusive early care and education in the “Open Hearts, Open Doors” booklet available at http://ocdd.org/images/uploads/openHeartsBooklet.pdf.

A quick handout on inclusion can be found in OKHS Volume 4: Appendix, Chapter A, “Bananas Handout: Inclusion – Caring for Children with Special Needs.”

This section gives general information about caring for children with special needs. Remember, good early care and education begins with identifying the special gifts of all children. Like all children, each child with special needs is unique and needs to be seen as an individual. Information that applies to caring for children with special needs is incorporated throughout the E-Reference under specific topics.

**The Americans with Disabilities Act (ADA) and early care and education**

The ADA offers civil rights protection to individuals with visible and hidden disabilities. It covers employment, state and local government services, and public accommodations. These include most early care and education centers and family home providers.
A key point of the ADA is all children must be treated as individuals. Under the law, a provider cannot turn a child away simply because the child has a disability. Rather, the early care and education program and its staff have a responsibility to provide “reasonable accommodations” to serve children with special needs. The section below will provide suggestions on reasonable accommodations and other responsibilities.

Adaptations or accommodations necessary for a child’s care must be made unless they create an undue burden to the program. Undue burden may include unreasonable expense or extensive change to the early care and education program. See the Chapter A Resources section, “Caring for children with special needs,” for help with accommodations.

EARLY CARE AND EDUCATION PROGRAM RESPONSIBILITIES

• Eliminate policies that single out or exclude children with disabilities. Example: Eliminate policy that all children must be capable of using the toilet.

• Provide access, on an individual basis, for a child with a disability unless it will create an undue burden. Example: Part of the playground can be a hard surface area so a child using a walker, crutches or a wheelchair can join the group.

WORKING WITH FAMILIES

Caregiver tips for creating an inclusive environment

Treat all families with dignity and show respect for their individual needs and differences.

• Be aware of your own feelings and responses to children with different abilities and needs.

• Be accepting of any change that may be needed for accommodation.

• Develop partnerships with the families.

• Assure confidentiality (i.e., obtain written consent from the family before accessing or sharing information).

• Make a plan for the child that builds on the child’s strengths.
• Consider the child’s unique abilities and needs when planning developmentally appropriate activities. Think about ways other children might enjoy adaptations required by one child. For example, everyone might like doing art on the floor when one child has difficulty sitting for a long period.

• Consider family members to be the experts in their child’s care.

• Seek additional training or consultation if needed. This might be available from a specialist who works with the child. Obtain parental consent to communicate with professionals already working with the child.

• Keep a record of the child’s behaviors and achievements.

• Use community resources to help you with supports and accommodations.

DEVELOPING A PLAN TO SERVE CHILDREN WITH SPECIAL NEEDS

Caregiver tips for building a partnership with families

• Ask families to help develop a care book for their children with information you think may be helpful. The book might include information on medications, allergies, emergency contacts, specific accommodations needed, and types of activities the child enjoys.

• Take time to get to know the family and share positive comments as well as concerns.

• Show sensitivity toward the emotional needs of the family, including the need for privacy.

• Design flexible schedules for families to participate in the early care and education setting during the day.

• Remember that families of children with special needs experience the same stresses all families do. They also have challenges above and beyond those of other families.

Where do I begin when enrolling a child with special needs in this early care and education setting?

• Start with the same process you use with all families. Invite the parents to visit your center and complete the initial application. You may need to
collect additional information in order to determine the child’s needs and whether you can meet them by making reasonable accommodations. You can use the care plans and Emergency Information Form for Children with Special Needs in OKHS Volume 4: Appendix, Chapter A, “Caring for children with special needs” to collect this information.

• Once you have identified the child’s needs, consider what resources are available.

• Respectfully ask the family about services they are currently receiving that may help support the child’s care. The family may not know about available services. If not, help the family make use of some of the resources you know. These may include those described below.

• If the family may be eligible for an early care and education subsidy, contact your local Oregon Department of Human Services (DHS) office or local Child Care Resource & Referral (CCR&R) Program. The organizations' websites and telephone numbers are included in Resources, “General contacts and links” at the end of Chapter A.

• Ask about the availability of a special-needs rate. This rate is designed to help with the costs of early care and education for children who require a different level of care than others the same age. In addition to the special-needs rate, the state subsidy program also provides a high-needs rate. This rate is intended for children with exceptionally high needs. It is added to the special-needs rate. The high-needs rate is based upon an individual assessment of the type and level of care required for the child. Contact your local DHS office or the Inclusive Child Care Program (see information in Chapter A Resources section, Caring for children with special needs, “Inclusive Child Care Program Oregon Council on Developmental Disabilities’) for information on subsidies for children with special needs.

• If a family is not eligible for the DHS early care and education subsidy, the Inclusive Child Care Program may be able to help. The program includes a supplemental subsidy to help with costs of accommodations needed for the child to be in an early care and education setting. For example, if a child needs to receive a medical procedure that a registered nurse must delegate to you, the subsidy may be used to pay for the nurse’s time if other resources are not available.

• The Individuals with Disabilities Education Act (IDEA) includes early intervention services for infants and toddlers and early childhood special education services for preschoolers. IDEA supports inclusion of young
children with special needs in settings with typically developing peers. Early intervention and early childhood special education professionals may be able to consult with or train early care and education providers and center staff to work with a specific child.

- The Individual Education Plan (IEP) is for children 6 years of age or older who are receiving special education services. The IEP is coordinated through the local school district. The Individual Family Service Plan (IFSP) for children 0 to 5 years old is coordinated through the local early intervention/special education program. If the child and family receive services through IEP or IFSP, know their plan and how you can support the child to achieve these goals. Ask the parent about the child’s plan.

- Children with medical concerns may need special procedures. Some procedures must be delegated by a nurse. This means the nurse trains the early care and education provider to do the procedure.

- If the child receives physical, speech, occupational or other types of therapy, see if you can observe while the therapist works with the child. The therapist may be able to provide some services in your early care and education setting. Ask about the possibility of incorporating some of the therapy activities into the child’s daily routine at your early care and education site. Some of these activities may be suitable for all children.

- Call an agency in your area that serves children with special needs and ask for ideas.

- For information about training and community resources, contact your local CCR&R agency.

- Develop a Special Needs Health Care Plan with the parents and health provider to respond to the individual needs of a child in care. See OKHS Volume 4: Appendix, Chapter C, “Special Health Care Plan.”

**Where do I find information about including children with special needs in my early care and education?**

- Call your local CCR&R. Ask about workshops or classes in your community.

- Contact the Inclusive Child Care Program (see the Resources section at the end of this chapter, Caring for children with special needs, “Inclusive Child Care Program”). The program can share written information and helpful websites and may know about resources in your area.
• Visit the Center for Inclusive Child Care website: http://www.inclusivechildcare.org. The site offers podcasts and other resources.

Where can I find information about different medical conditions?

• Ask parents for information.

• Ask parents if you can contact the child’s doctors for information about the condition.

• If the child has a public health nurse (e.g., through the Babies First or CaCoon nurse programs), you can ask the parent for permission to talk with the nurse.

• The National Dissemination Center for Children with Disabilities offers fact sheets on many types of childhood disabilities and disorders. Go to http://nichcy.org/disability.

• There are several good care plans for different conditions at the following website: http://www.ucsfchildcarehealth.org/html/pandr/factsheetsmain.htm.
As an early care and education provider, your regular contact with children and their caregivers means you have a critical role in protecting children. Early care and education providers have a responsibility to report suspected child abuse. You also have a responsibility to make sure that child abuse does not occur in your early care and education setting.

Child abuse is any form of abuse, including abuse through neglect and abuse or neglect by a third party, of a person under age 18. Child abuse occurs in all cultural, ethnic and income groups.

You do not need to define an injury as physical or other type or abuse or neglect when you make a report. Abuse is separated below into different categories to help you understand how the law defines abuse. Simply report specific, accurate information about a given child’s condition, behavior or circumstances by calling your child abuse hotline number listed in this chapter’s Resources section, “Responding to child abuse and neglect.”

DEFINITIONS OF ABUSE

**Physical abuse:** Oregon law defines physical abuse as “an injury to a child that is inflicted or allowed to be inflicted by non-accidental means.” Examples: bruises, cuts, head injuries, poisoning, fractures, burns, internal injuries that do not result from accidents.

**Mental injuries:** Mental injury is the result of cruel treatment and/or statements made, threatened to be made, or permitted to be made by a caregiver. Examples: ridiculing, terrorizing and isolating.

**Sexual abuse:** Child sexual abuse occurs when another person uses or attempts to use a child for his or her own sexual gratification. This includes incest, rape, sodomy, sexual penetration, fondling, voyeurism and other sexual acts. Examples: touching or exposing genitals and sexual contact.

**Neglect:** Neglect is failing to provide adequate food, clothing, shelter, supervision or medical care.
**Threat of harm:** Threat of harm is subjecting a child to a substantial risk of harm to the child’s health or welfare including domestic violence. Example: living with or being cared for by someone convicted of child abuse or neglect.

**DUTIES OF THE EARLY CARE AND EDUCATION PROVIDER**

In Oregon, registered and certified early care and education providers are required by law to report any suspicion of child abuse or neglect. The report must be made immediately after learning of the suspected abuse. It is not your role to have proof of abuse or to investigate the situation.

If you have cause to believe that a child is being abused or neglected and you report in good faith, you are immune from liability.

**SIGNS OF ABUSE AND NEGLECT**

- Child has unexplained or repeated injuries (welts, bruises, burns).
- Child has injuries that take the shape of an object (bruises with the shape of a belt buckle, electrical cord, wooden spoon).
- Child has injuries that don’t make sense for his or her age (bruises on the legs or bottom of a child too young to walk).
- Child or parent gives unlikely or different explanations for an injury.
- Child looks neglected (dirty; hungry; wearing inappropriate clothes for the weather; showing signs of health problem but not getting medical attention).
- Child seems afraid to go home at the end of the day.

**HOW TO REPORT SUSPECTED ABUSE**

The law requires an oral report of child abuse, so most reports are made by phone; however, written materials may be requested. To make a report, call your local DHS office (see [http://www.oregon.gov/DHS/children/localoffices.shtml](http://www.oregon.gov/DHS/children/localoffices.shtml) for list of local numbers). For phone numbers. If you report after business hours, most areas have hotlines or other ways to take calls after hours. If you need to report abuse after hours, you may also contact your local law enforcement agency. When a report is made to DHS, the report is shared with law enforcement and vice versa, so you only need to report to one agency.
Continue to call and report each incident of suspected abuse as it occurs. Be prepared with information. If possible, report the following:

- Name and address of the child and parents;
- The child’s age;
- The type and extent of abuse;
- Any previous evidence of abuse;
- Any information that might help establish the cause of the abuse or identify the abuser;
- The names of any witnesses.

Record what you see and what you hear. Keep a written record of each incident and your calls, and make notes of your conversations with the Child Protective Services (CPS) worker. Make a call each time you observe something suspicious, even for the same child. Remember, you may be the child’s only advocate.

CPS has resources to help parents meet the challenges of caring for children.

Do not discuss a report with the parents. Let the police or CPS make the appropriate notifications. Premature notification may endanger the child or compromise the investigation.
FOLLOWING GOOD HEALTH PRACTICES

Caring for young children is very important and rewarding. Promoting and protecting your health is essential to maintain your own quality of life. Also, remember that you are a role model. Children look up to you and mimic what you do. The more you follow good health practices, the more likely children will also develop them.

There are some potential health hazards in this line of work, such as:

- Exposure to communicable diseases;
- Potential for back injury;
- Stress;
- Exposure to toxic chemicals.

To protect and promote your own health, it is important for you to follow good health practices, such as:

- Get regular health check-ups.
- Let your health care provider know about the kind of work you do, so you can receive advice to protect you from hazards in your work setting. See this volume’s Chapter B, Resources section, “General health resources for children and families,” for information about the Oregon Health Plan and other medical insurance information.
- Eat a variety of healthy foods.
- Be physically active.
- Get enough rest.
- If you smoke, quit. Quitting takes practice, but it is worth the effort. You can get free help if you need it. Call the Oregon Tobacco Quit Line at 1-877-270-STOP (7867) or visit http://www.quitnow.net/Oregon/. For more information on reducing children’s exposure to secondhand and thirdhand smoke, see this volume’s Chapter B, Resources, Healthy indoor air, “Healthy Environments for Children.”
• Notify your supervisor when you’re ill or injured if you work in a center. If you are a home early care and education provider, establish a policy for what you do when you are ill. Take the time needed to recover before returning to work.

• To lower risk of illness and communicable diseases, avoid germs by hand washing (see Chapter C, Preventing illness in early care and education settings, Preventing the spread of disease, “Washing hands”) and avoid exposure to blood.

• Follow the guidelines in the rest of this section on stress management, immunization, and prevention of back injury and exposure to toxic materials.

For the specific procedure, see “How to Handwash” poster in OKHS Volume 4: Appendix, Chapter C.

LEARNING TO RECOGNIZE STRESS

Early care and education providers and families have very stressful jobs. Because caregivers have constant demands on their time and energy, they are at risk of emotional and physical burnout. To avoid this, create the opportunity for some self-care measures and learn to recognize your own warning signals. Plan daily stress reducers in your busy schedule.

Some common symptoms of stress

• Frequent illnesses (colds, sore throats, etc.);
• Appetite and/or sleep disturbances (either a significant increase or decrease);
• Chronic fatigue — lack of energy even for fun activities;
• Accident-prone behavior;
• General irritability, difficulty relating to others, easily angered;
• Increased smoking, drinking or drug usage;
• Diarrhea, indigestion, stomach ailments;
• Increased muscular tension (head or neck aches, low back pain);
• Inability to concentrate, disorientation;
• Sadness or helplessness.

If ignored and allowed to become chronic, stress symptoms can affect all areas of your life and lead to serious illness.
LEARNING TO MANAGE STRESS

Strengthen your business skills

• Manage your time efficiently.
• Develop clear work policies and processes, especially regarding arrival and departure times and procedures, holiday and vacation scheduling, payment, late charges, health and illness, and behavior and discipline. Enforce all policies. Do not make exceptions.
• Obtain training in areas of your work that you are not comfortable in performing.
• Take a money management class. Pay your bills on time.
• Establish a rainy-day fund.
• Read and understand policies about how payment will be made in those cases where payment for a child’s care is paid by an agency.
• Work on communication and assertiveness skills.
• Learn to set realistic goals and priorities.
• Learn to say “no” and ask yourself “Whose responsibility is it?”
• Learn to set limits with your clients and stick to them. Don’t take on the families’ problems.
• Network with other providers.
• Join an early care and education professional organization.

Incorporate stress-reducing techniques into your workday

• Expect the unexpected. Know that you will have challenges.
• Focus on what’s good about today. Use positive self-talk.
• Set aside time for a break each day.
• Take walks, play, garden, stretch with children.
• On rainy days, move with children while listening to exercise tapes.
• Play soft music at appropriate times (nap time).
• Delegate responsibility.
• Ask for help when you need it.
• If you get frustrated with an infant, place the infant in the crib and take some deep breaths; get a drink of water.
Use the following techniques during your non-work hours:

• **Interpersonal techniques**
  - Share meals with friends.
  - Surround yourself with positive people.
  - Stay in touch with your personal network of family and friends.
  - Be an active part of your community (e.g., church, school, online chat rooms).
  - If you have children, arrange for your spouse or another adult to care for your own children on a regular basis after your work is over for the day.

• **Physical techniques**
  - Be physically active — Garden, walk, stretch.
  - Practice deep breathing — Breathe in relaxation; exhale stress.
  - Take a hot bath or shower.
  - Get a massage.
  - Practice yoga.
  - Eat a variety of healthy foods.

• **Distracting techniques**
  - Listen to soft music.
  - Daydream — Use creative visualization; take a mini-mind vacation.
  - Read for pleasure.
  - Sing out loud (in shower, in car).

• **Personal techniques**
  - Spend time on yourself every day (minimum 15 minutes). Relax in a hot tub or read.
  - Schedule weekly renewal time; mark date and time on calendar and keep an appointment with yourself to go to a library, museum, window-shopping.
  - Spend time on a hobby.
  - Buy yourself some flowers.
  - Write in your diary/journal.
- Learn to recognize your own signs of stress.
- Seek professional help when you need it.
- Limit use of alcohol.
- Avoid drugs.
- Read books about stress or attend stress management class.
- Find ways to laugh. Humor is a great stress reducer.

- **Spiritual technique**
  
  - Meditate

Never smoke or drink during the hours you are providing early care and education.

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**IMMUNIZATIONS FOR EARLY CARE AND EDUCATION PROVIDERS**

Vaccines help keep you healthy. When you get vaccines, you also protect kids because you won’t spread the diseases to them. While immunizations are not required for early care and education providers in Oregon, it is recommended that they have immunity to the diseases listed in the following table. See this volume’s Chapter C, Immunizations, “Vaccine-preventable illnesses,” for a description of these diseases.

<table>
<thead>
<tr>
<th>Adult immunization</th>
<th>Tetanus, diphtheria and pertussis (Tdap and Td)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How often?</strong></td>
<td>The vaccine is usually given in childhood. Adults without childhood vaccination need three doses. All adults need a booster vaccine every 10 years.</td>
</tr>
<tr>
<td><strong>Information</strong></td>
<td>One dose of Tdap vaccine is recommended to protect adults under 65 against pertussis, especially if caring for infants.</td>
</tr>
<tr>
<td>Adult immunization</td>
<td>Measles, mumps, rubella (MMR)</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>How often?</td>
<td>Experts recommend two doses of MMR for people born in 1957 or later. People born before 1957 are presumed to be protected.</td>
</tr>
<tr>
<td>Information</td>
<td>Persons born in 1957 or later can be considered immune to measles, mumps and rubella if they have documentation of a) physician-diagnosed measles, mumps and rubella; or b) laboratory evidence of measles, mumps and rubella immunity; or c) vaccination against measles, mumps and rubella. Measles, mumps and rubella vaccines are usually given together as MMR, even if a person is protected against one or two of the diseases.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adult immunization</th>
<th>Chickenpox (varicella)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often?</td>
<td>Two doses (given four weeks apart) of varicella vaccine are recommended for adults who have not had chickenpox.</td>
</tr>
<tr>
<td>Information</td>
<td>History of disease is considered proof of immunity. Blood tests can be done for adults with uncertain history.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adult immunization</th>
<th>Influenza (flu)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often?</td>
<td>An annual vaccine is recommended.</td>
</tr>
<tr>
<td>Information</td>
<td>All adults are advised to get a flu vaccine.</td>
</tr>
<tr>
<td>Adult immunization</td>
<td>Hepatitis A</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>How often?</strong></td>
<td>Two doses are given six months apart.</td>
</tr>
<tr>
<td><strong>Information</strong></td>
<td>Children can pass on the disease to caregivers without looking sick. Providers are encouraged to consider vaccination.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adult immunization</th>
<th>Hepatitis B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How often?</strong></td>
<td>Three doses are given over a six-month period of time.</td>
</tr>
<tr>
<td><strong>Information</strong></td>
<td>Hepatitis B is passed through contact with blood from a person with hepatitis B. Early care and education providers need to be vaccinated if they care for children who are infected. Providers who want to reduce their risk are encouraged to consider vaccination.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adult immunization</th>
<th>Tuberculosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How often?</strong></td>
<td>A TB test every two years is recommended.</td>
</tr>
<tr>
<td><strong>Information</strong></td>
<td>It is highly recommended that new early care and education providers have a TB test prior to their first day on the job. In Oregon, early care and education workers are not required to have evidence of a skin test for tuberculosis. However, given the rise in tuberculosis, the National Association for Education of Young Children recommends a skin test.</td>
</tr>
</tbody>
</table>
PREVENTING INJURY

Ergonomics

Ergonomics is a way of designing workstations, work practices and work flow to accommodate the physical needs of the worker and to prevent injury. Ergonomics focuses on body mechanics. Some examples of ergonomics in the early care and education setting are changing tables and drawers at waist height and hands-free phones to avoid hunching one shoulder to cradle the phone.

To help prevent injury:

- Reduce repetitive tasks;
- Reduce static work;
- Take deep-breathing mini-breaks;
- Listen to your body;
- Do easy stretches.

Preventing back injury

In the early care and education setting, back injury is one of the most common injuries experienced by providers. Working in early care and education means being physically active. It’s good for children when you share their activity: playing with them, bending and getting down at their level and holding or lifting them. Being physically active is good for your back, as long as the activity is performed correctly. If not performed correctly, some of these activities may put stress on your back. These guidelines are written to help you stay active while reducing the chances you will have any back problems.

When you lift, bend or twist, use caution.

- To lift properly, keep the child (or object) close to your body. A way to remember to do this is to “hug your work.” If you care for infants and toddlers, consider using a front or back carrier. When lifting, get close and don’t bend at the waist more than required. Bending your knees can help reduce the stress on your back, but only if it helps you get the object close to your body’s center of gravity (abdominal area). Also, don’t twist; move your feet instead.
- Make sure you have a clear path and a good view of where you are going when you carry something. Get help if you have to move a large or heavy item.
- Push, don’t pull, objects. Pushing puts only half the stress on the back as pulling.
• Bending over is a common activity for early care and education providers, but over time this can stress your back. Instead of bending at the waist, alternate with squatting or kneeling down, or even sit on a low chair if it is comfortable for you.

• Encourage independence in children whenever feasible to decrease the amount of lifting you need to do. For example, consider installing safe steps for older toddlers to climb up to the diaper changing table.

When you find a moment to sit, sit wisely

Sitting puts more stress on your back than standing or even jogging. Sitting can take the natural curve out of your lower back (especially if you slouch or do not have a pillow or other lower back support). This natural curve is important and contributes to the spring-like ability of the spine to flex, move and support the upper body.

• If you have a regular chair, support the natural curve in your lower back by putting a small pillow or towel roll on your chair behind your lower back. Also, it is good for your back to use arm rests, change positions often, and to use a foot rest instead of letting your feet dangle.

• When sitting on the floor, sit up against a wall or furniture for back support.

Be physically active

The muscles of the back and stomach are the most important element for healthy backs. Muscles that are fit can support the spine all day long without tiring. Regular aerobic exercise will build muscles that improve fitness and endurance. It will also help prevent stress, overweight and heart disease. Contact your health care provider if:

• You have severe back pain, or if you have weakness, numbness or tingling in your arms or legs.

• You don’t seem to be improving after approximately a week.

AVOIDING EXPOSURE TO TOXIC CHEMICALS

Many items used in early care and education programs, even if listed as natural or earth-friendly, may have harmful effects on adults and children. Toxic chemicals can be found in many supplies common in early care and education settings:

• Arts and craft supplies;
• Cleaning supplies;
• Latex gloves.

The following suggestions will help decrease exposure to toxic chemicals:

• Check the ingredients of paints, clays, cleaning supplies, etc. and use only non-toxic materials. Use only paints, clays and other art supplies that are labeled as certified non-toxic by the *Art & Creative Materials Institute (ACMI)*. These certified supplies are marked with a circular stamp labeled “AP.”

• Always maintain good ventilation and circulating air, and use gloves when working with dangerous or irritating substances. Air fresheners and scents are not a good substitute for fresh air, and may actually cause breathing difficulties. Open windows and use fans in the bathroom and kitchen to circulate air.

• When using cleaning supplies, be sure to read the labels and follow all instructions about wearing gloves, using ventilation and reducing exposure. Many items used in early care and education programs, even if listed as non-toxic, may have harmful effects on adults and children.

• Check with your poison control center or the manufacturer if you have questions about materials. (See Chapter D, Resources, “Poison prevention” for more information.)

• If skin is irritated, protect it with gloves and/or moisturizing lotion.

• Replace latex gloves with a non-latex variety to prevent a potential allergic reaction in yourself or children in your care.

• If you have questions about materials, check with the manufacturer or poison control center. Cleaning supplies may contain ingredients that cause allergies, irritation or asthma symptoms; ingredients are not always listed on the labels.

*Signal words — caution, warning and danger — tell you whether a product is likely to cause immediate harm. Caution is mildly hazardous; warning is moderately hazardous; and danger is highly hazardous.*
SPECIAL HEALTH CONCERNS FOR EARLY CARE AND EDUCATION PROVIDERS WHO ARE PREGNANT

If you are pregnant, there are some occupational hazards for you to discuss with your health care provider. Exposure to viruses such as cytomegalovirus (CMV) and fifth disease during pregnancy may increase the risk of fetal damage. There are no licensed vaccines against these viruses. Most people have been exposed to these viruses and are immune. To prevent your exposure, be sure to use gloves when changing diapers (see Chapter C, Preventing illness in early care and education settings, “Using gloves” and “Changing diapers”). Also wash your hands as recommended, including after handling toys that have been mouthed by children (see Chapter C, Preventing illness in early care and education settings, “Washing hands”). For descriptions of these viruses, go to OKHS Volume 4: Appendix, Chapter C, “Links to Information on Specific Illnesses.”

Rubella, particularly during the first trimester, can also be a concern for your baby. If you are not immune to rubella, it is important to be vaccinated before you become pregnant. If you have never had chickenpox, exposure to it in the third trimester can be a concern. A vaccine for chickenpox is available. Pregnant women are encouraged to receive a flu shot when the shot is available before or during flu season.

Fatigue, back problems and frequent urination, often associated with pregnancy, can provide some challenges in the early care and education setting. Talk with your health care provider about ways to protect your health during pregnancy. Be sure to tell your health care provider that you are an early care and education provider.

- If pets are a part of your early care and education setting’s learning environment, cats may be a concern. By cleaning a cat litter box without gloves or by not washing her hands after handling a cat, a pregnant woman puts herself at risk for toxoplasmosis (an infection that cats carry) and other infectious diseases carried by cats that may harm the fetus. It is a good idea for pregnant women to avoid cleaning the cat litter box.

- Fifth disease, a viral rash (See OKHS Volume 4: Appendix, Chapter C, “Links to Information on Specific Illnesses”) is common in children. Exposure to this infection during the first half of a pregnancy may cause complications. If you are pregnant and know that you have been exposed to an infected child, consult with your obstetrical care provider.
GENERAL CONTACTS AND LINKS

Addictions and Mental Health Division, Oregon Health Authority
Oregon’s umbrella agency administering programs for people with mental health conditions and developmental disabilities
http://www.oregon.gov/oha/amh/Pages/index.aspx

American Academy of Pediatrics Internet Resource Guide
General information on children including definitions of terms, tips, tools, etiquette and a list of other related sites
http://www.healthychildren.org/English/Pages/default.aspx

Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Early Care and Education Programs, 3rd Edition
Best practices and standards to be downloaded from the web or ordered as a handbook

Child Care Law Center
Information about the Americans with Disability Act and early care and education
415-394-7144
http://www.childcarelaw.org

Child Care Resource & Referral (CCR&R) Network
All-purpose provider resource information and source for local agency phone numbers. Information on training opportunities and schedules, resources to help providers meet health and safety standards, and local provider support organizations
1-800-342-6712
http://oregonccrr.com/

County health departments in Oregon
http://public.health.oregon.gov/PROVIDERPARTNERRESOURCES/LOCALHEALTHDEPARTMENTRESOURCES/Pages/lhd.aspx
Employment Related Day Care, Oregon Department of Human Services
Provides an early care and education subsidy for low-income families
http://www.oregon.gov/DHS/children/childcare/ and

National Child Care Information and Technical Assistance
Center (NCCIC)
Information resources for early care and education providers; answers to
specific questions or direction to resources for specific disabilities
http://www.icfi.com/insights/projects/families-and-communities/national-child-
care-information-center

Oregon Administrative Rules (OARs) related to early care and education
Search by clicking on ORS General Index, Quick Search, Child Care.

- Related to early care and education
  http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_414/414_tofc.html

- Related to food sanitation rules
  http://public.health.oregon.gov/HealthyEnvironments/FoodSafety/
  Documents/foodsanitationrulesweb.pdf

Oregon Association for the Education of Young Children (OAEYC)
An organization of early childhood educators and others dedicated to
improving the quality of programs for children from birth through third grade
503-233-0190
http://www.naeyc.org

Oregon Center for Career Development in Childhood Care
and Education
Portland State University training, mentoring and Professional
Development Registry for early care and education providers
503-725-8535
http://www.centerline.pdx.edu

Oregon Department of Human Services
general
http://www.oregon.gov/DHS

office locations and contacts
Oregon Health Authority Public Health Division, Office of Family Health
Information about health in early care and education settings, with links and resources
http://public.health.oregon.gov/HealthyPeopleFamilies/Pages/index.aspx

Documents and forms to download and print – General
(Go to OKHS Volume 4: Appendix, Chapter A.)

- Child Enrollment and Authorization form
- Child Care Enrollment Infant and Toddler Information form
- Safe n’ Sound: Child care health and safety tips

EARLY CARE AND EDUCATION PROVIDER ORGANIZATIONS

Oregon Association of Child Care Directors
www.orchildcare.org

Oregon Family Child Care Network
503-551-7609
www.oregonfamilychildcarenetwork.org/

Provider Resource Organization (PRO)
Opportunities, resources and recognition for the professional development of family early care and education providers
503-224-9787 (for local chapter information)

CARING FOR CHILDREN WITH SPECIAL NEEDS

Americans with Disabilities Act (ADA) information for child care providers
http://www.oregon.gov/EMPLOY/CCD/docs/forms/ADAEnclosure.pdf

CaCoon (Care Coordination)
Child Development and Rehabilitation Center (CDRC) programs for families whose children have special health needs
503-494-4219 or 1-800-452-3563
http://www.ohsu.edu/xd/outreach/occyschn/programs-projects/cacoon.cfm
Child Development and Rehabilitation Center (CDRC)
Specialty care for children and young adults with special health needs provided by Oregon Health & Science University
1-800-452-3563
Eugene: 541-346-3575 or 1-800-637-0700
http://www.ohsu.edu/cdrc/

Commonly Asked Questions about Child Care and the Americans with Disabilities Act
http://www.usdoj.gov/crt/ada/childq&a.htm

Disability and Business Technical Assistance Center (DBTAC Northwest – ADA Information Center)
1-800-949-4232
http://dbtacnorthwest.org

Inclusive Child Care Program, Oregon Council on Developmental Disabilities
Helps lower-income working families of children with disabilities, emotional/behavioral disorders or special health care needs, including a supplemental subsidy to help with higher-cost care
Portland: 971-673-2286
toll-free: 1-866-837-0250
http://oregoninclusivecc.org

National Dissemination Center on Children and Youth with Disabilities (NICHCY)
The National Dissemination Center for Children with Disabilities (NICHCY) has a bank of resources and information on youth and children with disabilities. This online resource will end on 9/30/14.
http://www.nichcy.org

Open Hearts Open Doors: Providing Inclusive Child Care

Documents and forms to download and print – Caring for children with special needs
(Go to OKHS Volume 4: Appendix, Chapter A.)

- Americans with Disabilities Act (ADA) Information for Child Care Providers
- Bananas Handout: Inclusion — Caring for Children with Special Needs
- Emergency Information Form for Children with Special Needs
• Handouts on DHS Child Care Program subsidies for children with special needs:
  » DHS High Need Child Care Rate Information for Parents and Child Care Providers
  » DHS Child Care Program Special Needs Rate and High Need Rate: How are they different?
  » Targeted Populations Supplemental Subsidy Information for Parents and Child Care Providers

• Including Children with Special Needs: Tips for Child Care Providers, Health and Safety Notes. California Childcare Health Program

• Inclusive Child Care Program
  » Inclusive Child Care Program flyer (English and Spanish)
ENVIROMENTAL HEALTH

Art & Creative Materials Institute (ACMI)
Provides non-toxic art and creative materials for children and artists; all products undergo extensive toxicological evaluation and testing before they can bear the ACMI certification seals
http://www.acminet.org/

Metro Hazardless Home Handbook
Information on common hazardous ingredients, potential hazards, responsible use and storage, proper waste management and alternatives for most common hazardous household products
http://www.oregonmetro.gov/index.cfm/go/by.web/id=1400

RESPONDING TO CHILD ABUSE AND NEGLECT

Child abuse and neglect reporting numbers

Child Abuse Hotline
For cases of suspected or known child abuse call 503-731-3100, 24 hours a day, seven days a week in Multnomah County; call local CAF branch office if outside Multnomah County.

Child Abuse Resource for Mandatory Reporters: What You Can Do About Child Abuse and Neglect
Helps mandatory reporters understand child abuse, what to report, and when and how to report it; gives an idea of what happens after making a child abuse report.

Documents and forms to download and print – Responding to child abuse and neglect

(To go to OKHS Volume 4: Appendix, Chapter A.)

- Child Abuse Reporting Phone Numbers, by county, revised 11-14-08
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INTRODUCTION

Healthy growth and development is influenced by the child’s inherited characteristics and environment. The E-Reference gives you a basic understanding of the relationship between health and safety and child development. It also shows how early care and education providers can create healthy and safe environments.

It is important to know about normal growth and development so that you can:

- Create a safe and stimulating environment for children in your care;
- Recognize children who are not developing according to stages of development as described in OKHS Volume 4: Appendix, Chapter B, “Child Development.”

Growth

Growth refers to the body getting larger in size. The three main factors that affect children’s growth (height and weight) are:

- **Biological parents**: Children inherit growth characteristics. For example, tall parents tend to have taller children and short parents have shorter children.

- **Environment (living conditions)**: The most important environmental factors affecting growth are nutrition (eating a balanced diet), physical activity, safety, freedom from toxins and toxin exposure and social/emotional nurturing.

- **Illness**: Children who are frequently ill or who have a serious or chronic illness may grow more slowly than other children.

Development

Development refers to the body becoming more skilled or mature. It occurs in the following areas:
• **Muscle skills:** These skills include how well a child moves all the muscles in the body, how muscles work and how the nervous system tells the muscles what to do.

• **Language skills:** These skills include how a child speaks, hears and understands.

• **Social and emotional skills:** How a child learns to see himself or herself as a loved, loving, able, unique human being are key skills. Social and emotional skills also involve how a child knows what is expected and how to act in his or her culture or society.

• **Sexuality:** Sexual development begins at birth and is influenced by physical, emotional and intellectual growth as well as by social and cultural expectations.

• **Thinking (intellectual) skills:** These skills involve how a child thinks and learns.

Many factors can affect a child’s normal development. The overall health of the child can influence a child’s energy and interest in learning new things. Poor nutrition; illness; lack of enough sleep at regular intervals; exposure to violence; toxins such as lead, pesticides or cleaning chemicals; and emotional stress can slow a child’s developmental course. Caregivers who provide a consistently healthy and safe, warm and interesting environment help children develop their full potential. The E-Reference provides information about how you can encourage healthy growth and development.

**CHILDREN’S HEALTH HISTORIES, PHYSICAL EXAMS AND IMMUNIZATIONS**

As an early care and education provider you can do several things to help the children in your care stay healthy.

• You can review children’s health records and remind parents of the importance of regular health care. Regular care, such as well-child exams and immunizations, can prevent illness and poor health.

• A regular review of health records can also help you identify any developmental delays or illnesses. Early treatment is more effective.

**What you can do to promote healthy growth and development**

Keep health records for each child that include:
• Consent for emergency medical and dental care;
• Health history information;
• Date of last physical exam;
• Completed Certificate of Immunization Status (CIS) form (for a copy, see OKHS Volume 4: Appendix, Chapter C, “Oregon Certificate of Immunization Status”);
• The name and contact information of each child’s medical and dental care provider.

Help parent/guardian find out about health care options and social service resources in your community.

• Families may be eligible for the Oregon Health Plan (OHP) or Oregon’s Medicaid Program. In some cases children may be eligible for the Oregon Health Plan, even though their parents are not, through the Children’s Health Insurance Program (CHIP) or Healthy Kids. Children with disabilities may be eligible for benefits through the Supplemental Security Income (SSI) program. To obtain information about the OHP, see this chapter’s Resources section, “General health resources for children and families.”

• The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides healthy foods, nutrition education, counseling and referrals to qualified pregnant and breastfeeding women, infants and children up to the age of 5. Foster parents, fathers, grandparents and other guardians may also be eligible to apply for their children (see this chapter’s Resources section, Nutrition, “The Supplemental Nutrition Program for Women, Infants and Children”).

• Families may be eligible to receive help with their monthly food budget through the Supplemental Nutrition Assistance Program (SNAP).

RELATIONSHIP OF NUTRITION, PHYSICAL ACTIVITY, TOXIN-FREE ENVIRONMENTS AND OVERALL HEALTH TO DEVELOPMENT

Early brain development

• What’s new?

We used to believe that babies were born with fully developed brains, but research has found that, at birth, the brain is about one-quarter the size
of an adult’s brain, and that it is not fully developed. The first three years of life are remarkable because, during that time, the brain goes through its most rapid stage of development during the human lifespan. This rapid development is the foundation for future learning. When the infant learns something new, brain cells connect to each other to form an expanding network. When the infant uses what is learned, brain connections are strengthened. After age 3, brain growth slows a bit, but learning builds on earlier experiences. By age 10 brain connections that are not often used may be naturally “pruned” or disappear.

You play a very important role in the development of the children in your care. Children learn when they have a special relationship with adults who are sensitive to their experiences and try to meet their needs. Early care and education providers who promote healthy social and emotional development also promote learning. Children feel safe and cared for when they are consistently encouraged to explore and return to caregivers for reassurance when needed, comforted when upset, included in activities even when shy or uncertain, and helped to understand and learn about their own actions and sometimes overwhelming feelings. They soon develop a picture of themselves as loveable and capable. Meeting the needs of the many children in your care can be a difficult job, but it is well worth the effort and can be a source of mutual pleasure for you and your little charges.

Science has found that timing of new experiences is important, too. Children develop at different rates, but the pattern of development is similar for all. There are “windows of opportunity” when the infant is ready to learn certain things. For example, if the opportunity for the first connection to learning language is missed, the child’s ability to learn language will be permanently affected.

These “windows of opportunity” are also “windows of vulnerability” as children develop. Exposure to a toxic material at a key time can lead to irreversible health problems. Because children eat, drink and breathe more than adults, they also take in higher concentrations of pollutants. Protecting children from exposure to lead, pesticides, cleaning supplies and other toxic materials helps them reach their full potential.
• What can you do?

The more consistent experience a child has, the greater the opportunities for learning. Infants and young children depend on their parents and caregivers to supply what they need to learn. When a caregiver knows about these “windows of opportunity” and is prepared with games, toys and activities that help the infant learn when ready, brain connections are made and healthy development continues. Breast milk has unique nutritional benefits for improved brain development and promotes attachment and healthy social and emotional development. The quality of early experiences makes a big difference, too. Healthy and safe practices, healthy food, as well as rich experiences in a warm, responsive and interesting atmosphere can help the infant learn and develop.
PHYSICAL DEVELOPMENT

Height and weight from birth through 12 years

During the first year, and especially the first six months, infants experience rapid growth. Growth rates of breastfed and formula-fed infants differ. Breastfed infants grow more rapidly in the first two to three months but less rapidly from 3 to 12 months of age. Infants born premature — a month or two earlier than expected — will often reach developmental milestones a month or two later than those born when expected.

Growth rate declines during the early childhood period (ages 1 to 4 years). Children experience slow, steady growth during ages 5 through 10 years. Adolescence (11 to 21 years) is a time of phenomenal growth, second only to the growth that occurs during the first year of life. It is important to remember that growth patterns vary for individual children. See the following chart for general growth rate information.

The “Child Development” document in OKHS Volume 4: Appendix, Chapter B provides information on stages of physical development and gives suggestions on ways you can help children learn. Remember that children develop at varying rates. If you think a child is not developing as expected, talk to the family about your concerns. Families may have feelings about their children's development that are based on cultural beliefs and past experiences. They may have some of the same concerns. Your interest may help them decide to visit their health care provider and find out more.
## Growth averages by age

<table>
<thead>
<tr>
<th>Age</th>
<th>Average weight</th>
<th>Average height</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>7 pounds</td>
<td>20 inches</td>
</tr>
<tr>
<td>6 months</td>
<td>Double birth weight</td>
<td></td>
</tr>
<tr>
<td>1 year</td>
<td>Triple birth weight</td>
<td>Birth length increases by 50 percent</td>
</tr>
<tr>
<td>2 to 10 years</td>
<td>Quadruple birth weight by 2 years. Ages 2 years to puberty, the average gain is 4.5 to 6.5 pounds per year.</td>
<td>From 2 years to puberty growth averages 2.5 to 3.5 inches per year. At 4 years, birth length doubles.</td>
</tr>
<tr>
<td>11 to 21 years</td>
<td>50 percent of adult weight is gained. During preadolescence and early adolescence, body fat increases in preparation for this growth spurt.</td>
<td>Between 11 and 21 years 80-85 percent of adult height is gained.</td>
</tr>
</tbody>
</table>
HEALTH BENEFITS

The basis for a lifetime of physical activity begins in childhood. Infants and young children who are physically active have a greater likelihood of developing and growing normally. Early motor skills form the foundation for early learning and language development. Early physical activity builds strength and forms the basis for later sport, dance and exercise activities.

Your support and enjoyment of movement and motor skills will help children continue to be physically active. We know from research that physical activity is important for healthy brain development and learning. We also know that children experience a feeling of accomplishment when they are active. To support children’s energy needs, their diets should contain a wide variety of healthy foods.

In the United States we are seeing an alarming increase of overweight children across all ages. There are many reasons for this epidemic. Two major causes of overweight are poor eating behaviors and low levels of physical activity. Being overweight can result in serious health problems. We know that a sedentary lifestyle and overweight are linked to the development of heart disease, diabetes and other chronic conditions in adulthood. Now we are seeing more children with health problems such as diabetes, high blood pressure and high blood cholesterol related to overweight.

The most important strategies for preventing obesity are healthy eating behaviors, regular physical activity and limits on sedentary activities such as watching television and playing computer games. These preventive strategies are part of a healthy lifestyle that should be developed during early childhood. **The goal is to teach and model healthy and positive attitudes toward food and physical activity without emphasizing body weight.**
PHYSICAL ACTIVITY GUIDELINES

The following guidelines are adapted from the National Association for Sport and Physical Education. The organization’s motto is “All children birth to age five and school-age children should engage in daily physical activity that promotes movement skillfulness and foundations of health-related fitness.”

Children with special health care needs benefit from regular physical activity just like other children. It can make the tasks of daily living easier for them. It can improve their health, prevent additional illness during adulthood, and help normalize their daily living experiences. Activities may need to be adapted to help the child have a positive experience participating in them. It is essential to work together with the child and his or her parents to find out what level of participation is best.
### Physical activity guidelines for children from birth to 5 years

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Ways to incorporate physical activity</th>
<th>Limit</th>
<th>Not recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infants (birth to 12 months)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Guideline 1</strong></td>
<td>Infants should interact with caregivers in daily physical activities that are dedicated to exploring movement and the environment.</td>
<td>Play baby games such as peek-a-boo and pat-a-cake.</td>
<td>Infant walkers and exercise saucers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hold and rock infants and carry to new environments.</td>
<td>Physical activity that is not developmentally appropriate. Includes but is not limited to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Place infants on stomach and encourage to move about on a clean or blanketed floor (could place a rattle or favorite toy just out of their reach).</td>
<td>• Running</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide safe objects of different textures, sizes, colors, shapes and weights to allow infants to practice grasping and hand control.</td>
<td>• Throwing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>While awake, infants should spend less than 30 minutes a day in confining equipment.</td>
<td>• Catching</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Examples:</td>
<td>• Overly structured activities that do not interest or engage infants.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Swings</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bouncy chairs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Car seats</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Strollers</td>
<td></td>
</tr>
</tbody>
</table>

While awake, infants should spend less than 30 minutes a day in confining equipment. Examples:
- Swings
- Bouncy chairs
- Car seats
- Strollers

Infant walkers and exercise saucers

Physical activity that is not developmentally appropriate. Includes but is not limited to:
- Running
- Throwing
- Catching
- Overly structured activities that do not interest or engage infants.
Physical activity guidelines birth to 5 years (continued)

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Ways to incorporate physical activity</th>
<th>Limit</th>
<th>Not recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants (birth to 12 months) continued</td>
<td>and should promote movement skills by providing opportunities for structured and unstructured physical activity.</td>
<td>Toddlers (12 to 36 months)</td>
<td></td>
</tr>
<tr>
<td>Guideline 1</td>
<td>Toddlers should engage in a total of at least 30 minutes of structured physical activity each day.</td>
<td>Toddlers should spend less than 30 minutes in confining equipment while awake.</td>
<td>Toddlers should engage in the following:</td>
</tr>
<tr>
<td>Guideline 2</td>
<td>Toddlers should engage in at least 60 minutes — and up to several hours — per day of unstructured physical activity and should not be sedentary for more than 60 minutes at a time except when sleeping.</td>
<td>Toddlers should spend less than 30 minutes in confining equipment while awake.</td>
<td>Toddlers should engage in the following:</td>
</tr>
<tr>
<td>Guideline 3</td>
<td>Toddlers should be given ample opportunities to develop movement skills that will serve as the building blocks for future motor skillfulness and physical activity.</td>
<td>Toddlers should spend less than 30 minutes in confining equipment while awake.</td>
<td>Toddlers should engage in the following:</td>
</tr>
</tbody>
</table>

- Act out imaginative poems.
- Play chase games.
- Crawl under and around playground structures.
- Grasp large balls and inflatable toys.
- Dig and build in sandboxes.
- Have objects for the toddlers to ride, push, pull, balance on, climb up and jump safely down from and to ground level.

Examples:
- Car seats
- Strollers

More than 60 minutes of sedentary activity at a time, except while sleeping.

Infant walkers

Physical activity that is not developmentally appropriate. Includes but not limited to:
- Hopping on one foot
- Skipping
- Climbing on the monkey bars
- Competitive games
## Physical activity guidelines birth to 5 years (continued)

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Ways to incorporate physical activity</th>
<th>Limit</th>
<th>Not recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Toddlers (12 to 36 months) continued</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Guideline 4</strong></td>
<td>Toddlers should have access to indoor and outdoor areas that meet or exceed recommended safety standards for performing large muscle activities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Guideline 5</strong></td>
<td>Those in charge of toddlers’ well-being are responsible for understanding the importance of physical activity and promoting movement skills by providing opportunities for structured and unstructured physical activity and movement experiences.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preschoolers (3 to 5 years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Guideline 1</strong></td>
<td>Preschoolers should accumulate at least 60 minutes of structured physical activity each day.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Guideline 2</strong></td>
<td>Preschoolers should engage in at least 60 minutes — and up to several hours — of unstructured physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Offer a large variety of safe objects for children to roll, kick, throw or catch.</td>
<td>Avoid more than 60 minutes of sedentary activity at a time, except while sleeping.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Play simple non-competitive games.</td>
<td>Do not encourage developmentally inappropriate physical activity, including but not limited to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Explore large outdoor toys and equipment, including preschool playground equipment and</td>
<td>• Riding a two-wheel bike</td>
<td></td>
</tr>
</tbody>
</table>
activity each day, and should not be sedentary for more than 60 minutes at a time except when sleeping.

**Guideline 3**
Preschoolers should be encouraged to develop competence in fundamental motor skills that will serve as the building blocks for future motor skillfulness and physical activity.

**Guideline 4**
Preschoolers should have access to indoor and outdoor areas that meet or exceed recommended safety standards for using large muscle activities.

**Guideline 5**
Caregivers and parents in charge of preschoolers’ health and well-being are responsible for understanding the importance of physical activity and for promoting movement skills by

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Ways to incorporate physical activity</th>
<th>Limit</th>
<th>Not recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschoolers (3 to 5 years) continued</td>
<td>activity each day, and should not be sedentary for more than 60 minutes at a time except when sleeping.</td>
<td>wheeled toys. • Offer opportunities for climbing, balancing, swinging, hanging and sliding. • Play in outdoor settings where natural shrubbery allows children to move vigorously around or through it. • Take children on walks around local environments.</td>
<td>• Roller-skating/blading • Elimination games</td>
</tr>
</tbody>
</table>
Physical activity guidelines birth to 5 years (continued)

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Ways to incorporate physical activity</th>
<th>Limit</th>
<th>Not recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschoolers (3 to 5 years) continued</td>
<td>providing opportunities for structured and unstructured physical activity.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chart adapted from Active Start: A Statement of Physical Activity Guidelines for Children Birth to Five Years, 2nd edition, The National Association for Sport and Physical Education.

Physical activity guidelines for school-aged children

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Ways to incorporate physical activity</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>(ages 5 to 12 years)</td>
<td>Good activities for the school-age child are those that:</td>
<td>More than 120 minutes (two hours) of sedentary activity at a time.</td>
</tr>
<tr>
<td></td>
<td>• Focus on having fun and developing motor skills rather than on competition.</td>
<td>Elimination games</td>
</tr>
<tr>
<td></td>
<td>• Have flexible rules.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Require little instruction.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Do not require complex motor and cognitive skills.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Examples of good activities are walking, biking, hiking, skating, dancing and swimming.</td>
<td></td>
</tr>
</tbody>
</table>
Physical activity guidelines for school-aged children *(continued)*

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Ways to incorporate physical activity</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>(ages 5 to 12 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>health, wellness, fitness and performance benefits.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Guideline 4**
Extended periods (of two hours or more) of inactivity are discouraged for children, especially during the daytime hours.

Adapted from *Physical Activity for Children: A Statement of Guidelines for Children Ages 5–12, 2nd edition*, The National Association for Sport and Physical Education.

<table>
<thead>
<tr>
<th>Activity type</th>
<th>Intermittent</th>
<th>Continuous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate activities</td>
<td>Games such as hop-scotch and four-square; some positions in sports such as goalie in soccer; some chores and yard work</td>
<td>Walking to school, bike riding, some chores and yard work, hiking, canoeing</td>
</tr>
<tr>
<td>Vigorous activities</td>
<td>Active games involving running, chasing, etc.; playing sports</td>
<td>Self-selected activities such as jogging</td>
</tr>
</tbody>
</table>
Play outdoors safely

Children need opportunities to spend time outdoors for physical activity and play. They learn many skills as well as learn about their environment, science and nature. When the weather poses a health risk, children should not play outdoors. The National Weather Service has identified a wind chill factor at or below minus 15 degrees F and a heat index at or above 90 degrees F that poses a health risk.

In warm weather children should be encouraged to drink water and play areas should have shelter from the sun such as shady trees or covered areas. Hats and light long-sleeved shirts and pants can prevent sun exposure between 10 a.m. and 2 p.m. Sunscreen should be applied before outdoor play in the sun with written permission from parents. Avoid sunscreen with insect repellant in it. Never use insect repellant on infants. If you must use repellant on children, the American Academy of Pediatrics recommends no more than 10 percent DEET. Use care to wash off repellant when returning indoors.

In cold weather, caregivers should check for warmth in the child’s hands and feet every 15 minutes.

Caregivers should also be aware of potential environmental hazards when selecting an area to play outdoors. Choose a play area away from contaminated water, loud noises, lead in soil or grass recently treated with pesticides or herbicides. If playground equipment is made from treated wood, it may contain arsenic; be sure to coat wooden play equipment with a water-based sealant once a year.

Children should not play outdoors when authorities announce unhealthy air quality.

Opportunities for physical activity should never be withheld for children who misbehave. The early care and education setting may be the only daily opportunity for active play for many children. (See Chapter D, “Indoor, outdoor and transportation safety checklists.”)

SCREEN TIME GUIDELINES

Children spend an average of six hours each day watching television, DVDs, video games, recreational computer and other screen media. This takes the place of other activities that promote brain development such as reading, interacting with family and caregivers, playing with friends, exploring their
environment, or being physically active. Poor health effects can result from watching too much television and using other screen media. These include increased risk for:

- Violent and aggressive behavior
- Obesity
- Sexual activity
- Poor academic performance
- Negative body image and dieting behavior
- Poor quality diet
- Substance use and abuse
- Excessive exposure to advertising and marketing

Additionally, research has shown that DVDs and videos marketed to parents of infants and toddlers (8-16 months old) are associated with fewer words learned for every hour the infant or toddler views baby videos/DVDs.

The American Academy of Pediatricians recommends the following screen media guidelines:

- Best practice for early care and education is for children ages 2 through 5 years to have no more than 30 minutes’ screen time the entire week (not per day).
- Limit children’s total media time (e.g., television, video and computer use) to no more than one to two hours of quality programs per day.
- Children less than 2 years old should not watch television. Talking, playing, singing and reading together should be encouraged.
- Children should watch shows that are informational, educational and non-violent. Caregivers need to monitor the shows.
- Encourage other kinds of activities for children such as reading, physical activity, hobbies and creative play.

If television is allowed in your early care and education setting, allow only programs or videos appropriate for the ages and development of the children. Make sure the programs have minimal or no advertising. Caregivers need to monitor the shows and advertising. Do not use television to reward or punish children.
Encourage parents to develop positive television viewing habits for the family. This means to limit their own and their children’s television viewing, turning off the TV during mealtimes and removing TVs from bedrooms. Also, parents should be involved in choosing programs with their children as well as discussing the content of the programs and advertising exposure during and after watching.

**Screen time guidelines**

<table>
<thead>
<tr>
<th>Age</th>
<th>Recommended</th>
<th>Limit</th>
<th>Not recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to 2 years</td>
<td>Talking, playing, singing and reading together</td>
<td>Screen time for children less than 2 years of age. Screen time includes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• TV or DVDs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Computer</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Video games</td>
<td></td>
</tr>
<tr>
<td>2 years and above</td>
<td>Screen media needs to be informational, educational and non-violent. Reading, physical activity, games, hobbies and creative play</td>
<td>Limit screen time to under one hour* a day. Screen time should be supervised. Parent permission should be requested for children participating in any screen time. This includes:</td>
<td>More than one hour of screen time. Meal and snack times should be free from screen exposure.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• TV or DVDs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Computer</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Video games</td>
<td></td>
</tr>
</tbody>
</table>

*It is recommended that screen time be limited to one hour or less in early care and education with the knowledge that children will likely get additional screen time at home.

**There is a link between watching television and being overweight. Take a break from the TV and video games and get moving.**
Because children spend most of their time indoors, a healthy indoor environment is essential. Unfortunately, studies show that indoor air quality is typically between three and five times — and sometimes as much as 100 times — worse than outdoor air. Keeping your air circulating, controlling dust and avoiding common contaminants are good practices for avoiding the air quality problems that can trigger allergies, asthma and other chronic health problems.

**AIR FLOW**

Air circulation can help remove pollutants, control the moisture that leads to mold and mildew, and keep odors under control. Be sure to regularly use bathroom and kitchen fans; they are vented to the outdoors and are often the easiest way to remove air pollutants. Throw open the windows for 10 minutes each day to circulate air — even when it is cold or rainy. If your facility is located on a busy street or near a pollution source, you may wish to open the windows in the evening or morning when traffic or industry is less active.

**DUST CONTROL**

Indoor dust has been found to contain dozens of contaminants including pesticides, lead, toxic flame retardants, cleaning chemicals and more. Because children play on the ground and put their hands to their mouths more often than adults, they experience greater exposure. Dusting regularly with a damp (water-only) cloth or microfiber cloth can control pollutants.

**COMMON CONTAMINANTS**

Air fresheners and scented products used to mask odors can contain chemicals that create allergies, trigger asthma or lead to chronic health disorders. Instead, use baking soda as a safer odor absorber on carpets and in diaper pails.

Immediate and long-term chronic exposure to car exhaust can be very harmful. Establish a no-idling zone at your facility.
Avoid aerosol sprays. Aerosol sprays create tiny droplets that children can breathe deep into their lungs, triggering asthma and allergies. Avoid furniture polish, carpet cleaner, hair spray, deodorant and other aerosols.

Protect children from cigarette smoke. Ways to protect children in your care from second-hand smoke (inhaling smoke) and third-hand smoke (touching smoking residue on clothing, hair and furnishings) include these best practices:

- If you do smoke, smoke outside and wear a smoking jacket that you can remove indoors.
- Don’t smoke indoors, within sight of the early care and education center or in the car used to transport children.
- Wash your hands after smoking.

For information about the Eco-Healthy Child Care endorsement, see the Resources section at the end of this chapter, Healthy indoor air, “Eco-Healthy Child Care.”
Many things influence food choices and food preparation. Food choices people make depend not only on their nutrition needs but also on their culture, religion, access to food, environment and enjoyment of certain foods. Children with disabilities may not be able to follow the dietary guidelines that apply to other children. It is important to encourage children and families to maintain the healthy eating behaviors that are part of their cultures. Foods that are important in various cultures can be used in education efforts. Talk with families to find out their food practices and beliefs.

HEALTHY EATING AND PHYSICAL ACTIVITY

Healthy eating and physical activity are important at every age. It is important to keep children free from hunger, make sure that water is freely available, and create a relaxed and pleasant environment for eating that fosters healthy digestion and positive social behaviors. Good habits can prevent health problems such as iron deficiency anemia, overweight, diabetes or heart disease. Healthy eating and physical activity can improve well-being through:

- Increasing strength and endurance
- Building healthy bones and muscles
- Developing motor skills and coordination
- Controlling weight, building lean muscle and reducing body fat
- Reducing feelings of depression and anxiety
- Promoting a good attitude

Food for the brain

Healthy eating is also important for children’s brainpower. Children need good nutrition for:

- The brain to grow and develop
- Learning at school
• Listening to instructions
• Finishing projects and tasks

What is the MyPlate food guide?
The MyPlate food guide replaces MyPyramid. MyPlate promotes healthy eating behaviors. It helps children and adults choose different types of foods and the amounts needed from each group. Each of the food groups provides some, but not all, of the nutrients and energy needed. No single food group is more important than another.

The food groups

- **Grains and cereals** — especially whole grains
- **Vegetables** — especially dark green, leafy and deep yellow
- **Fruits** — especially deep orange, yellow and red whole fruits. All fruit juices limited to not more than six ounces per day for children 1 year of age and older
- **Milk** — whole or reduced fat (2 percent) for children at risk for obesity or hypercholesterolemia, for children between 1 year and 2 years of age; skim or 1 percent for children 2 years or older; unsweetened low-fat yogurt, low-fat cheese (e.g., cottage cheese)
- **Meats** — baked or broiled chicken, fish, lean meat, dried peas and beans
- **Oils** — vegetable

Source: U.S. Department Agriculture

The USDA Child and Adult Care Food Program (CACFP) is a valuable resource for providers. The USDA food program’s guidelines for specific meals are based on MyPlate. See **OKHS Volume 4: Appendix, Chapter B, “USDA Child and Adult Care Food Program”** for USDA Child and Adult Care Food Program Guidelines.
**Tips to improve healthy eating**

Children need to eat a wide variety of foods they will enjoy into their adult years. Here are some ways to improve healthy eating in children:

- Serve many different kinds of foods within each of the food groups.
- Serve an appropriate portion size of food (see *OKHS Volume 4: Appendix, Chapter B. CACFP Food Chart for the Child — age 1–12*).
- Serve lots of whole grains, fresh vegetables and fruits.
- Choose bright-colored vegetables and fruits such as carrots, red and yellow peppers and strawberries. These foods are often highest in vitamins A and C. Serve at least one vegetable or fruit at every meal or snack.
- Scrub all produce thoroughly with plain, cold water to remove pesticide residue. Choose organic produce when available.
- Limit high-fat foods and use low-fat cooking methods whenever possible. For example, broil and roast meats rather than frying them. Steam, lightly stir-fry or parboil vegetables instead of deep-frying or boiling them. This reduces fat and holds on to the greatest amount of vitamins and minerals.
- Serve water, rather than fruit drinks or soda pop, for thirst.

Vegetables and fruits play an important role in preventing many diseases. They also help maintain a healthy weight. Look under Resources in this section for books with recipes and ideas on how to eat more vegetables and fruits.

Clean drinking water should be readily available in indoor and outdoor areas throughout the day. When children are thirsty, water is the best choice. In most cases, tap water is a better choice than bottled water. To reduce exposure to lead from pipes, be sure to let the faucet run at least 30 seconds or until water is noticeably colder before using it for drinking, cooking or formula. Infants should not be given water in the first six months; offer additional human milk or formula. Water needs vary among young children and increase during hot days, exercise and dry days in the winter.
HOW TO DEVELOP POSITIVE ATTITUDES TOWARD FOOD

Do:

- Eat in a pleasant, unrushed environment.
- When appropriate, involve children with food preparation, setup and cleanup.
- Serve meals family-style so children can choose their own portion sizes. Check with the Oregon Employment Department Child Care Division on specific requirements if serving family-style meals.
- Let children judge their own hunger cues to stop eating when they are full.
- Sit with children and eat the same foods they do. Adult companionship at meals and snacks improves young children’s eating habits.

Don’t:

- Make children taste every food. Forcing the child to eat something they don’t want to eat can reinforce the child’s dislike of the food.
- Bribe kids to eat. Rewarding a child with dessert or more playtime sends the wrong message about food.

PUTTING GOOD NUTRITION INTO PRACTICE

Healthy food habits

- Set a good example by eating a balanced diet high in vegetables, fruits and whole grains. Remember that children learn what they see.
- Make sure to teach the importance of breakfast.
- Provide healthy snacks such as vegetables, fruit, low-fat unsweetened yogurt or toast squares.
- Teach children the difference between snacks and treats.
- Share nutrition information with the children and parents.
- Encourage children to tell their parents about new foods they have tried during early care and education.

“Adults are in charge of what food is served, and when and where they serve it; children are in charge of how much of that food they eat and whether they eat any of it at all.”

**Activity ideas**

Here are some great activities to do with kids:

- Visit a local farm or farmer’s market, produce stand or grocery store.
- Bake whole-wheat bread and allow the children to shape the dough into different animal shapes.
- Create smiling faces using rice cakes and cheese, or make frozen banana sticks or applesauce.
- Let children taste, smell and feel different foods. Help them learn about the textures, colors and shapes of foods.
- Have the children reach into a “mystery bag” to feel foods of different sizes, shapes and textures. Have them describe what they feel and identify the food; give them the option of tasting it.
- Build an “edible pyramid” with foods from the different food groups of the MyPlate food guide.
- Reinforce information with families — sharing recipes and ideas, promoting family meals with parents.

**INTRODUCING NEW FOOD**

- Children should be introduced to a new food by their family or caregiver.
- Introduce only one new food at a time.
- Offer new foods often and remember that children may need to see a new food six to 12 times before they will decide to like it.
- Serve new foods in small amounts and when children are hungry.
- Teach children where foods come from and how foods are grown. (Start a vegetable garden allowing the children to take part in planting and taking care of the garden.)
- Offer foods from other cultures and talk about where each food originates.

The following table presents information about recommended foods by age of child. Remember to talk with families about their food practices and beliefs.
### Recommended foods by age

<table>
<thead>
<tr>
<th>Age</th>
<th>Recommended foods</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Birth</strong></td>
<td>• Breast milk or iron-fortified formula throughout the first year</td>
<td>• Breast milk or iron-fortified formula meets all of the infant’s nutritional needs until about 6 months.</td>
</tr>
</tbody>
</table>
| **Approximately 6 months** | • Infant cereal (iron-fortified), rice, oatmeal or barley; feed by a spoon  
• Meat | • Introduce iron-fortified infant cereal, using single grains, starting with rice cereal. Mix with infant formula or breast milk and feed from a spoon.  
• Don’t put cereal or other solids in the baby’s bottle.  
• Introduce one new food at a time.  
• Allow a week for each new food.  
• Watch for problems that may be allergy-related, such as diarrhea, gas, intestinal discomfort, constipation, hives or rashes. |
| **6 to 8 months**  | • Vegetables and fruits, strained/blended  
• Liquids from a cup | • Introduce liquids from a cup.  
• Offer fruit and vegetables the family typically eats, but strained/blended. The purpose of introducing foods at this time is to expose the infant to new flavors and textures.  
• Offer the new food in the morning or early afternoon. Begin with just 1 teaspoon of new food. Place a small amount of the food on a small spoon and place midway back on the infant’s tongue (not too far back or the baby may choke).  
• Never force infants to eat. If they don’t like a food, don’t push it. Try it again in a few weeks. |
## Recommended foods by age (continued)

<table>
<thead>
<tr>
<th>Age</th>
<th>Recommended foods</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 8 to 10 months | • Protein foods: cottage cheese, yogurt, strained meats, boneless chicken, fish, beans, tofu, egg yolk (no whites)  
• Other infant cereals such as wheat and mixed grains  
• Mashed vegetables and fruits  
• Begin offering finger foods: toast squares, Cheerios®, Kix®, toasted oat rings, cooked vegetables, peeled and soft fruit wedges or slices, small tender pieces of meat | • Begin offering small amounts of protein foods, gradually increasing the amount.  
• Some fruits may need to be peeled (apples, pears).  
• Serve no more than 4-6 ounces of 100 percent fruit juice a day.  
• Do not leave a child alone with finger foods, which may cause choking. (Later in this chapter, see list of foods that can cause choking.) |
| 10 to 12 months | • Food from family table (feeds self)  
• Cooked vegetables and soft pieces of fruit  
• Cereal, bread  
• Cooked beans  
• Tofu  
• Small pieces of fish, meats, chicken  
• Cheese  
• Casseroles | • Give egg yolks at this time.  
• Infants will start feeding themselves by picking up food with their fingers.  
• Expect the infant to be very messy during this stage.  
• Offer small amounts of a variety of good foods. |
| 1 year | • Can drink whole milk from cup (buy vitamin D-fortified)  
• Whole egg (yolk only before 1 year of age)  
• Wean from bottle to cup | • The first year of life is a period of rapid growth.  
• You may notice the baby’s appetite drops off at this time.  
• He/she may seem to have many likes and dislikes.  
• Serve colorful foods that are crunchy, smooth or warm.  
• Do not force a child to eat more than wanted. Remember that all babies are different and, like adults, they differ in how much they will eat. |
NUTRITION FOR INFANTS

Infants have special needs because they grow and develop quickly. Breast milk is the best food for infants. Breast milk should be given for at least the first year of life, and longer if desired. An added benefit of breastfeeding is promotion of attachment and healthy social and emotional development. If the infant is not breastfed, iron-fortified formula is recommended until 12 months of age. Avoid serving regular cow’s milk until the infant is 1 year old to prevent possible allergic reaction, stomach problems and low blood iron (anemia).

When preparing baby’s food, formula or breast milk, remember:

- Wash your hands.
- Do not heat baby foods, formula or breast milk in the microwave. The heat is uneven and can produce “hot spots” that can burn a baby’s mouth and throat, as well as destroy nutrients.
- Avoid feeding directly from the baby food jar since the bacteria from a baby’s mouth can grow in the food before it is served again, which can make a baby sick.
- Throw away any food left uneaten in the dish.
- Choose glass, stainless steel or BPA-free baby bottles. Discard hard, clear plastic polycarbonate bottles if they are scratched or heated. Do not heat baby food or formula in plastic containers.

Note: Honey should never be given to infants under 1 year of age. It can lead to a very serious disease called infant botulism that can be fatal. Avoid cooked or raw honey in any food product during the baby’s first year. Honey is OK for children over the age of 1 and adults.

BREASTFEEDING

How early care and education providers can support families

As an early care and education provider, you are a very special person. You play an important role in supporting healthy growing families. You can help families breastfeed successfully by supporting their feeding choices. Breastfeeding benefits mothers, babies, families and early care and education providers.

Breastfeeding is best for babies because:

- Breastfed babies are healthier babies.
• Breastfed babies have a reduced risk of SIDS (sudden infant death syndrome), infections, allergies and diabetes.
• Breast milk is easy to digest and changes to meet baby’s changing needs.
• Breastfeeding helps mom and baby develop a special closeness.

Breastfeeding is best for mothers and families because:
• Mothers that breastfeed tend to lose weight and get back in shape more quickly.
• Mothers that breastfeed have a reduced risk of breast and ovarian cancers, and diabetes.
• Mothers tend to feel better about themselves when they are able to provide the unique gift of breast milk even when they have to be away from baby.
• If baby is healthier, parents miss less work.
• Breastfeeding costs less than formula feeding even if mom has to use a breast pump.

Caring for a breastfed baby is easy for early care and education providers because:
• Breastfed babies have better smelling stools.
• Breastfed babies are less likely to get sick.
• Breastfed babies tend to spit up less.
• Breast milk does not stain clothing.
• The use of breast milk reduces trash and pollution because there are fewer cans, bottles and nipples to throw away.
• Families appreciate support for their breastfeeding decision.

Being a breastfeeding supporter can bring you business. Most breastfeeding families look for an early care and education provider that supports their feeding decision. You can help breastfeeding go well when mom returns to work by:
• Encouraging mom and letting her know you like to care for breastfed babies. Refer her to other breastfeeding resources if she needs help.
• Respecting parents’ wishes about the baby’s feeding plan. Find out if parents want baby to have any foods other than breast milk.
• Finding out what calming techniques work for baby, other than feeding.
• Timing feedings so baby will be ready to eat when mom is ready to nurse.
• Offering mom a quiet, comfortable place to nurse baby before, during and after her workday.
• Letting parents know how baby is doing each day.

Proper storage, handling and warming of breast milk

• Ask mom to store breast milk in hard plastic bottles or freezer-safe storage bags and label with baby’s name and date milk was collected.
• Store breast milk according to storage guidelines. (Refer to “Food requiring special care” later in this chapter for more information.)

<table>
<thead>
<tr>
<th>Breast milk storage guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room temperature</td>
</tr>
<tr>
<td>Freshly expressed breast milk</td>
</tr>
<tr>
<td>Thawed breast milk (previously frozen)</td>
</tr>
</tbody>
</table>

Source: USDA “A Guide for Use in the Child Nutrition Programs” (pg. 20121)

• Use the oldest milk first.
• Thaw only as much frozen breast milk as baby needs for a feeding.
• Thaw frozen breast milk in the refrigerator or hold it under running cold water.
• If breast milk has a bad odor after thawing, it should be thrown out.
• Shake the bottle of breast milk before feeding because breast milk separates in two layers when it is stored.
• Do not thaw breast milk at room temperature, by heating on the stove, in a microwave, or in a bottle warmer. Excessive heat destroys some of the
immunological benefits of breast milk. Microwave heating can create hot spots in the breast milk that can burn the baby’s mouth and throat.

- For babies who prefer a warm bottle, hold the bottle under running warm (not hot) water immediately before feeding the baby.
- Thawed breast milk must be used within 24 hours. Never refreeze thawed breast milk.

**Feeding the breastfed baby**

- When and how to introduce the bottle: If a baby will need to be bottle-fed sometimes, bottles of expressed breast milk can be introduced once the baby is at least 3-4 weeks old and breastfeeding is going well. Someone other than the breastfeeding mother can begin offering a bottle to baby periodically. This helps baby get used to being fed this way. (Note: In regulated early care and education facilities, children must be 6 weeks old before they can be enrolled.)

- Waste not, want not: If the breast milk mom brings is not separated into feeding quantities, pour only the amount you think the baby will take into a bottle or cup. You can always give baby more, and this will avoid wasting lots of precious breast milk.

- What to do with the leftovers: If any breast milk is left in a bottle or cup after the feeding, throw it away. Germs from the baby’s mouth contaminate the breast milk that is left in the container.

- How much will baby eat: The amount of breast milk the baby takes may vary from day to day. Younger babies may take one to four ounces per feeding. When babies are growing, they may begin eating more at one feeding. Some breastfed babies eat small amounts when away from mom, and nurse a lot to compensate once they are with mom again. Let parents know each day how feeding went.

- If baby refuses the bottle: Babies sometimes refuse to take a bottle. That is one way they communicate with us. If baby refuses the bottle, try holding the baby in different positions. Try warming the bottle nipple. If baby cries when you offer a bottle, stop offering and calm baby, then try to offer again in a few minutes. Try offering the bottle to baby when you are standing up and walking around, or when baby is sleepy and relaxed.

*All babies need the same things. They need to be warm, dry, fed, cuddled and loved. Thanks for creating a supportive, loving environment for breastfed babies.*
If baby refuses to eat, check for other signs of illness and alert parents. Never prop a bottle to feed a baby.

- Plan for the “what ifs”: Talk with parents and develop a plan of action for times when you use up all the expressed milk mom has left, or baby repeatedly refuses a bottle. Only offer formula or other foods to baby if parents request it.
- Babies older than 6 months can learn to drink breast milk from a cup.

**NUTRITION ISSUES AND CONCERNS**

**Managing food allergies and allergic reactions**

Food allergies are very common in infants and children because their digestive and immune systems are still not completely developed. As children get older, they often outgrow their food allergies, but some food allergies will stay with children through adulthood.

An allergic reaction can take from a few minutes to several days to happen. It is important to know what the symptoms of food allergies look like since they can cause chronic health complaints and, in very bad cases, life-threatening reactions.

Providers need to identify and document allergies and food intolerance when enrolling a child in care. You need to also identify acceptable food substitutions.

**Foods most likely to cause allergies in children**

- Cow’s milk
- Soy
- Wheat
- Peanuts
- Tree nuts (walnuts, cashews, etc.)
- Seeds
- Fish and shellfish
- Eggs (especially the egg whites)
Some common symptoms of allergic reactions

- Hives
- Eczema
- Diaper rash
- Nausea and vomiting
- Diarrhea
- Sneezing
- Swelling of the throat
- Nasal congestion
- Conjunctivitis
- Coughing
- Asthma
- Sleep disturbances
- Diarrhea
- Difficulty breathing

How to manage an allergic reaction

- Develop a written policy on parent/caregiver responsibilities related to allergic conditions.
- List and post foods children are allergic to and suggestions for food substitutes.
- Obtain permission from parent to give the appropriate medications. Training to safely give medication for anaphylactic shock is also recommended.
- Avoid cross-contamination of cutting surfaces and utensils.
- Encourage handwashing to prevent unintentional contact with offending food item.
- Consider banning certain foods (peanuts/peanut butter) if a highly susceptible child is in your care.
- Identify who needs to be contacted in case of an emergency or if you have questions.
- Don’t use latex gloves when preparing foods.
Vegetarian diet

Vegetarian eating practices are chosen for religious, health, environmental, cultural and ethical reasons. These diets usually include at least a few foods of animal origin, usually dairy products and eggs. Vegan diets exclude the use of animal foods of any type. Written documentation needs to be provided that includes detailed information about foods eaten and foods restricted.

Vegetarian eating practices have many positive health aspects since these diets usually provide more vegetables, fruits and fiber, as well as less fat than diets containing meat products. With careful planning, vegetarian diets can provide a variety of nutritious foods that promote healthy growth and development. It is important to work with the parents in order to meet their child’s nutrition needs.

Following a vegan diet may place infants and children at risk for poor nutrition unless specially fortified foods or supplements are added (specifically vitamins B12 and D). Overly restrictive or poorly selected vegetarian diets can result in malnutrition. For concerns about a child’s diet, refer the family to a health care provider.

Choking on food

- Children ages 4 and under, and some children with special needs, are at high risk for choking on food. Do not prop a bottle to feed a baby. Also, some foods should be left out of the diet until the child can chew and swallow (approximately age 4).

Some childhood favorites can be offered if you just change the form

- Shred or cut tender meat into small pieces.
- Cook carrots or celery until slightly soft, then cut into sticks.
- Cut grapes or cherries into small pieces.
- Thinly spread peanut butter on bread or crackers.

Vegetarian is a general term used to describe people who exclude meat, fish, poultry or animal-derived foods from their diets.
### Foods that may cause choking

<table>
<thead>
<tr>
<th>Property of food</th>
<th>Examples of food</th>
<th>Change the form of food</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hard</td>
<td>Hard pretzels, hard candy, chips, rice cakes</td>
<td>Do not offer</td>
</tr>
<tr>
<td>Small</td>
<td>Peanuts, other nuts and seeds</td>
<td>Do not offer</td>
</tr>
<tr>
<td>Round</td>
<td>Popcorn, raw peas, ice cubes</td>
<td>Do not offer</td>
</tr>
<tr>
<td>Slippery</td>
<td>Whole grapes</td>
<td>Cut grapes into small pieces</td>
</tr>
<tr>
<td>Smooth</td>
<td>Spoonfuls of peanut butter</td>
<td>Thinly spread peanut butter onto bread or cracker</td>
</tr>
<tr>
<td>Sticky</td>
<td>Marshmallows, hard cookies</td>
<td>Do not offer</td>
</tr>
<tr>
<td>Dense or easy to compress</td>
<td>Hot dogs** or other meat sticks</td>
<td>Cut hot dogs into very small strips**</td>
</tr>
<tr>
<td>Tough</td>
<td>Chunks of meat</td>
<td>Shred or cut tender meat into small pieces*</td>
</tr>
<tr>
<td>Hard to chew</td>
<td>Fruit with pits or stones like cherries, fish with bones</td>
<td>Cut cherries into small pieces; serve fish in small pieces without bones*</td>
</tr>
<tr>
<td>Does not easily dissolve</td>
<td>Hard pieces of raw fruits and vegetables like carrot rounds</td>
<td>Cook vegetables like carrots until slightly soft and then cut into sticks*</td>
</tr>
<tr>
<td>Food with non-edible parts</td>
<td>Chewing gum</td>
<td>Do not offer</td>
</tr>
</tbody>
</table>

* Food for infants should be cut into 1/4 inch or smaller pieces; Food for toddlers should be cut into pieces 1/2 inch or smaller.

** Hot dogs are a common food that can result in young children’s choking.

For what to do in case a child chokes see Volume 3: E-Reference, Chapter D, “Choking.”
Picky eaters

Some children are choosier than others about what they eat, and what they eat often varies from day to day. Many young children want to eat the same foods every day. Some children only eat certain food textures. All of these eating behaviors are normal. Remember, “Adults are in charge of what food is served, and when and where they serve it; children are in charge of how much of that food they eat and whether they eat any of it at all.” - Ellyn Satter.

What you can do:

• Talk with parents about a child’s eating patterns.
• Offer a variety of foods.
• Serve new foods along with favorite foods.
• Let the child serve himself or herself.
• When appropriate, involve children with food preparation.
• Keep mealtimes positive.

Children with special health care needs

Children with special health care needs have more risk of nutrition-related health problems. Common nutrition problems include:

• Different energy and nutrient needs
• Slow growth
• Problems with swallowing and chewing
• Elimination problems
• Medications that affect their diet
• Changes in appetite
• Unusual food habits
• Dental problems
• Appetite cues

It is important to work with the parents to find out how best to feed their child. Written instructions should be provided and included in the child’s record. Ask about special utensils. Food may need to be changed in texture, such as by mashing, or foods may have to be substituted to meet special diet needs.

Source: Adapted from the Child Care Health Handbook, Child Care Health Program, Public Health, Seattle & King County, 2001
The Centers for Disease Control and Prevention (CDC) estimates that each year, 76 million Americans get sick; more than 300,000 are hospitalized; and 5,000 die from foodborne illnesses.

Food safety is extremely important in preventing foodborne illnesses in the early care and education setting. Germs, such as bacteria and viruses, grow quickly in food. By using safe practices you can reduce the possibility that you, other staff and children will experience foodborne illnesses. Foodborne illnesses can cause diarrhea, vomiting, fever and stomach pain. Many early care and education providers and staff in early care and education facilities are required to obtain food handler certification. Learn more about certification at www.childcarefoodhandler.org.

CLEAN, SEPARATE, COOK AND CHILL

By following the four steps of food safety — clean, separate, cook and chill — you can prevent food illnesses from occurring in your early care and education home or center.

Adapted for the early care and education worker, this food safety section provides guidance in keeping food safe for children. Remember, if you are ill or experience symptoms including vomiting, diarrhea and infectious skin sores that cannot be covered, you should not be handling food. Also, don’t handle food if you are or think you are infected with bacteria, viruses or parasites that can be carried in food.

Step 1: Clean

Cleanliness is very important in the early care and education setting. An excellent start to safe food preparation is cleaning your hands. The best
practice is to wash your hands with warm running water and soap for at least 15 seconds and dry with a disposable paper towel. Remember to turn off the faucet handle with the paper towel.

A clean kitchen is also important in preventing foodborne illnesses. Germs can grow and viruses may survive on unclean counters, cutting boards, refrigerators, food equipment and tableware. It is important to regularly clean and sanitize these areas. It is safe to use sponges for cleaning, but not for sanitizing. In addition, unclean walls and floors may contribute to a less-than-desirable area to safely prepare foods.

Always clean vegetables and fruits by washing with cool running water before slicing and eating or cooking. Remove visible soil by scrubbing and washing.

**Washing and sanitizing**

Washing and sanitizing kitchenware, dishes, utensils and cup ware are important steps in preventing illnesses. Do not use sponges for sanitizing. A home-style dishwasher with a sanitizing cycle is adequate for most home care settings. A larger center requires a commercial dishwasher or a three-compartment sink to **clean** and sanitize kitchen and tableware. If your home does not have a dishwasher, the following method of **cleaning**, rinsing and sanitizing may be substituted.

- Scrape food particles.
- Wash and **clean** all food contact items using hot water and detergent.
- Rinse with warm water.
- Sanitize the items in a **clean** sink or **clean** dishpan by immersing for at least 10 seconds in a lukewarm (not less than 75 degrees F) chemical sanitizing solution. You can make a sanitizing solution by mixing 1 teaspoon of household unscented bleach per gallon of water. Always follow the manufacturer’s labeled directions. Do not make the solution with hot water or add soap to it.
- Air-dry all sanitized items.
- A cloth that can be laundered should be used instead of a sponge.
- Other methods or sanitizers may be used if approved by the health department.

All food preparation areas and equipment should be easy to **clean** and maintained to ensure food safety in the early care and education setting.
Step 2: Separate

Cross-contamination can be effectively avoided by having a separate area for food preparation, handling and storage. Remember, separate; don’t cross-contaminate. Cross-contamination results when a clean area is subject to germ transfer from unclean articles, unwashed foods, raw meats, poultry or seafood, or other practices that contribute to unsafe food handling.

Examples:

- If toys are cleaned and sanitized in the kitchen, separate them from food when it is being prepared.
- Store uncooked meats, poultry, fish and raw unpasteurized eggs on the lower shelf of the refrigerator in containers that will prevent liquids from dripping and cross-contaminating ready-to-eat foods such as vegetables or fruits.
- Discard any food left at the serving table and do not place leftover baby food from bowls into the original container. Remember, separate; don’t cross-contaminate.
- Separate toxic cleaners and chemicals from food preparation and storage areas.
- Do not use latex gloves in food preparation because of a possible allergic reaction. You can use disposable gloves made of vinyl, polyvinyl or nitrile.

Safe and secure storage of cleaners and disinfectants/sanitizers

Cleaning products and disinfectants/sanitizers should always be used in accordance with the manufacturers’ instructions. Always label with the products’ name (when transferred to other non-original product containers) and store these products so that food, counters and equipment are not subject to accidental contamination. These products should also be stored out of the reach of children.

- Store cleaning solutions away from food and preparation areas.
- Disinfectants are generally used as surface applications on non-food-contact items (such as floors and walls, equipment exteriors, door handles, trash receptacles, etc.). These products should be stored away from food preparation and adjacent food items.
• Sanitizers may be stored safely in the kitchen below and away from food and children. These products may be used on food-contact surfaces such as tables, highchair trays, counters, cutting boards, etc.

• It is important to properly store and label the products used in keeping a kitchen clean and sanitary. This minimizes children’s and staff’s risk of food contamination and exposures.

• When transferring food to non-original containers, the containers must be either new or unused or so clean that no residue of the previous content is present.

Step 3: Cook

Prepare food safely by cooking foods at proper temperatures to kill germs that cause illness. Using the proper temperature is an important part of your responsibility in food safety. Completely cook all meats, poultry, fish and eggs before serving. Only by checking the internal food temperatures with a food probe thermometer (0-220 degrees F) can you be assured that germs will be destroyed.

• **Hamburger** products require a minimum 155 degrees F. Do not rely on visual indicators, such as clear meat juices, during the cooking process.

• **Poultry** products require a minimum 165 degrees F. *Recommendations of 180 degrees F are also published for food safety.*

• **Fish** products require a minimum 145 degrees F.

• **Eggs** require a minimum 145 degrees F.

Do not use plastic containers or plastic wrap in the microwave. Heated plastic may leach toxic materials when it comes in contact with food. Transfer food to a glass or ceramic container for thawing or heating.

Leftovers stored in the refrigerator should be dated and labeled and used within 24 hours.

• When reheating, bring liquids such as soup, gravy or sauces to a boil.

• Other reheated foods require a minimum 165 degrees F.

Reheat (within two hours) and use leftovers only one time; discard any foods not eaten. Discard any leftovers within two hours of serving.
DO NOT thaw frozen foods on the kitchen counter. Use one of these methods to defrost frozen food:

- Thaw frozen foods in the refrigerator; plan ahead to allow time to defrost.
- Thaw under cold running water.
- Thaw food using the defrost setting of a microwave oven.

Cook foods immediately after they have completely thawed. Use your thermometer to check the internal food temperature.

**Step 4: Chill**

Rapidly refrigerating (chilling) your perishable foods will minimize the growth cycle of harmful germs. After you return from shopping or a vendor leaves perishable products, immediately place food in the refrigerator or freezer.

- Refrigerator temperatures should be 41 degrees F or colder.
- Freezer temperatures are recommended to be 0 degrees F or colder.
- Use refrigerator/freezer thermometers to measure air temperatures.

By rapidly cooling foods you will slow the growth of harmful germs. Rapidly chill leftovers by placing small portions into shallow containers *(no more than two inches deep for soft thick foods such as refried beans, and up to four inches for thin soups or sauces)* and place in refrigerator.

- Cover, date and label the food after it has cooled to 41 degrees F.

Remember: By following the four steps of food safety — clean, separate, cook and chill — you can prevent food illnesses from occurring in your early care and education home or center.

Check out this chapter’s Resources section, “Making food safe for children,” for more information on food safety.

**FOODS REQUIRING SPECIAL CARE**

Certain foods for children with special diets may require special handling to prevent foodborne illness or nutritional deficiencies. It is recommended that you have a written policy for how food brought from the child’s home is stored and served. The policy should include special feeding instructions, bottle washing...
and formula mixing. In addition, the early care and education provider and staff should be aware of any food allergy or sensitivity that may affect the child. Always follow the four steps of food safety (clean, separate, cook and chill).

Visually check commercially prepared infant foods after opening for signs of glass or other foreign material. Put food in a clean dish or bowl; do not serve directly from the original container. Feed the child with a spoon designed for infants.

*Discard any leftovers from the serving dish/bowl portion. If a child wants more food, obtain a clean spoon and serve. Never place unused portions back into the jar.*

When parents bring a special milk for their child (soy, rice, organic, etc.), staff must date-mark the milk after opening and discard any leftovers after seven days regardless of the expiration date on the milk.

The opened jar may be returned to the refrigerator (name- and date-labeled) for another feeding that same day. Food remaining in the refrigerated jar may be sent home with the parent at the end of the day. Discard any leftovers in the jar after 24 hours.

**Formula**

To ensure that an infant receives correctly prepared and safe formula be sure that you:

- Follow any special instructions from parents.
- Follow directions on the product container to prevent nutritional deficiencies that may affect normal development of the infant.
- Use water from a health department-approved source. Water can be brought to a rolling boil and stored in a clean container for formula mixing.
- Avoid using water from the hot water tap, or the first gush of water from a tap that has not been used for six hours. This water may be contaminated with lead from the plumbing. Flush cold water from the tap for at least 30 seconds before using.
- Label the formula with the child’s name and provide appropriate nipple guards/covers.
- Discard unused formula that is left over from the feeding. Contents of bottles should be discarded one hour after being taken from the refrigerator to prevent bacterial growth in milk.
• Never leave formula at room temperature or in a bottle warmer after feeding. Discard immediately after the feeding.

• Bottles, caps and nipples must be washed, rinsed and sanitized after use. In early care and education homes, either using the dishwasher or boiling for one minute is recommended. In a center, a commercial dishwasher is required or the boiling procedure may be used. Store in a clean, protected area. Excessive heat will damage the latex nipples. Return the bottles to the parent at the end of the day.

**Warming formula or breast milk**

Thaw frozen breast milk under cold running water or in the refrigerator. Never thaw by placing on the counter or in a microwave. The nutritional advantages of breast milk can be compromised by excessive heat.

• Warm formula or breast milk in water not exceeding 120 degrees F immediately before feeding the baby.

• Do not use the microwave for bottle warming, breast milk or infant food warming.

• Crock pots may be used to warm bottles.

• Using the microwave to preheat the water for bottle and breast milk warming is also acceptable.

• Shake the bottle gently to distribute the warmth. Test the temperature of the milk before feeding it to the infant.

**Special events/field trips**

Provide non-perishable foods for special events and field trips. Remember, germs grow quickly when foods that require special handling are not chilled properly.

Here are some tips for storing and transporting food:

• Insulated coolers or other temperature-controlled equipment provide safe food-handling temperatures.

• Disposable service ware is recommended.

• Moist-packaged towelettes provide a temporary alternative to hand washing if running water and soap are not available.
NORMAL DENTAL GROWTH AND DENTAL CARE

Primary teeth are important for eating and speaking, as well as for appearance and as placeholders for permanent (adult) teeth. A total of 20 primary or baby teeth begin to come in when infants are approximately 4 to 6 months old. All primary teeth are in the mouth by 2 to 3 years of age. The lower front teeth are usually the first to appear, followed by the upper front teeth. Children vary widely in the age and pattern of tooth eruption. Permanent teeth begin to come in at approximately 5 to 6 years of age. The permanent teeth follow the same pattern as the primary teeth, with most of the teeth in the mouth by 12 to 13 years of age. The permanent molars start to come in around age 6. They come in behind the primary teeth, BUT they do replace primary teeth.

Dental care for young children

Children should visit the dentist after the first tooth comes in or by their first birthday and at least once per year after that. Dental professionals can help prevent oral health problems if they see children early and as they grow. You can play an important role by:

- Encouraging families to take their young children to the dentist;
- Encouraging families to lift the child’s lip and check the upper front teeth once per month for chalky white or brown spots along the gum line, which are the first sign of a cavity;
- Noting emergency dental care provider contact information in the child’s health record.

As soon as teeth come into the mouth, they are at risk for cavities. Bacteria (called mutans streptococci) stick to the surfaces of the teeth and form plaque. Daily removal of this sticky white film or plaque is very important to help prevent cavities. Untreated cavities cause high levels of the bacteria, which then increase the risk of infecting other teeth in the mouth. Mothers’ oral health is especially important because the bacteria can be passed from mothers to their infants by such things as sharing eating utensils or kissing on the mouth. Encourage...
mothers to help improve the oral health of their children by taking care of their own teeth and gums.

Dental problems that are left untreated in children can lead to:

- Pain due to infection;
- Systemic infection;
- Early tooth loss;
- Permanent teeth that are crowded or out of line;
- Problems with eating, speaking and learning;
- Poor self-image.

Cleaning

- **Birth to 24 months**
  
  - **Do** gently clean baby’s teeth and gums as soon as the first tooth erupts. Clean after feeding or at least two times a day with water and a clean, damp washcloth wrapped around your finger or a small, soft baby toothbrush. Clean the front and inside of each tooth at the gumline with four small circles. Gently scrub the tops of the teeth with a back-and-forth motion. This helps break up the plaque and prevents plaque build-up. You can hold the child in your lap or use the knee-to-knee position. In this position, the parents or caregivers sit with their knees touching and the child cradled across their laps. One person holds and entertains the child with songs or a story while the other brushes the teeth. For a larger child, sit in a chair or sofa and have the child sit on the floor with his or her head leaning back into your lap.
  
  - **DO NOT** use toothpaste with infants under 2 unless their dentist recommends it, as they may swallow more fluoride than is recommended.

- **2 years and older**
  
  - Do use a small pea-sized amount of fluoride toothpaste on the toothbrush after age 2, if the child can spit out the excess. It is the fluoride in the toothpaste that strengthens the tooth and helps prevent cavities.
  
  - Do not give more than one child toothpaste from the same tube
because of possible contamination. To easily dispense toothpaste in early care and education settings, cut a paper plate into sections. Place a small pea-sized amount of toothpaste on an individual section of a paper plate. Have each child pick up one spot of toothpaste with toothbrush.

- By the age of 2 years, the child may be old enough to hold a toothbrush while the caregiver guides the child’s hand during brushing in gentle circles along the gum line. Children do not develop the fine motor skills needed to properly clean all the tooth surfaces themselves until they are about 6 or 8 years old (sometimes older). Daily practice in the early care and education program can help develop those skills. Help children practice brushing. Establish a pattern of brushing that includes all the surfaces of the teeth.

- Children should ideally brush for between two and four minutes. Use a timing device that is either visual (like a sand timer) or audible (like an egg timer) or play a musical tape to keep the children interested.

- Introduce daily flossing by the time the first adult molar comes in, which is about age 6 to 8.

- Until the child is older, it is ideal if an adult thoroughly cleans the teeth daily. Talk with families about letting children practice the brushing skills they are learning at the center, but also emphasize the need to have an adult thoroughly clean the teeth to prevent cavities.

- Do provide children soft toothbrushes and time after each meal, or at least once per day, to brush their teeth. Clearly label each brush with the child’s name. Clean brushes with running water and allow them to air-dry between uses. Hang or store brushes separately so that cross-contamination from bristles does not occur. Holders should be cleaned on a routine basis but avoid exposing brushes to any soap or other chemicals. Be sure to replace brushes when bristles look worn and have lost their shape (approximately every two to three months) or after a child’s illness to prevent reinfection.

If brushing is not possible in your early care and education setting, do encourage the children to swish and swallow with water after meals.

**Children with special health care needs**

Tooth brushing may be more complicated for some children with special health care needs. Children may require special positioning or special oral hygiene aides, such as an electric toothbrush or an easy-grip handle toothbrush.
Fluoride is very important for these children due to their increased risk of oral health problems as a result of special diets and medications. If the child has difficulty with swallowing or spitting, dip the toothbrush into a mouth rinse that contains fluoride. Consult with the child’s family or oral health care provider to individualize care.

Using and handling toothbrushes

Tooth brushing is a lifelong positive habit important to maintain oral health and help prevent cavities. Tooth brushing in the early care and education setting helps children develop this lifelong habit.

To brush teeth properly and to prevent infections from spreading from germs found in saliva and blood on toothbrushes:

- Always supervise children when they are brushing their teeth.
- Make sure that each child has his/her own toothbrush clearly labeled with his/her name. Do not allow children to share or borrow toothbrushes.
- For children over the age of 2, apply (or have child apply) a small pea-sized amount of fluoride toothpaste to a dry toothbrush.
- Instruct each child to brush his/her teeth and then spit out the toothpaste into a disposable cup, or a bathroom or classroom sink.
- Using a paper cup, each child should rinse out his/her mouth with water. Dispose of the cup.
- After brushing, rinse the brush with running water and hang or store each toothbrush separately so it cannot touch any other toothbrush. Allow it to air-dry. An old spice rack makes a good toothbrush storage rack.
- Never disinfect toothbrushes by any method. If a child uses another child’s toothbrush or if two brushes come in contact, throw them away and give the children new toothbrushes.
- If a child uses the toothbrush of another child known to be ill or have a chronic bloodborne infection (such as hepatitis B or HIV), parents of the child who used the ill child’s brush should be notified. Replace the toothbrush.
- Replace toothbrushes every three to four months or sooner if bristles have lost their shape or look worn. Toothbrushes should also be replaced after a child’s illness to prevent reinfection.
Fluoride

In communities that do not have fluoride in the drinking water, the following supplement schedule is recommended. Families should check with their dentist or health care provider to see if their children should take daily fluoride supplements.

**Teething**

Babies can be fussy during teething. Chewing on something cold often soothes babies during teething. The best thing to use before teeth are present is a liquid-filled teething toy that has been chilled. After teeth are in, use a cold damp cloth or a solid teething toy that has been chilled. Do not coat teething toys or pacifiers with any substance or use food items as teething aids. Using food items can decrease babies’ appetite for nutritious food at mealtimes and can cause cavities.
The type of diet that promotes healthy development for infants to adolescents will also promote oral health. The following foods are best eaten as part of a well-balanced nutritious meal, when the child can brush afterwards:

- Foods high in sugar such as baked goods, dried fruits, candy, fruit rolls, juices and sodas;
- Foods high in starch such as crackers, dry cereals and teething biscuits.

Frequent or constant snacking or sipping of these foods between meals can increase the risk of cavities. Oral bacteria use sweet and starchy sticky foods to make an acid. The acid is what can cause a cavity by attacking and breaking down tooth enamel.

Do offer nutritious snacks such as fruits, raw vegetables, whole-grain foods and cheese more often. (Refer to the MyPlate section in this chapter, Nutrition, Healthy eating and physical activity, “What is the MyPlate guide?”)

Avoid letting children fill up on juice. Limit juice to four to six ounces a day.

If tooth brushing is not practical after meals, the child can swish and swallow with water. Water is also a good thirst quencher that does not cause cavities. Always remember to be a good role model and follow healthy eating and drinking behaviors yourself.

**Infant feeding and early childhood cavities**

Early childhood cavities — also known as baby-bottle tooth decay or nursing-bottle mouth — happen when liquids that contain sugar (e.g., milk, formula, soda, Kool Aid® or any other sugar-containing liquid) are left in a baby’s mouth for a long time. Early signs of this type of cavity can be seen on the four upper-front primary teeth. You can check for early childhood cavities by drying the teeth and looking for chalky white or brown spots on the front or back surfaces of the front teeth along the gum line.
Preventing cavities by breaking the bottle habit

You can play an important role in helping prevent early childhood cavities by beginning to offer a cup for drinking liquids instead of a bottle at 6 months of age, or slightly older for some children. It may be messy at first, but it is worth the effort. Praise children and make it a sharing time as they practice this new skill. By 1 year of age or slightly older, a baby should be weaned from the bottle.

Here are some suggestions for breaking the bottle habit:

- Gradually dilute the bed or nap-time bottle contents until only water is offered.
- Offer a clean pacifier. Do not dip the pacifier in honey, syrup or anything sweet.
- Put the child to bed without a bottle by using culturally appropriate methods such as:
  - Singing or playing music
  - Holding or rocking the child
  - Giving a back rub
  - Using a musical mobile
  - Reading or telling a story
  - Giving a favorite blanket or toy

Preventing cavities in nursing babies

Breast milk contains sugar. If an infant sleeps at the breast all night, he/she may be getting too much sugar. You may want to provide parents with information on causes and ways to prevent early childhood cavities (see the end of this chapter’s Resources section, Oral health, “Keep Your Baby Smiling...Prevent Nursing Bottle Mouth”). Encourage them to take the child to the dentist for evaluation and treatment as needed.

PREVENTING DENTAL PROBLEMS CAUSED BY THUMB SUCKING

Non-nutritive sucking (sucking not related to eating) is common in infants and toddlers. Sucking is one of a baby’s natural reflexes. As infants get older, sucking serves many purposes. Infants and young children may suck on thumbs, fingers, pacifiers or other objects because it may help calm them when
they are feeling insecure or seeking comfort. Since sucking is relaxing, infants or young children may suck in the evening or when they are tired. Most children stop this habit by the age of 2.

In a few children, aggressive thumb sucking can cause problems with primary teeth such as crowded or crooked teeth or bite problems. These problems can also occur if, after the permanent teeth come in, sucking continues. If this habit is still present after age 4, you might want to work with the child’s family to help the child give up the habit. Use positive approaches such as praise when the child is not sucking his or her thumb. Avoid using negative techniques such as pulling the thumb out of the mouth, scolding or shaming.

Here are a few suggestions:

- Do praise them when they are not sucking.
- Do focus on correcting the cause of the anxiety instead of the thumb sucking, and comfort them.
- Do reward them when they do not suck their thumb during a difficult time, such as being separated from their parents.
- Involve older children in choosing the method of stopping (i.e., will stop sucking at night or naptime, or will stop sucking altogether by the next birthday or major holiday, etc.).
- Do encourage the family to consult a dentist if these approaches do not work and there are concerns about the thumb sucking.

Many children substitute thumbs or fingers with a pacifier, especially at bedtime. Today’s pacifiers are designed not to cause problems with oral growth and development. A pacifier can be used instead of a bottle to satisfy a child’s desire to suck and not cause cavities. It is also often an easier habit to break. However, a pacifier may increase the risk of ear infections (otitis media).
GENERAL HEALTH RESOURCES FOR CHILDREN AND FAMILIES

Eligibility for most of these programs is based on the family’s average monthly gross income. For more specific information, you will need to contact a program representative at one of the toll-free numbers.

<table>
<thead>
<tr>
<th>Who is eligible?</th>
<th>What resources are available?</th>
<th>Who do you contact?</th>
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<td>Pregnant women</td>
<td>Oregon Health Plan</td>
<td>1-800-699-9075</td>
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<td><a href="http://www.oregon.gov/OHA/healthplan/">http://www.oregon.gov/OHA/healthplan/</a></td>
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<td>Children birth to 19 years</td>
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<td><a href="http://www.oregon.gov/OPHP/kidsconnect/index.shtml">http://www.oregon.gov/OPHP/kidsconnect/index.shtml</a></td>
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<tr>
<td>Adults</td>
<td>Oregon Health Plan</td>
<td>1-800-699-9075</td>
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<tr>
<td>All family members</td>
<td>Oregon Medical Insurance Pool (OMIP)</td>
<td>Denied insurance for health reasons</td>
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<td><a href="http://www.oregon.gov/OHA/OPHP/OMIP/index.shtml">http://www.oregon.gov/OHA/OPHP/OMIP/index.shtml</a></td>
<td>1-800-848-7280</td>
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<td>Adults over 65 years and/or on Social Security Disability for two years or who have permanent kidney failure</td>
<td>Medicare/Social Security Administration</td>
<td>1-800-722-4134 or 1-800 772-1213</td>
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<td><a href="http://www.ssa.gov/disability">http://www.ssa.gov/disability</a></td>
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Oregon Food Bank
The Oregon Food Bank is a hunger-relief agency. The organization distributes emergency foods to 20 food banks across Oregon and operates two food banks serving the Portland area.
1-800-777-7427
http://www.oregonfoodbank.org/?c=129412317402914539

Oregon SafeNet
SafeNet is a phone information and referral line and website designed to link low-income Oregon residents with health care services in their communities. SafeNet provides information and referrals for a wide range of services to low-income women, children and families.
1-800-SAFENET (1-800-723-3638)
http://oregonsafenet.org/

Aging and People with Disabilities

Vaccines and immunizations
Oregon Health Authority Public Health Division Immunization Program
http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/
Pages/index.aspx

THE BASICS OF CHILD GROWTH AND DEVELOPMENT

Ages and Stages questionnaires
http://www.asqoregon.com

Books and reference materials

- Emotional Intelligence
  D. Goleman

- Inside the Brain: Revolutionary Discoveries of How the Mind Works
  R. Kotulak.

- Touchpoints, The Essential Reference: Your Child’s Emotional and Behavioral Development
  T. Berry Brazelton, M.D.
• **What Kids Need to Succeed: Proven, Practical Ways to Raise Good Kids**
  Peter L. Benson, Judy Galbraith and Pamela Espeland

• **Yardsticks – Children in the Classroom Ages 4–14: A Resource Guide for Parents and Teachers**
  Chip Wood

**Brochures**
At local Oregon libraries and public health departments, or Oregon Commission on Children and Families
503-373-1283
OCCF-Mail@class.oregonvos.net

**How to talk to kids about violence, sex, drugs, etc.**
[http://www.talkingwithkids.org/television](http://www.talkingwithkids.org/television)

**Local directory for teens and parents**
[http://www.child.net](http://www.child.net)

**Raising Safe Kids: One Stage at a Time**

Documents and forms to download and print — General health resources
(Go to **OKHS Volume 4: Appendix — Chapter B.**)

• Child Development
PHYSICAL ACTIVITY

Active Start
Tools to enhance policies, practices and environments in early care and education by improving the nutritional quality of food served, amount and quality of physical activity, staff-child interactions, and facility nutrition and physical activity policies and practices and their related environmental characteristics

- **Active Start: A Statement of Physical Activity Guidelines for Children Birth to Five Years**
  Information about the guidelines and copies of the publication from The National Association for Sport and Physical Education
  1900 Association Drive
  Reston, VA 20191
  [http://www.aahperd.org/naspe](http://www.aahperd.org/naspe)

American Alliance of Health, Physical Education, Recreation and Dance
[http://www.aahperd.org](http://www.aahperd.org)

Bright Futures in Practice: Physical Activity
U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Center for Education in Maternal and Child Health, Georgetown University

Color Me Healthy — preschoolers moving and eating healthy
[http://www.colormehealthy.com](http://www.colormehealthy.com)

Eat Well Play Hard in Child Care Settings Curriculum
[http://www.health.state.ny.us/prevention/nutrition/cacfp/ewphccs_curriculum/index.htm](http://www.health.state.ny.us/prevention/nutrition/cacfp/ewphccs_curriculum/index.htm)

Go Out and Play! Kit
Helps early childhood educators monitor development through play with activities designed for children 3 through 5 years of age

Got Dirt?
Garden toolkit for implementing youth gardens
[http://www.dhs.wisconsin.gov/physical-activity/FoodSystem/Gardening/GotDirt/index.htm](http://www.dhs.wisconsin.gov/physical-activity/FoodSystem/Gardening/GotDirt/index.htm)
President's Council on Fitness, Sports and Nutrition
Physical activity is an essential component of a healthy lifestyle. Getting active is easier than you may think. Find ways to add in or mix up daily activity and discover a healthier you.
http://www.fitness.gov/be-active/

Let’s Move! Child Care
Helps early care and education providers use physical activity, nutrition and screen time best practices. Providers can also sign up here for Start Early Start Smart and receive the online version of the Let’s Move! Checklist. Providers who complete an online checklist will receive a customized action plan designed exclusively for them to help reach their goals.
http://healthykidshealthyfuture.org/welcome.html

Let’s Move Child Care Checklist: Recommendations for Preschoolers, Infants and Toddlers

Guide to Licensing Toolkits to Promote Healthy Weight
The prototype supports people who license early care and education facilities and provide early care and education. The goal is to promote children's healthy eating habits and activities.

The toolkit is based on Caring for Our Children, 3rd edition,
http://nrckids.org/ToolKit/LicensingToolKit.pdf

Moving and Learning: the Physical Activity Specialists for Kids Birth through Age 8
Intervention for Head Start
http://www.movingandlearning.com/

MyPlate Physical Activity for Preschoolers
http://www.choosemyplate.gov/preschoolers/physical-activity.html

National Center for Education in Maternal and Child Health
http://www.ncemch.org/

Nutrition and Physical Activity Self-Assessment for Child Care – NAP SACC
http://gonapsacc.org/
Physical Activity for Children, A Statement of Guidelines for Children Ages 5—12
2nd edition, National Association for Sport and Physical Education

Ready for Life: Little Bits, Big Steps video

Safe outdoor play

- Eco-Healthy Child Care
  Fact sheets on avoiding treated playground equipment, pesticides and lead in soil
  http://www.cehn.org/ehcc

- Heat index information
  http://www.nws.noaa.gov/om/heat/index.shtml

- Wind chill information
  http://www.nws.noaa.gov/om/windchill/index.shtml

SCREEN TIME RESOURCES

Active Bodies Active Minds
Contains screen time reduction information and resources for people who care for preschool-aged children
http://depts.washington.edu/tvhealth/

ClicKit! To Reduce Television in Early Childhood
Has lesson plans and resources for early childhood educators to help children and families get enough physical activity and use television wisely
http://depts.washington.edu/tvhealth/clickit.htm

Inactive Time
http://www.choosemyplate.gov/preschoolers/physical-activity/inactive-time.html

Limit Screen time for Healthier Kids
http://www.kp.org/tvturnoff

Marketing to Kids: Talking Points
http://public.health.oregon.gov/PreventionWellness/Nutrition/KidsJunkFood/Pages/talking-points.aspx
Mommy, I’m Scared: How TV and Movies Frighten Children and What We Can Do to Protect Them
J. Cantor.

Screen-Free Week
http://www.commercialfreechildhood.org/screenfreeweek/

Too Many Ads: Marketing Junk Food to Kids
Parent awareness campaign

TV Parental Guidelines
Includes descriptions and explanations of ratings and other information in Spanish and English
http://www.tvguidelines.org

TV Ratings: A Guide for Parents
TV parental guidelines (also called rating system) and tips for parents

Why Weight? Reducing the Influence of Television on Children’s Health
Oregon State University Extension lesson plans
http://extension.oregonstate.edu/fch/sites/default/files/documents/fcd05-01_why_weight_teacher_guide.pdf

You Have the Power: 5 Steps To Guide Your Child’s TV Time
Site is in English and Spanish.
http://public.health.oregon.gov/HealthyPeopleFamilies/wic/Documents/you_have_the_power.pdf

Documents and forms to download and print — Screen time resources (Go to OKHS Volume 4: Appendix, Chapter B.)

- Marketing to Kids: Talking Points
- You Have the Power – 5 Steps to Guide Your Child’s TV time
HEALTHY INDOOR AIR

Eco-Healthy Child Care
Endorsing facilities committed to creating a safer, healthier environment for children to learn and grow

Healthy Environments for Children
http://public.health.oregon.gov/HealthyEnvironments/HealthyNeighborhoods/Pages/kids.aspx

Model Asthma Plan in Child Care: Best Practices to Prevent Environmental Asthma Triggers in Child Care
http://www.health.state.mn.us/divs/eh/indoorair/childcare/

U.S. EPA: Indoor Air Quality Tools For School
http://www.epa.gov/iaq/schooldesign/index.html

NUTRITION

Breastfeeding information
Including breastfeeding and returning to work
http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/Breastfeeding/Pages/index.aspx

Child & Family WebGuide
Directory that evaluates, describes and provides links to hundreds of sites containing child development research and practical advice
http://www.cfw.tufts.edu

Child and Adult Care Food Program
http://www.ode.state.or.us/search/results/?id=209

Feeding Infants — A Guide for Use in the Child Nutrition Programs

Food and Nutrition Information Center

Food Research and Action Center
The afterschool resource center at the Food Research and Action Center. Information on nutritional guidelines and an after-school guide that includes
information on how to access nutrition programs and resources for incorporating nutrition education in school-age care
http://frac.org/federal-foodnutrition-programs/afterschool-programs/

Good Nutrition Pays
USDA Child and Adult Care Program
http://www.ode.state.or.us/services/nutrition/cacfp/fdch/pdf/2009/020609attach1.pdf

Healthy Food for Healthy Celebrations
http://cehn.org/ehcc

Information on ethnic foods
http://www.eatethnic.com/

It’s Time to Eat: Food for Your Baby
WIC brochure on adding new foods

MyPyramid for Kids
2 to 6 years old

MyPyramid for Preschoolers
Relates to children 2 to 5 years of age. Has personalized eating plans and interactive tools to help you plan/assess your food choices based on the Dietary Guidelines for Americans. Click on the blue button to get a customized MyPlate Plan for your preschooler.
http://www.choosemyplate.gov/preschoolers.html

Nutrition for Kids
http://www.nutritionforkids.com

Oregon Department of Agriculture
http://www.oregon.gov/ODA/

Preventing Childhood Obesity in Early Care and Education Programs, second edition
http://nrckids.org/default/assets/File/PreventingChildhoodObesity2nd.pdf
The Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
Provides healthy foods, nutrition education and counseling, and referrals to qualified pregnant and breastfeeding women, infants and children up to the age of 5. Encourages foster parents, fathers, grandparents and other guardians to apply for their children too.
http://www.oregon.gov/DHS/ph/wic

USDA Recipes for Child Care
http://www.nfsmi.org/Templates/TemplateDefault.aspx?qs=cElEPTYzJmlzTWdyPXRydWU=

The Vegetarian Resource Group
Information on vegetarianism, feeding vegetarian children and recipes
http://www.vrg.org

WIC county contact information
http://public.health.oregon.gov/HealthyPeopleFamilies/wic/Pages/countyinfo.aspx

Documents and forms to download and print — Nutrition
(Go to OKHS Volume 4: Appendix — Chapter B.)
- CACFP Food Chart for the Child — age 1–12
- It’s Time to Eat – Food for Your Baby
- USDA Child and Adult Care Food Program flyer

MAKING FOOD SAFE FOR CHILDREN
Allergist: Sponsored by the American College for Allergy, Asthma & Immunology

Caring For Our Children, Chapter 4
Nutrition and Food Service

Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care
Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov/foodsafety/

Children and Microbial Foodborne Illness

Eco-Healthy Child Care
Helps early care and education providers reduce children’s exposure to toxic hazards common to the early learning environment
http://www.ecohealthychildcare.org

EWG’s (Environmental Working Group) Shopper’s Guide to Pesticides
http://www.foodnews.org/walletguide.php

Food probe thermometers
(Chef’s thermometer, metal stem thermometer, instant read thermometer) available at major retail outlets (Fred Meyer, Wal-Mart, K-Mart, etc.) in the houseware/cookware sections.

Food Safety and Inspection Service publications

Food Safety A to Z Reference Guide
http://www.fda.gov/Food/FoodScienceResearch/
ToolsMaterials/ucm216150.htm

Oregon Child Care Food Handlers Certification
http://www.childcarefoodhandler.org

Oregon Department of Agriculture Food Safety Division
http://www.oregon.gov/ODA/FSD/

Partnership for Food Safety Education
http://www.fightbac.org/

The Thermy Campaign

U.S. Food and Drug Administration
http://www.fda.gov/
ORAL HEALTH

American Academy of Pediatric Dentistry
Fact sheets, research articles and anticipatory guidance relative to children’s oral health
http://www.aapd.org

American Dental Association
Check the section “Oral Health Topics” from A-Z, which also has answers to frequently asked questions.
http://www.ada.org

American Dental Hygienists’ Association
“Kidstuff” section for fact sheets and interactive games
http://www.adha.org

Centers for Disease Control and Prevention, Oral Health Division
Fact sheets on infection control
http://www.cdc.gov/chronicdisease/resources/publications/aag/doh.htm

Colgate Bright Smiles Bright Futures
Free teaching guides/activities/coloring pages designed for use by parents and teachers
http://www.colgatebsbf.com

Emergency care and Oregon Health Plan Open Card
1-800-723-3638

How to get help to obtain dental care
If you have insurance, contact your dental insurance plan for the names of participating dentists.

Keep your baby smiling … Prevent early childhood cavities
Oregon Health Authority Public Health Division, Office of Family Health – Oral Health Program
503-731-4098
Oregon Health Authority, Public Health Division, Office of Family Health, Oral Health Program
Promotional/educational materials, curriculum guides, fluoride program guidelines, recommendations for children’s oral health and videos
971-673-0252
http://public.health.oregon.gov/PreventionWellness/oralhealth/Pages/index.aspx

Oregon Health Plan

- Application
  1-800-359-9517 or TTY 1-800-621-5260. (Must meet eligibility criteria.)
- Eligibility and service questions
  1-800-273-0557

PLAK SMACKER inc.
Toothbrushes, toothbrush storage systems, toothpaste, stickers, etc. Discounted rates available to Head Start, county and government programs.
1-800-558-6684
4105 Industrial Way
Riverside, CA 92503

Procter and Gamble (Crest)
Patient education information sheets to download and print. Available in a variety of languages.
http://www.dentalcare.com

Statewide dental care resources
http://www.oregondental.org/custom/directory/community_access_dir.cfm?pageid=3677&showTitle=1

Documents and forms to download and print — Oral health
(Go to OKHS Volume 4: Appendix — Chapter B.)

- National Children's Dental Health Month Resources
- School-based Dental Sealant Program
CHAPTER C
PREVENTING AND RESPONDING TO ILLNESS
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Disease and illness caused by germs and sometimes parasites are easily spread from one person to another in early care and education settings. These diseases and illnesses are described as infectious, communicable or contagious and include flu, pink eye, lice (parasite), chicken pox and other diseases. The word “prevention” means stopping something before it happens. Clean and safe habits can help prevent illness in early care and education settings.

WHAT CAUSES INFECTION AND ILLNESS?

Many germs and other organisms that cause disease are too small to be seen with the naked eye, including bacteria, viruses, fungi and some parasites. Other parasites, such as head lice, are much larger. Many of them like to live in dark, wet and warm places, and they need food and water to grow in number.

Not all of these organisms are harmful; in fact, many can be helpful. Still, some can make people very sick. An example of a good germ gone bad is the story of staphylococcal food poisoning. Staphylococcus is a bacterium that lives on human skin and noses without causing any problems for most people. But, if that germ gets into certain foods, it can grow in number and produce poisons that make people sick. If the food is eaten, it can cause food poisoning that is uncomfortable and sometimes life-threatening.

PREVENTING THE SPREAD OF ILLNESS

Illness can be spread in many ways. The most common include:

- Contact with human and animal waste (stool and urine);
- Contact with other body fluids (drool, blood, nose or eye discharge);
- Direct skin-to-skin contact;
- Touching an object that may have illness-causing organisms on it (for example, a toy, the telephone, someone else’s hairbrush);
- The air in droplets from sneezing and coughing.
Not all germs spread this way. Some are very sensitive to light and dryness and require intimate or sexual contact to be spread from person to person.

Infection can enter the body in different ways. Common ways include through the eyes, nose, mouth and broken skin. If a germ enters the body and finds a warm place to grow, illness can occur.

You can take steps in your early care and education program to prevent or limit the spread of illness. Since any body fluid can contain organisms that cause illness, anything that limits touching these fluids or prevents the sharing of these fluids with others will prevent illness. Using care in the following activities can prevent the spread of illness. Each of these activities is discussed in the E-Reference. Click on the following:

- **Washing hands**;
- **Changing diapers**;
- **Cleaning toys and other soiled objects and surfaces**;
- **Handling soiled clothing, and bedding**;
- **Making food safe for children**.

**Prevention is critical!**

The *best way to prevent the spread of many infections is to develop consistent hand washing and good cleaning methods*. Early care and education providers and children should wash their hands well and often, using running water and liquid soap. Hands should be dried on disposable paper towels or single-use towels.

Early care and education providers should clean soiled surfaces daily. They should then apply a bleach solution prepared daily or an approved sanitizer.

**Washing hands**

Washing your hands helps prevent illness.

It sounds like common sense, but it is easy to forget when you are in a hurry or thinking of other things. Germs can be picked up on the skin or under the nails and passed to the mouth, onto food, or directly to another person. Frequent hand washing is very important!

Besides reducing illness, hand washing also has great economic benefits. Illnesses that can be prevented by proper hand washing have been shown to
cause billions of dollars in lost revenue, productivity and medical costs yearly in the United States.

Rubbing hands together under running water is the most important part of washing away infectious germs. Washing with plain soap and water is one of the most important ways to keep germs from spreading. However, antibacterial soap is not recommended. Antibacterial soap with the ingredient “triclosan” does not control germs better than plain soap. It can cause skin irritation and, over time, lead to bacteria that are harder to treat with antibiotics.

Pre-moistened towelettes or wipes and waterless alcohol-based hand rubs such as liquid, gel or foam hand sanitizers are not a substitute for washing hands when soap and running water are available. The 60 percent or more alcohol contained in these products makes them effective germ killers. They are highly toxic if swallowed by children, and they are flammable. Keep these products away from children and never allow them to be used without adult supervision.

Towelettes should only be used to remove residue, such as food off an infant’s face or feces from an infant’s bottom during diaper changing. When running water is not available, such as during an outing, towelettes may be used as a temporary measure until hands can be washed under running water.

Waterbasins should not be used as an alternative to running water. If forced to use a water basin as a temporary measure, clean and disinfect the basin between each use.

Provider checklist: Field trips

Below is a list of things you might consider taking on field trips to keep kids safe and healthy:

- A few gallon jugs of water for hand washing (if no running water is available)
- Liquid soap
- Hand wipes
- Paper towels
- Tissues
- Alcohol hand sanitizer
- First-aid kit
- Sunscreen
- Disposable gloves
- Cell phone
- Pen and small notepad (for taking down emergency notes or instructions)
- Parent permission forms authorizing medical treatment
Infectious outbreaks have been linked with sharing wash water and washbasins.

Frequent hand washing may irritate cuts and sores or lead to cracked and dry skin. Keeping a jar of hand lotion at the sink for staff to use can help reduce this problem. Cuts should be washed well with soap and water and kept covered with a dry, clean bandage.

When should early care and education providers wash their hands?
Administrative rules state that early care and education providers need to wash their hands:

- Immediately before handling food, preparing bottles or feeding children;
- After using the toilet, assisting a child in using the toilet or changing diapers;
- After contacting a child’s body fluids, including wet or soiled diapers, runny noses, spit, vomit, etc.;
- After handling pets, pet cages or other pet objects;
- Whenever hands are visibly dirty or after cleaning up a child, the room, bathroom items or toys.

The Oregon Administrative Rules state that early care and education providers who handle food must double hand wash (wet hands, soap up, scrub, rinse, soap up again, scrub, rinse and dry with paper towel) after any contact with body fluids. Best practices recommend that early care and education providers also wash their hands:

- Upon arrival at work or returning after breaks, smoking or handling their own body fluids, such as blowing their own nose;
- After removing gloves used for any purpose;
- Before giving or applying medication or ointment to a child or self;
- Before going home.

When should children wash their hands?
Administrative rules state that children need to wash their hands:

- Immediately before and after eating;
- After using the toilet or having their diapers changed;
• After handling pets, pet cages or other pet objects;
• Whenever hands are visibly dirty.

Best practices recommend that children also wash their hands:
• Upon arrival at the early care and education setting;
• After playing on the playground;
• Before using water tables;
• Before going home;
• After sneezing or touching body fluids.

How to wash hands
• Turn on water to a warm temperature.
• Wet hands.
• Soap up with liquid soap and rub hands together for 20 seconds.
• Rinse well under running water.
• Dry hands with paper towels, paper napkins, hot air blow dryer or single-use towel.
• Turn off water with the used paper towel(s) before throwing towel(s) in the wastebasket.
• Use hand lotion if desired.
• Clean fingernails daily or when hands have become very dirty.

See OKHS Volume 4: Appendix, Chapter C, for the following hand washing posters in English and Spanish: “Infant Handwashing” and “Washing Your Hands” (child).

Using gloves
Many early care and education settings encourage or require their workers to wear gloves when changing diapers or performing other tasks, including food preparation. The National Institute for Occupational Safety and Health (NIOSH) advises that exposure to latex may result in allergic reactions. Single use natural latex gloves are not recommended for use by early care and education workers.

• Why latex gloves can cause serious allergic reactions
  Wearing latex gloves or inhaling airborne latex particles can cause a
variety of symptoms including an irritant skin rash; hives, nose, eye or sinus symptoms; and asthma. Exposure to latex can even cause a life-threatening reaction in sensitive individuals. Early care and education workers as well as infants and children in their care are exposed to this risk of allergic reaction. Individuals who wear latex gloves often, or those who have allergies, hay fever, asthma or skin problems have a higher risk of developing a latex allergy.

• **How to protect workers and children from latex exposure**

Do not use latex gloves and other latex products in your early care and education setting. Adopt a policy that prohibits the use of latex gloves by your workers. Single-use vinyl and polyvinyl chloride gloves do not contain latex, are appropriate for use in early care and education settings and are cost-effective. It’s also important to remind workers to have good personal hygiene and prevent cross-contamination among workers and children. **Wearing gloves is not a substitute for frequent and thorough hand washing. Remember: You need to wash your hands after wearing gloves.**

**Changing diapers**

Many early care and education programs serve infants and toddlers in diapers. The diaper-changing activity requires extreme care to prevent the spread of viruses or bacteria that may cause illness. Illness can be spread by contact with feces on hands, clothing or the diaper-changing area. Both the child’s and caregiver’s hands should be washed after the child’s diaper is changed. The diaper-changing area should be disinfected before another child’s diaper is changed.

It is a good idea to develop policies and procedures for diaper changing. The Oregon Employment Department Child Care Division has specific requirements for diaper-changing procedures in early care and education settings. Because of the possibility of contamination, children’s cloth diapers should never be rinsed or washed in the early care and education setting. Instead, place the soiled diaper or clothing in a plastic bag. Seal the bag and store it in an area away from food preparation and early care and education areas; send it home with the child at the end of the day.

In early care and education, it is easy to spread germs when repeatedly handling diapers. Disposable diapers should be placed in a receptacle that is lined with a
plastic liner and covered. Commercial-grade or equivalent foot-operated closed containers are recommended.

See “Diapering Procedure” English and Spanish poster in OKHS Volume 4: Appendix, Chapter C.

Cleaning, sanitizing and disinfecting surfaces and toys

Cleaning, sanitizing and disinfecting are often thought to mean the same thing, but they do not.

To clean means to physically remove dirt and contamination. The friction of cleaning removes most germs and exposes any remaining germs to the effects of a sanitizer or disinfectant used later.

To sanitize means to reduce germs on inanimate surfaces to levels considered safe by public health codes and regulations.

To disinfect means to destroy or inactivate most germs, but not bacterial spores, on an inanimate object.

<table>
<thead>
<tr>
<th>Surface</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diapering surfaces, toilet seats and hand washing sinks</td>
<td>Disinfectant – 1/2 tablespoon bleach per pint of water OR 1 tablespoon bleach per quart of water OR 1/4 cup bleach per gallon of water</td>
</tr>
<tr>
<td>Toys, food service and hard surfaces</td>
<td>Sanitizer – 10 drops of bleach per pint of water OR 1/4 teaspoon of bleach per 1 quart of water OR 1 teaspoon bleach per gallon of water</td>
</tr>
</tbody>
</table>

The bleach solution should be made daily because it weakens over a day’s time and then will not be strong enough to get rid of germs. Any store-purchased unscented liquid chlorine bleach mixed with cool water will do. A bottle of bleach that has been open for more than six months will not be strong enough to make an effective solution and should be replaced. Marking each bottle of bleach with the date it is opened will help keep track of how long you should use it.

Other Environmental Protection Agency (EPA)-registered or local health department-approved cleaning solutions are poisonous and must be kept out of children’s reach or locked up. Be sure to store cleaning products away from foods.
disinfectants or sanitizers may be used in the early care and education setting. Always follow the manufacturer’s instructions for the correct solution strength and contact times for the surface you are disinfecting or sanitizing. If in doubt, contact your local health department for additional guidance. (See this chapter’s Resources section for a list of county public health departments.)

Disinfectants and sanitizers require a cleaning process prior to application. Always follow the manufacturer’s instructions. Never use more bleach than recommended, and always mix your solution away from children in a room with good ventilation. Bleach odor can irritate lungs, and children are more sensitive to bleach than adults.

How to disinfect or sanitize surfaces:

- Clean the area with soap and water.
- Wet the entire area with solution until it glistens.
- Leave solution on the surface for two minutes.
- Dry with a paper towel or air-dry.

Sanitizing toys

Baby toys that young children play with and put in their mouths should be made of washable materials and sanitized every day. Toys used by older children do not need to be cleaned every day but sanitizing is recommended once a week. Toys should be cleaned in one of the following ways:

- Wash with soap and water to remove obvious dirt.
- Run toys through full wash and dry cycles of the dishwasher.
- Wash cloth toys in the washing machine with detergent and water; air-dry or machine-dry.
- To disinfect mouthed toys, either run them through the dishwasher/sanitizer or spray with bleach solution and let them air dry. If needed right away, spray the toy with bleach solution and let it dry for between three and five minutes; rinse with water before giving to the child.
Handling clothing and bedding

Some germs can be passed from child to object to another child. Anything that comes in close contact with the child can carry disease. To prevent this, regulations for early care and education programs state that certain items must be used by only one child or be laundered before use by another child. Assign blankets, sheets, cots, cribs and mattresses to individual children. Store bedding (sheets, pillows, blankets) individually. Plastic bags (always kept out of children’s reach), blanket bags, separate drawers, shelves or cubbyholes are all acceptable ways to separate a child’s belongings from others.

If clothing, towels, bedding, diapers, etc. become soiled, store them safely out of reach until they are laundered (or put in the garbage if they are to be thrown away). Dirty cloth diapers and clothing should be placed in a plastic bag and sent home with the child at the end of the day. Laundry should not be kept in food preparation or early care and education areas.

The most important way to reduce germs in soiled clothing, towels, etc. is with soap and water. Adding bleach to the rinse cycle will also reduce the number of germs.

Clothing or other material soiled with body fluids should be washed in a washing machine separately from other items. Pre-soaking may be necessary for heavily soiled clothing. Otherwise, wash and dry as usual. If the material will not be damaged by bleach, add the amount of bleach recommended for laundry on the bleach bottle (examples of non-chlorinated bleach are Clorox II® and Borateem®). Always wash you hands after handling soiled laundry.

Cleaning soiled floors

If a hard-surfaced floor is soiled (blood, vomit, stool, etc.), wear gloves and blot up as much as possible. Then mop or wipe the area with a germicidal detergent or disinfecting bleach solution (¼ cup of bleach per one gallon of water or 1 tablespoon of bleach to one quart of water). Check to make sure it is safe for the floor. After 10 minutes rinse the area with clean water and dry.

If a rug is soiled, blot up visible material with disposable paper towels. Spot clean the area with germicidal detergent, applying and removing until visible...
soil is gone. Shampooing or steam cleaning may be necessary. Then apply a 
sanitizing solution according to the manufacturer’s instructions and dry.

You may use (and reuse) utility or dishwashing-type gloves for cleaning, but use 
disposable gloves if there is blood or bloody body fluid in the spill. Reusable 
gloves should be cleaned and rinsed with water and then rinsed again with 
fresh disinfecting solution.

Mop heads, buckets and dustpans should be soaked in detergent and rinsed 
with water, rinsed with fresh disinfecting solution, wrung out and air-dried.

Remember that bleach fumes are irritating to lungs and may cause asthma 
symptoms. Bleach fumes are heavier than air and tend to linger near the floor. 
If you can smell bleach, children at floor level are being exposed at greater 
levels. Always make sure windows are open or other ventilation is used to 
control bleach fumes.

**Protecting yourself from bloodborne pathogens**

In recent years, the risks from exposure to bloodborne pathogens (disease-
causing organisms carried in the blood), such as HIV and hepatitis B viruses, 
have become a concern in the workplace.

The procedures to prevent illness that are described in this E-Reference — such 
as hand washing, wearing gloves when providing first aid, and disinfecting — 
are the same measures that will protect you from bloodborne pathogens. For 
more information contact your local health department. (See Resources at the 
end of this chapter, “**County public health departments**.”)
In the previous section we discussed ways to prevent illnesses from spreading in early care and education settings. Even with the best prevention practices, children sometimes get sick. It is best to be prepared. In this section we will describe some common illnesses, their treatments, and what you can do when you have a sick child in your care.

Communicable or contagious illnesses are caused by viruses, bacteria or parasites that move from a sick person to another person in body fluids on unwashed hands, toys, food, dirty diapers and other objects. Some people who have these illnesses may not feel sick, but can pass them on to others. Early care and education providers should be careful at all times when handling body fluids such as drool, stool, blood and discharge from eyes or nose. The importance of washing hands often and well to prevent the spread of illness cannot be stressed enough for early care and education providers and children alike (see Resources at the end of this chapter, General resources, “Preventing illness in early care and education settings”).

Both children and early care and education providers can spread germs and illness to others. Excluding a sick staff member or child may be the best way to prevent spreading illness. The following guidelines can help you to decide when it would be better for children to stay home and when early care and education providers should not provide care. Be sure to follow Oregon rules covering excluding children from early care and education.

**SYMPTOMS THAT MAY INDICATE CONTAGIOUS ILLNESS**

It is recommended that parents seek advice from their health care provider if these symptoms are present. If you are unsure about when to exclude a child from care, discuss the symptoms with the parents and seek advice from the child’s health care provider, the health department or an early care and education health consultant.
Children with the following symptoms are likely to be contagious:

- **Diarrhea:** Three or more watery stools in a 24-hour period if not caused by dietary changes, medications or passing hard stool;
- **Blood in the stool;**
- **Stomach pain for two hours, or pain with fever or other symptoms;**
- **Eye infection:** Thick mucus or pus draining from the eye with the white part of the eye looking pink or red;
- **Mouth sores with drooling;**
- **Body rash, especially with a fever, itching or sores (not a diaper rash, heat rash, and/or allergic rash, poison oak or insect bite);**
- **Sick appearance, not feeling good, unusually tired, pale, not hungry, hard to wake up, confused or irritable, or unable to keep up with program activities;**
- **Sore throat, especially with fever or swollen glands in the neck, or a cough that is not related to a cold. Vomiting two or more times in the last 24 hours.**
- **Ear infections cannot be spread from child to child. However, it is important that the child receives treatment and follow-up care. The decision to keep a child with an ear infection in care depends on his or her comfort and needs.**
- **Fever:** Fever alone is not necessarily a sign of illness nor is it, by itself, a reason to keep a child out of early care and education. Normal body temperature rises and falls throughout the day. If fever is accompanied by behavior changes or signs and symptoms of illness, it is more likely the child is getting sick. It is recommended that a health care provider examine any infant less than 4 months of age who has an unexplained fever. A child with a fever of 100 degrees F or more, measured under the arm, or 101 degrees F, measured by mouth must be excluded from early care and education. **Note:** Medication that reduces the fever will not change the child’s contagious condition.

- **Note:** Colds are common in children. If you exclude them from early care and education once they are sick, it is too late to prevent the spread of the virus. Children who have mild cold symptoms and who do not have any of the symptoms described above do not need to stay out of early care and education. Decisions about keeping a child with a cold in care depend on
how comfortable he or she is, and whether the staff can meet the child’s needs while caring for the other children. (See next section, Observing, reporting and documenting symptoms of illness, Respiratory problems, “Symptom: Sore throat,” “Symptom: Cough” and “Restrictable diseases.”

Early care and education providers with certain symptoms may be contagious.

Early care and education providers can also spread germs that cause illness. Any provider with an early care and education-restrictable disease must not provide care.

It is also good practice for early care and education providers with the following symptoms to not provide care:

- Diarrhea (same as for children);
- Vomiting (same as for children if not caused by pregnancy or digestive disorder);
- Respiratory illness (if the illness limits the provider’s ability to provide acceptable care).

OBSERVING, REPORTING AND DOCUMENTING SYMPTOMS OF ILLNESS

What you observe can help families and health care providers know how best to treat a child. The following are guidelines for observing, reporting and responding to symptoms of illness.

Children with special medical, developmental or behavioral needs may not show or express signs of illness like other children. Ask their parents and specialists for signs and symptoms. Also, know the signs related to medications and, very importantly, signs of reactions or side effects. Ask for another contact to call if the parent is not available in case of illness or reaction to medications.

- Document and report what you observe — Do not draw conclusions or diagnose. A clear picture of what you observe gives more information to the families and health care providers than a conclusion or diagnosis.
  
  Example: Observation: “Mary’s finger is swollen and bruised-looking.”

  Diagnosis: “Mary’s finger is broken.”
• **Give measurable facts** — Avoid vague statements.

  **Example:** Measurable: “Johnny has an oral temperature of 103 degrees F.”
  Vague: “Johnny is hot.”

• **Get a second opinion** — If possible, ask a coworker or the child care director if he or she agrees with your observation. It can give you confidence when reporting what you see. If you are the only adult providing care, you might want to review your report with your health care provider to check out your observation.

• **Write policies** — Policies about how illnesses will be handled in children help you to be prepared. The policies should be shared with parents so they know what to expect if their children become ill.

• **Note illnesses in the child’s file** — It may seem silly to write, “Johnny stayed home for three days due to a cold,” but recording information can help you see how often a child is ill. It can also help you to see if there are patterns to a child’s illness. Also, accurate record keeping helps you give factual observations to families and health care providers.

• **Report outbreaks of early care and education-restrictable diseases** —

  (See the following list of restrictable diseases.) In addition to reporting outbreaks of restrictable diseases to your local health department, you also need to post the occurrence of an outbreak in a place that all parents can see.

• **Always report illness to families** — For all illnesses other than restrictable diseases, report the illness to families immediately or at the end of the day, depending upon the seriousness of the illness.

**Restrictable diseases**

Early care and education facilities are required to “restrict” or keep children and providers from early care and education if they are ill with certain diseases. The purpose of the restriction is to stop the spread of disease to others in early care and education. Any child or early care and education provider who has a restrictable disease should not come to the early care and education facility until a health care provider determines that the person is no longer contagious. Restrictable diseases include the following:

- Chicken pox
- Diphtheria
• Food poisoning or waterborne illnesses
  • Campylobacteriosis
  • Cryptosporidium
  • Escherichia coli E. Coli, such as E. Coli 0157:H7
  • Giardia
  • Hepatitis A
  • Salmonellosis
  • Shigellosis
  • Typhoid
• Measles
• Pertussis (whooping cough)
• Rubella
• Scabies
• Streptococcal infection
• Staphylococcal infection
• Tuberculosis (Tb)

An outbreak is two or more cases of a restrictable disease among children in your care and/or staff members. Notify families quickly when a restrictable illness occurs.

Report outbreaks of restrictable diseases to your local county health department. (See Resources section at the end of this chapter for a list of health departments, do an internet search or consult the government pages of your phone book.)

For information on a variety of specific illnesses go to OKHS Volume 4: Appendix, Chapter C, “Links to Information on Specific Illnesses.”

**Actions to take**

It is important that early care and education providers be able to recognize dangerous or life-threatening conditions, know what to do and be able to quickly get urgent or emergency medical attention when needed. Be prepared by having emergency contact information for each child easily available. It is strongly recommended that early care and education providers take first-aid training and periodically update it. (See Chapter D, First aid.)

This section is designed to help you decide what to do if you see signs and symptoms that a child may be becoming ill. A decision chart is included with each symptom.
Follow the arrows down and across, being sure to answer all of the questions. Each question asks you about symptoms you are observing.

For each question you should be able to answer either yes or no.

Follow the arrows from the yes and no answers, which will lead to the action you should take or to the next question you need to answer.

Be sure to read the general information below each chart.

Symptoms and signs are listed in alphabetical order.

**Ear**

**Symptom: Earaches**

Is there ear discharge?

- **YES**
  - (See ear discharge, later in this symptom list.)

- **NO**

  Does child have severe ear pain, fever, irritability or decreased hearing?

  - **YES**
    - Call parent/guardian. Child may have a middle ear infection and need medical evaluation.

  - **NO**

There are two kinds of ear infections:

- Otitis media (middle ear infection);
- Otitis externa (outer ear infection or “swimmer’s ear”).

Otitis media is caused when bacteria or viruses become trapped and grow in the middle ear. Children with otitis media often complain of earache, have fever and are irritable. They may have cold symptoms, decreased hearing and ear discharge. Antibiotics are sometimes needed to treat otitis media.
• Otitis media is not communicable and children do not need to be excluded for this condition unless they are too ill to be adequately cared for in early care and education. Some children who have had many middle ear infections have an operation where tubes are placed in their eardrums. These tubes allow the middle ear to drain so they don’t get as many infections. When children have tubes in their ear drums, they should not get water in their ears. Repeated middle ear infections can sometimes cause permanent hearing loss and speech delays.

• Swimmer’s ear (otitis externa) is an infection of the ear canal. Children may complain of itchy ears and moving the ear lobe may cause pain. There may also be ear discharge. Eardrops are sometimes prescribed to treat this condition. Swimmer’s ear is not easily passed on to others, so children should not be excluded from early care and education for this problem. Children with swimmer’s ear should not use a swimming pool because the ear needs to remain dry to heal.

Recommendations about the use of antibiotics for ear infections/otitis media have changed in recent years. Because of increasing concerns about antibiotic resistance and because most ear infections will get better on their own (without antibiotics), fewer health care providers are now prescribing antibiotics for routine cases of otitis media. A health care provider will decide when and if antibiotics are needed. Pain medications may help with discomfort.

• If a child has been complaining of ear pain and there is white, yellow or green discharge, it may mean the child’s eardrum has burst.

Pain is greatest before the eardrum bursts because of the pressure built up in the middle ear from pus. A ruptured eardrum (unless it is chronic) is part of the healing process and won’t permanently affect the child’s hearing, but the child needs medical care.

Children often like to put things such as peas or beans in their ears. This often causes ear discharge and/or pain. A health care provider should remove these items.
Symptom: Ear discharge

- Is the discharge ear wax? 
  - Yes: No need to do anything.
  - No:
    - Is the discharge bloody or like pus? 
      - Yes: Call parent/guardian. Child needs medical evaluation.
      - No:
        - Is there fever, cold, severe ear pain, irritability, decreased hearing? 
          - Yes: Call parent/guardian. Child needs medical evaluation. May be middle ear infection. (Refer to earaches – see previous page.)
          - No:
            - Is there itching, red or wet ear canal, and/or pain when ear lobe is moved? 
              - Yes: Inform parent/guardian of symptoms when they pick up child at the end of the day. May be swimmer’s ear. (Refer to earaches – see previous page.) May need medical evaluation.
              - No:
                - Is discharge bloody or clear and accompanied by confusion, recent head injury or forceful vomiting? 
                  - Yes: Call and then parent/guardian. Child needs immediate medical care.
                  - No: 

OREGON KIDS – HEALTHY AND SAFE
Eye

Symptom: Decreased vision and crossed eyes

- Children who have problems seeing may squint or may not see objects when they are pointed out. Contrary to popular belief, headaches are rarely a sign of poor vision in children. Discuss with parent/guardian.

- Amblyopia (lazy eye) is a condition where the eyes don’t work together equally. This can lead to permanent decreased vision in one eye unless it is treated. Amblyopia sometimes develops when the eyes are aligned in different directions. This is called strabismus. If a child looks forward and the colored iris of one eye is not centered like the other eye, strabismus might be present. Discuss with the family.

- For any injury to the eye or sudden loss of vision, call and parent/guardian.
Symptom: **Eyes burning, itching; discharge**

- Pink eye (conjunctivitis) is an infection of the clear covering over the white part of the eye as well as the pink skin under the eyelids. It can be caused by either viruses or bacteria. If caused by a virus, no medicine is needed; the eyes will heal by themselves.

- The child with pink eye is contagious as long as he or she has eye discharge or, if the child has bacterial pink eye, he or she has been getting antibiotic eye drops for 24 hours. Exclude from early care and education until discharge and redness is gone or child has been on antibiotic eye drops for 24 hours and symptoms are improving (see **OKHS Volume 4: Appendix, Chapter C, “Links to Information on Specific Illnesses”**).
Fever

Symptom: Temperature above normal

Fever is often the body’s response to infection. A child’s temperature can vary during a typical day. A child is considered to have a fever when his or her temperature rises above a certain cut-off point (see “Taking a temperature” on following page). Other things also cause a child’s temperature to rise including too many clothes and being very active on a particularly warm day.

Many children can have a high temperature without appearing to be sick.

Steps to take when a child has a fever

- Take a closer look at the child to see if other symptoms such as diarrhea or rash are present. If so, consider excluding the child from early care and education.
• Evaluate the child’s behavior. If he/she is acting very ill and the staff is unable to care for the child, parent/guardian should be called to take the child home.
• Remove extra clothing and offer liquids.
• Don’t overdress the child or sponge with alcohol or water.
• Call parent/guardian if the child has a fever of over 100 degrees F (under the arm, or axillary) occurs in a child who is less than 6 months of age so that medical advice can be obtained that day. If a child has a fever and sore throat, ear pain, cough, rash or diarrhea, see the decision-making charts on those symptoms for more information.
• Give medicines only as prescribed by health care provider. Unless prescribed by a health care provider, aspirin should not be given to children under 18 because of the possible connection between aspirin and Reye’s syndrome (a serious disease that can cause death). (See this chapter, “Medications in early care and education” for more information.

Taking a temperature
• Only use a digital thermometer. Mercury thermometers should no longer be used and should be disposed of as hazardous waste. Information about hazardous waste disposal sites can be found in Section D, Resources section, Poison prevention, “Hazardous materials.”

Using a thermometer – Getting ready
• Don’t give cold or hot liquids for one-half hour before taking temperature by mouth.
• Comfort and stay with child and make sure she or he remains still.

Taking the temperature
• By armpit — Use this method on children/people of any age.
  ■ Place end of thermometer under the arm; hold arm snug against body.
  ■ Armpit should be dry.
  ■ Leave under arm for recommended time as indicated by manufacturer.
• **By mouth** — Only use on children 6 years and older.
  - Place end of thermometer under tongue.
  - Tell child to close mouth, not teeth, by bringing lips together. Caution child not to bite thermometer.
  - Leave under tongue two minutes or as indicated by manufacturer. Stay with the child to keep him/her still and comforted.

• **By ear** — This is an acceptable way to take a temperature, but sometimes accuracy can be affected by ear wax or a small curved ear canal. Follow manufacturer’s directions.

• **By forehead** — Forehead (temporal artery) thermometers are also available. While these are simple to use even while the child is asleep, they are new and their reliability has not yet been verified.

**Temperatures by various methods**

<table>
<thead>
<tr>
<th>Temperature by</th>
<th>Normal</th>
<th>Fever</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mouth</td>
<td>98.6 degrees F</td>
<td>100.4 degrees F or higher</td>
</tr>
<tr>
<td></td>
<td>(37.0 degrees C)</td>
<td></td>
</tr>
<tr>
<td>Armpit</td>
<td>97.6 degrees F</td>
<td>100 degrees F or higher</td>
</tr>
<tr>
<td></td>
<td>(36.4 degrees C)</td>
<td></td>
</tr>
<tr>
<td>Ear or forehead</td>
<td>97.6 degrees F</td>
<td>100.4 degrees F or higher</td>
</tr>
<tr>
<td></td>
<td>(36.4 degrees C)</td>
<td></td>
</tr>
</tbody>
</table>

**Cleaning thermometers**

• When possible, use a single-use disposable plastic cover on the thermometer or wash thermometer with soap and cool water, rinse, sanitize with bleach solution (1/4 teaspoon/1 quart water), rinse and dry.

• Store in a protective case.

If a child's temperature is over 100 degrees F, measured under the arm, the child must be excluded from early care and education.
A runny nose is very common in childhood. Children may have runny noses during crying and sometimes after exercising. The color of nasal discharge is not a good indicator of the cause of runny nose.

- If there is smelly discharge coming from one nostril, regardless of the color, the possibility of an object in the nose is high. The child may need to be referred to a health care provider for evaluation.
- Often children with a cold will develop greenish discharge after several days. This does not necessarily mean that they have developed a bacterial infection, so antibiotics may not be appropriate. Nasal discharge lasting 10 to 14 days – particularly if accompanied by fever, facial pain, etc. – may indicate sinusitis and should be evaluated by a health care provider.
Symptom: **Nosebleed**

- Picking the nose causes most nosebleeds. This causes tiny blood vessels in the nose to open and bleed. Nosebleeds may also be associated with colds and hay fever. A health care provider should evaluate a child if he or she experiences repeated nosebleeds.

- To stop a nosebleed, pinch the child’s nostrils together for at least five minutes without releasing pressure. The child should be seated. Do not tilt head back because the child might gag from blood dropping down the back of the throat. After the bleeding stops, make sure the child does not blow nose.

Has the child been picking the nose, or have a cold or hay fever?

- YES: If bleeding stops quickly, inform parent/guardian when the child is picked up at the end of the day.

- NO: Is the nose bleeding for more than 20 minutes?

- YES: Call parent/guardian. Child needs medical evaluation.

- NO: Was the nosebleed caused by a head injury?

- YES: Call 911 and then the parent/guardian. The child needs medical evaluation today.
Rashes

Symptom: Skin rash

Is there fever?

YES

Call parent/guardian. Restrict child from early care and education until parent/guardian and their health care provider can tell you that the rash is not contagious.

(Refer to measles, rubella, scarlet fever and chicken pox in OKHS Volume 4: Appendix, Chapter C, “Links to Information on Specific Illnesses.”)

NO

Is there itching?

YES

Call parent/guardian. Restrict child from early care and education until parent/guardian and their health care provider can tell you that the rash is not contagious.

(Refer to ringworm and scabies in OKHS Volume 4: Appendix, Chapter C, “Links to Information on Specific Illnesses.”)

NO

(Refer to diaper rash, on following page.)
• Children often have skin rashes with no other symptoms. Some of the rashes may be caused by allergic reactions, heat, viruses or reaction to medications. Mild rashes often disappear as fast as they come.

• One common rash that does not require exclusion is caused by fifth disease. Children typically have a slapped cheek appearance. Children are not contagious when this rash appears. (See OKHS Volume 4: Appendix, Chapter C, “Links to Information on Specific Illnesses.”)

Symptom: Diaper rash

Are the following present?
• Blisters;
• Small red patches beyond the diaper area

Discuss with parent/guardian at the end of day when the child is picked up. Encourage them to consult their health care provider. Diaper rash may be caused by staphylococcus germs or yeast and may need treatment.

Is the rash only in the diaper area?

YES

Mention rash to parent/guardian when they pick up the child.

NO

Probably not just a diaper rash.
(Refer to rashes, in this section.)
Steps to treat simple diaper rash:

- Keep diaper dry and change as much as possible.
- Allow the diaper area to dry when possible by removing diaper for short periods.
- When washing area, use plain water and soap only. Avoid commercial diaper wipes since they contain alcohol, which is painful to raw skin.

Symptom: Other common baby rashes

There are two very common kinds of baby rashes: One is typically on the face (milia), and the other can be on any part of the body (heat rash). Small white bumps over the infant’s forehead, nose and cheeks are called milia. If the bumps on the face are red they are sometimes called infant acne. No treatment is needed; they go away eventually and are harmless. They are most commonly seen on newborns and very young infants. Small red bumps, usually in the skin fold areas and often on the neck and upper chest, are called heat rash. This may mean that the infant is bundled too much. The rash quickly goes away once the baby is unbundled. This rash is also harmless.

Symptom: Cradle cap (seborrhea)

Cradle cap and dandruff are the same thing. Cradle cap happens when oil glands in the scalp become overactive. An infant with cradle cap has thick, oily, yellow, scaling patches on the scalp. Frequently, there are very small bumps on the child’s forehead and behind the ears. Although it is not attractive looking, it is not harmful to the infant. It can be treated by using a soft scrub brush to wash the scalp once a day. Sometimes it helps to put a little oil on the scalp, let it soak in for about 15 minutes and then completely wash off the oil. If oil is left on the scalp, the cradle cap will get worse.

Symptom: Childhood eczema

Eczema or atopic dermatitis is a common childhood condition that leads to chronic skin irritation. Commonly affected sites include the face — especially cheeks — elbow creases and behind the knees. These areas become red and itchy. Scratching can lead to secondary infection. In many children eczema gets worse in dry winter weather. Treatment includes topical skin products (such as moisturizing ointments and steroid creams), bathing in tepid water with cleansing products designed for sensitive skin, and
avoidance of weather exposure. Children typically have less trouble with eczema as they grow older, but some continue. Eczema is not contagious.

**Respiratory problems**

**Symptom: Cough**

Did violent cough begin suddenly without signs of a cold and is there difficulty breathing?

**YES**

Child may have inhaled object now stuck in airway.

- Call 911.
- Call family.

**NO**

Severe difficulty breathing?

- Child faints with coughing spasms?
- Lips and skin are bluish?
- Child is tough to rouse?

**YES**

Needs urgent medical care

- Call 911.
- Call family.

**NO**

Are any of the following present?

- Fits of coughing with some difficulty breathing;
- Vomiting after cough.

**YES**

Call family. Child needs medical evaluation right away or call 911. See Whooping Cough, OKHS Volume 4: Appendix, Chapter C, “Links to Information on Specific Illnesses.”

(Continued on next page)
Discuss with family when child is picked up from care. Child needs medical attention.

- Is there a persistent and continuous cough lasting longer than four weeks?
- Does cough bring up mucus or sputum?

Call family. Child needs medical evaluation right away. Children and staff with cough and fever should stay home until 24 hours after fever is gone.

Any of the following present?
- Fast or mildly difficult breathing;
- Sucking in ribs without seeming to get enough air;
- Fever.

Mention to family when child is picked up from care.
• Coughing has many causes and can accompany the following illnesses: colds, flu, pneumonia, whooping cough. Sometimes a cough may be a sign that a child has inhaled a foreign object such as a peanut.

• For all coughs, allow the child to be in the most comfortable position that makes it easiest to breathe.

• Persistent and continuous coughs that last more than four weeks and don’t seem to be getting better may mean there is a chronic illness or problem and the child needs to be medically evaluated. Asthma is a common cause of a chronic cough. (See “Asthma management in child care settings” later in this chapter for a discussion of asthma management in early care and education settings.)

Croup

Croup is a respiratory problem most common in children ages 2 to 4 years. It may accompany a viral infection, such as a cold. Croup can cause the child’s airway to swell, making it hard to breathe. The main symptom is a harsh cough that sounds like a seal’s bark. A fever of 100 degrees F to 101 degrees is common. The child may become very frightened. Croup usually gets worse at night and may last one to seven days. If these symptoms occur while the child is in your care, contact the family so the child can be cared for at home. Until the family arrives, you can do the following to help the child be more comfortable:

• Stay calm. The child is already frightened and needs reassurance.

• Get moisture into the air to make it easier for the child to breathe. Take the child into the bathroom and turn on all hot water faucets. Then sit on the floor in the steamy room and read a story together.

• Bundle up and take the child outside for a walk in fresh air. Cool, moist air is best.

• If the child starts crying, this may be a positive sign that he or she is breathing more normally.

• Emergency medical care is needed immediately if these signs of respiratory distress appear:
  - Squeaky or raspy sound as child inhales (stridor);
  - Sucking in or retraction between ribs as child inhales;
- Flaring nostrils;
- So short of breath she or he can’t walk or talk;
- Drools or is breathing with the chin jutting out and the mouth open;
- A fever of 102 degrees F or higher.

**Stomachaches and other intestinal problems**

A stomachache is a common complaint among children of all ages. A number of causes may be underlying the complaint. It is important for early care and education providers to be aware of potentially serious and less serious underlying causes.

Some children will complain of stomachaches when they are anxious or afraid. This pattern may recur. These symptoms may improve as the child becomes more secure in the early care and education environment. Notify the child’s parents of recurrent symptoms and monitor for changes. Even if there is a history of stomachaches due to anxiety or other psychological issues, it is important not to ignore these complaints because other conditions may arise.

A stomachache or abdominal pain — accompanied by vomiting, diarrhea or fever that occurs in a child who looks sick — should receive additional evaluation. Some potential causes of acute pain include gastroenteritis (sometimes called stomach flu, usually caused by a virus or contaminated food, and usually preceded by vomiting or diarrhea); appendicitis (typically pain in the right lower side of the abdomen in children over 5 years of age); urinary tract infection (bladder infection); pneumonia (lung infection); abdominal hernia and trauma. Constipation and lactose intolerance (intolerance to the sugars in dairy products) are relatively common sources of chronic or recurrent pain in children.

See the following sections on diarrhea and vomiting to help guide your actions.
Symptom: **Diarrhea**

Does the child act ill? Is there blood or pus in the stool? Are there signs of dehydration? Is the child’s mouth dry? Are there no tears when the child cries? Is the child not passing any urine? (See *dehydration*, *later in this section*.)

**YES**

- Call parent/guardian. Child needs medical evaluation. Restrict child from early care and education until diarrhea is gone and/or health care provider informs you that the diarrhea is not a hazard to others.

**NO**

- Discuss with parent/guardian at the end of the day when they pick up the child. Watch for continuing diarrhea.

Have there been recent diet changes with no other symptoms of illness?

**YES**

- Does the child act ill? Is there blood or pus in the stool? Are there signs of dehydration? Is the child’s mouth dry? Are there no tears when the child cries? Is the child not passing any urine? (See *dehydration*, *later in this section*.)

These symptoms of diarrhea are important because:

- Young children, especially infants, can become very ill with dehydration if diarrhea is severe.
- In group situations such as early care and education, diarrhea can spread rapidly. This can cause loss of income to parent/guardian, early care and education directors and staff because of work missed by parent/guardian who must stay home with ill children, low attendance at early care and education and work missed by ill staff. In extreme cases, early care and education facilities may need to be closed to control the spread of the disease.

Diarrhea is an increased number of watery stools over a 24-hour period. Some cases of diarrhea are communicable (easily spread) and some are not. Diarrhea with the following symptoms is more likely to be communicable:

- Child acts and looks ill.
- Bright red or coffee-colored blood in stool.
• Pus in stool.
• Fever.
• Weight loss or failure to gain weight.

Signs of dehydration:

• Child does not urinate or have a wet diaper for six hours.
• Tongue, lips, inside of mouth are dry.
• There are no tears when child cries.
• Child’s skin is dry.
• Child appears thirsty.
• Child has sunken eyes; infant’s head has sunken soft spot.
• Child is not moving around much or showing interest in things around him/her.

More than one case of diarrhea in the early care and education setting, particularly among children and staff who are in the same area, suggests a communicable diarrhea outbreak and should be reported to the local health department.

Steps to take for diarrhea symptoms

Separate and exclude children from early care and education who have diarrhea until they are seen by a health care provider.

Review with staff procedures for hand washing, diapering and sanitizing toys and tabletops. These measures can prevent the spread of disease.

Do not allow children or early care and education staff who have been excluded for diarrhea back into early care and education until they no longer have diarrhea, and/or a health care provider has determined that the diarrhea is not a health hazard.

Tell parent/guardian to inform their health care provider that their child is in early care and education and whether or not any other children or early care and education staff are ill with diarrhea. This information may influence whether the health care provider obtains a stool culture.
Symptom: Vomiting

- Some children vomit easily for many reasons such as illness, excitement, motion sickness, or even for no obvious reason. **Any child who vomits should be separated from other children.** After the child has vomited, avoid giving solid foods. Wait between one and two hours. Offer small amounts of liquids such as ice chips, sips of water or diluted apple juice to avoid dehydration.
Other signs of illness: If any of the following conditions exist, parent/guardian should be contacted because the child may need to be seen by a health care provider.

- Child has a fever.
- Vomiting occurs more than twice in one day.
- Child also has diarrhea.
- Child has stomach pains and is bloated.
- Child has pain when passing urine.

Call the health care provider and the parents immediately if:

- Child is lethargic (sleepy, not alert and unresponsive).
- Vomit contains blood and looks black or dark green.
- Vomiting occurs after a head injury.

Signs of dehydration: Dehydration is a major concern for children (especially infants) who vomit repeatedly and/or have diarrhea or a fever. The child may need to be examined by a health care provider. Notify parents if you see these signs.

- Child does not urinate or have a wet diaper for six hours.
- Tongues, lips, inside of mouth are dry.
- The child does not have tears when he or she cries.
- The child has dry skin.
- Child has sunken eyes, or infant has sunken soft spot on head.
- The child does not move around much or show interest in things or child is listless.
Throat

Symptom: Sore throat

- Though rare, untreated strep infections can cause rheumatic fever with resulting arthritis, heart or kidney disease.
- Although certain signs suggest “strep” as the cause of a sore throat, no one can tell if a sore throat is caused by a streptococcus germ until a throat swab or throat culture has been done.
- Strep infections are not communicable 24 hours after treatment with antibiotics. However, it is important for the child to take all the medication as prescribed (typically a penicillin-type of medicine).

Does the child have severe trouble swallowing or breathing, or is the child drooling more than usual?

Call ☎️ if child can’t breathe; then call parent/guardian. Child needs medical care immediately.

Are any of these symptoms present with the sore throat? Fever, large and tender glands in neck, headache, general discomfort, red sandpaper rash.

Call parent/guardian. Child needs medical evaluation. He or she may have scarlet fever or strep throat. ☎️
See OKHS Volume 4: Appendix, Chapter C, “Links to Information on Specific Illnesses” for more information about strep.

Report sore throat symptoms to parent/guardian at end of the day when the child is picked up.
Asthma

• Asthma management in early care and education settings

Not all symptoms of illness are caused by bacteria or virus. Symptoms such as coughing, wheezing, rashes, red eyes and more can be triggered by environmental factors. Children are more sensitive than adults to common indoor pollutants such as cleaning products, dust, mold, perfume and smoke. When a child has a chronic health problem such as asthma, this sensitivity to the environment is even greater. By ensuring fresh air and controlling indoor pollutants, you can avoid triggering symptoms in children, and also help keep them healthier as they grow.

Asthma is the most common chronic health problem among children. It is second only to tooth cavities. It is a breathing disorder that can make children very sick. They may even need to go to the hospital during an episode. Symptoms of an episode are coughing, wheezing and shortness of breath. These symptoms are caused by spasms of the air passages in the lungs. Breathing becomes hard when the passages swell, become inflamed and fill with mucus. Once a child has asthma, there are common triggers that can cause an asthma episode:

• Colds and respiratory illnesses;
• Allergies to food, dust and chalk dust, dust mites, pollen, mold or pets;
• Very active play or exercise;
• Roaches or rodents;
• Stress;
• Tobacco smoke and wood smoke;
• Outdoor pollutants, such as ozone;
• Indoor pollutants, such as paint, cleaning solutions and chemicals or perfumes;
• Temperature and weather changes;
• Others.
It is best to treat asthma at the very first sign or symptom, and not wait for the parent to come to treat the child. If a child in your care has asthma, the family and the health care provider must give you detailed information and instructions about the care of the child. Update the information as the child’s condition and needs change.

The plan should include:

- History and severity of asthma episodes;
- Triggers to be avoided (if possible);
- Early signs and symptoms;
- When to take action;
- Medications used for prevention and in an emergency;
- How to use the medications and treatments;
- Who to call for help;
- Emergency contacts. (The child’s health care providers should be available to you when you need them.)


Some older children give themselves their asthma medications at home. During early care and education, though, the parent and health care provider must both sign a document giving permission for the child to self-medicate. Also, it is not necessary to keep a child with asthma from physical activity unless the parent/guardian or health care provider has given you a written explanation for doing so.

**Preventing asthma episodes**

- Avoid asthma triggers in the child’s area.
- Stop exercise if the child begins to cough or wheeze.
- Avoid very vigorous exercise.
- Avoid cold damp weather and bring the child inside if cold air triggers an episode.

**What to do during an asthma episode**

- Stop the child’s activity and remove the asthma trigger, if known.
• Stay calm and keep the child calm.
• Give medication or treatment described in the child’s plan.
• Contact the parents.
• If there is not quick improvement and the parents are unavailable, call the doctor.
• If the child is unable to breathe, call 911.
• Write about the asthma episode in the child’s file. Include the child’s symptoms, how the child acted during the episode, medication given and when, and the cause of the episode, if known.

• Making your early care and education “asthma-friendly”

Reduce and control triggers.

• Control dust. If there is a need for carpet, low pile is best. Vacuum floors daily and dust often.
• Avoid feather pillows.
• Consider enrolling a child who is allergic to dogs or cats in a facility without pets.
• Avoid air fresheners and scented products and consider a scent-free policy.
• Open windows or use ventilation when mixing sanitizers and disinfectants to avoid exposure to fumes.
• Avoid food allergy exposures (see “A word about food allergies” in this section of OKHS Volume 3.)

Train staff

• Make sure that staff know how to care for the child to prevent asthma episodes.
• Orient staff to the child’s asthma management plan.
• Use community resources for information. (See Resources at end of Chapter C.)
Keep supplies on hand

- Make sure that your disaster plan includes a three-day supply of medications and addresses other needs the child might have. Refer to emergency preparedness pages in Chapter D, “Preparing for emergencies and natural disasters.”

- See that equipment (nebulizers, peak flow meters, inhalers, spacers, Epi-Pen) necessary to administer asthma medications are onsite and functional.

- Consult with family regarding possible insurance coverage for duplicate supplies to be kept at early care and education.

- **A word about food allergies**

  Allergies to foods may trigger asthma episodes in a small number of children. Some children have an intolerance to certain foods that causes symptoms such as stomach cramps or diarrhea; this is not an allergic reaction. Of greatest concern is the child who reacts severely (called anaphylaxis) to foods, insect stings or medications. This reaction can result in death. These children should be under the care of a health care provider, and have a plan on file (see OKHS Volume 4: Appendix, Chapter C, “Special Health Care Plan”).

  Some children (and adults) may have **life-threatening allergic reactions** to foods (e.g., peanuts, shellfish), medications, bee or other insect stings, latex particles or other allergens. Individuals (including children) with a history of severe allergic reactions should have access to **emergency medication** (epinephrine) at all times. Though uncommon, it is important to remember that individuals without a history of severe reaction may develop such a reaction at any time. In Oregon, any adult older than 21 years of age (including early care and education providers) can be trained and certified to recognize the signs and symptoms of a severe allergic reaction and to administer prescribed emergency medication for a child with known allergies. Contact your local health department or the Office of Family Health at the Oregon Health Authority (971-673-0259) for more information about training in your community.

**Diabetes**

- **Diabetes management in early care and education settings**

  Care for diabetes is more flexible than it used to be. Younger children may
require assistance with care. Older children may be able to do self-care. Children with diabetes can participate in all early care and education activities. The Americans with Disabilities Act considers diabetes a disability.

- **How is diabetes managed?**

Early care and education providers, in coordination with parents and health care providers, can prepare a care plan to meet the special needs of children with diabetes. Make sure the plan includes documenting important information about the child’s condition during the day as well as any tests or medications given to the child. A special care plan should include:

- When to test blood glucose, use insulin, or use a quick sugar source;
- Regular meal and snack times;
- Preferred snacks and party foods;
- Usual symptoms of hypoglycemia and preferred treatments;
- When and how to notify the child’s parents of problems;
- When and how to contact the child’s health care provider;
- Who will give insulin injections when needed.

Preschool-age children with diabetes often need frequent blood glucose tests. They have not learned yet to recognize the symptoms of low blood sugar. They may also drink and urinate a lot, so make sure they can go to the bathroom as often as they need.

For more information call the American Diabetes Association at 1-800-DIABETES.

**Seizures**

The brain is a complex and sensitive organ. It regulates all motor movement and sensation and generates thoughts and emotions. Sometimes the brain discharges abnormal signals that cause a seizure. This may happen even though there is no history of seizures.

The tendency to have seizures is called “epilepsy.” Epilepsy is not contagious. It is a disorder of the nervous system.
There are many types of seizures:

- **Partial seizures** (formerly called petit mal seizures). The child appears to be daydreaming for a few seconds. There is no loss of consciousness.

- **Tonic-clonic seizures** (formerly called grand mal seizures). There are two parts to these seizures. During the tonic phase the child loses consciousness and falls, rigid, to the floor. The second part is the clonic phase, where the body jerks and twitches. The child may lose bladder control. The child will slowly regain consciousness.

- **Febrile seizures**. These seizures are brought on by high fever, and may look like a tonic-clonic seizure. Some children are prone to febrile seizures.

**Terms to know**

- **Aura**. Sometimes children learn to recognize a warning sensation before a seizure happens. This is called an “aura.” It may be a sound, taste, smell or sensation of change in temperature.

- **Status seizures** or **status epilepticus**. This is the term for seizures that repeat so rapidly that the child does not regain consciousness between seizures. This is a medical emergency. Call 911 and then notify the family immediately. If a child has had status seizures in the past, an action plan should be developed and placed in the child's file. For information on preparing an action plan, go to OKHS Volume 4: Appendix, Chapter C, “Seizure Care Plan.”

Seizures may be easily controlled by medication and infrequent for some children. Others may still have seizures regardless of medication to control them. A child with epilepsy in your care should have a seizure plan on file. The plan should include:

- Types and frequency of seizures;
- Current treatment, including medications, dosages, administration instructions and side effects;
- When to call for emergency assistance;
- Observations that could help the health care provider adjust medications;
- Support for the child and family.
• **What to do during a tonic-clonic seizure**

  • Keep calm. You cannot stop a seizure once it has started. Let the seizure run its course.
  • Protect the child from injury. If possible, break the child's fall. Remove sharp, hard or hot objects from the child's area. Keep the mouth and nose clear to aid breathing.
  • Do not restrain the child's movements. Do not put anything in the child's mouth. This can injure the teeth and you could be bitten.
  • When the seizure is over, move the child to a quiet, safe place for recovery. Position the child on the side and stay with her or him. Allow the child to rest or sleep until ready to join the group again.
  • Emergencies. Call 911 if the seizure lasts more than five minutes, the child doesn’t wake between seizures, or the child isn’t alert for 20 minutes after a seizure.
  • Follow the emergency plan you have developed with the health care provider and the family.

• **Training staff**

  If you have a child in your care with a history of seizures, all staff, including substitute providers, should be aware of the child's history and emergency plan. Staff should be trained to observe and record any changes in the child's behavior and health, especially after medication changes are made. It is important to understand and acknowledge the family's ethnic or cultural beliefs and practices concerning seizures.

• **Making early care and education safe and friendly for the child with epilepsy**

  • Have a quiet place for the child to rest after a seizure.
  • Keep a change of clothing on hand for the child.
  • Supervise children with epilepsy when swimming or wading. When they are supervised, their risk of drowning is no greater than other children.
  • Note in the child’s seizure plan any activity restrictions.
  • When the child has a seizure, direct other children out of the area and reassure them that the child will get better.
Sometimes children need medications during their time in early care and education as they are getting well or for a chronic health condition. Medications, including over-the-counter medicines such as Tylenol® and sun screen, are powerful remedies. They can harm children if given at the wrong time, in the wrong amount, in the wrong way, or to the wrong child. It is important that they are given carefully, with attention to detail.

Parental or guardian consent is required for both prescription and over-the-counter medications before the early care and education provider gives them to the child. Updating this consent every month is a best practice. Find out from parents when medications are needed or any special considerations. See the Resources section at the end of this chapter, "Medication administration," for more information.

The following are general guidelines; there may be exceptions to these recommendations.

If it is your policy not to give medications at early care and education, you need to communicate this policy with parents at the time of enrollment.

**Should medication be given in early care and education?**

Develop a policy about when medication will be given in early care and education. Share your policy with your families.

Consider asking yourself these questions to decide whether a medication needs to be given during early care and education:

- Is the child too ill to be in early care and education today?
- Sometimes a medicine is being used to stop a symptom, such as a runny nose. Is this symptom bothering the child enough to interfere with sleeping, eating and normal activities?
- Is the medicine effective? For instance if A+D® or Desitin® ointments don’t improve a diaper rash in a few days, a prescription medication may be needed.
- If the medicine is a prescription, does it have to be given during early care and education, or can it be given at home before or after time in early care and education?
- Can the early care and education staff take the time to safely give the medicine?
If medication has to be given during early care and education, there are early care and education licensing requirements for the use of prescription and non-prescription medications including:

- Parental or guardian consent must be signed, dated and kept on file before any medication can be given in early care and education.
- Prescription medications must be kept in the original container and labeled with the child’s name, the name of the drug, dosage, directions for administering, date and physician’s name. (This applies to sample medications as well.)
- Nonprescription medication must be kept in the original container labeled with the child’s name, the dosage and directions for administering.
- A written record shall be kept of all medications administered. List, at a minimum, the name of the child, type of medication, the signature of the caregiver administering the medication, date, time and dosage given.
- All medications shall be stored in a tightly covered container with a childproof lock or latch so they are not accessible to children.
- Medications requiring refrigeration shall be kept in a separate covered container in the refrigerator and clearly marked “medication.”
- Parent/s shall be informed daily of medications given to their child.

All medications must be stored away from children and apart from food. It pays to be doubly careful. A locked container, such as a fishing tackle box with a small lock, can be used and then placed in a high cabinet away from children. For medicines that must be kept cold, the container can be put in the refrigerator.

If the request by parents for giving medication to their child fits your policy, use the following chart to help you make decisions about when to give medications in early care and education. For each question, you should be able to answer either yes or no. Follow the arrows to the yes and no answers, which will lead you on to the action you should take or to the next question you need to answer.
Decision chart for medications in early care and education

Is the medication request acceptable under the medication administration policy for your early care and education?

- YES
  - Have parent’s written permission and medication been obtained?
    - NO
      - Arrange for parent/guardian to administer medication either on site or at home.
    - YES
      - Is medication prescription?
        - NO
          - Is medication in original container?
            - NO
              - Do not give.
            - YES
              - Does the consumer label provide instructions for the child’s age?
                - NO
                  - Does the permission sheet provide instructions from the doctor?
                    - NO
                      - Do not give.
                    - YES
                      - Continue with medication procedure.
                - YES
                  - Continue with medication procedure.
  - NO
    - Is medication in original container with prescription label or written instructions from doctor?
      - NO
        - Do not give.
      - YES
        - Continue with medication procedure.

- NO
  - Is medication request acceptable under the medication administration policy for your early care and education?
General rules about giving any medicine

- Wash your hands first.
- Choose a clean surface to work on, away from diapering or toileting areas.
- Read the label: Do you have the right medicine at the right time, and the right amount for the right child?
- It is important to get as much detail as possible in an as-needed order. Over-the-counter medicines for the pain of teething or immunization reactions should be given for obvious pain situations but not over a long time.
- Explain to the child what is going to happen. Never refer to medicine as “candy.” It may taste sweet or taste like bubble gum, but the child should know it is medicine.
- Try to make the experience as pleasant and relaxed as possible. Praise the child after the medication is taken. Never force a child to take medicine, and tell parents if child refuses.
- Wash your hands after giving the medicine.
- Write down in the child’s file the name of the medicine given, the date, the dose and your name. This is especially important when medication is given over a long period of time.
- If the child shows side effects from the medication, stop giving it and inform the child’s parents or call 911 if it is a serious reaction.

How to give different types of medicines

- **Oral medicines (medicines that are swallowed)**
  - Measuring liquids is always done at eye level for accuracy. Pour on a flat, even surface and read measurements at eye level. Do not over- or under-fill. If using a syringe, avoid air bubbles by keeping the tip below the level of the liquid. Turn upside down and tap syringe to allow air bubbles to rise to the top. Gently push the plunger to expel air bubbles. Practice measuring liquid using a syringe.
  - Remember that liquids need to be measured by a calibrated device and not a kitchen spoon, plastic ware or kitchen measuring spoons. They are not accurate and can cause an underdose or overdose.
  - Use the dispenser provided by the parent. If no dispenser is provided, locate proper device from facility.
- Wash and disinfect dispenser after use unless disposable.
- Equivalents:
  - 1 cc = 1 ml
  - 1 teaspoon = 5 ml
- If the child vomits or spits out part of it, do not repeat dose unless a health care professional advises it.

**Eye drops**
- You may need an assistant.
- If eye drops are refrigerated, bring to room temperature. Shake if needed.
- Clean the child’s eyes first, using a clean tissue for each eye, wiping each eye from the inside of the eye to the outside.
- If the child is younger than 5, have the child lie down on his or her back. If seated, tilt the head back.
- Have the child look up, then open the eye by gently pulling back on the lower lid.
- Bring the dropper close to the eye and drop the medication in the inside corner outside the child’s field of vision. Then have the child blink.
- Do not touch the eye or anything else with the bottle or dropper.
- The bottle should be no more than one inch from the eye.
- Gently close the eye and have the child, if able, put pressure on the inside corner of the eye for approximately 20 seconds.

**Eye ointments**
- Eye ointments are difficult to apply. Ask the parent to ask the child’s health care professional if alternative forms are available.
- Ointments are applied along the lower lid.
- Hold the eyelid open for a few seconds and then have the child hold the eye closed for 20 to 30 seconds.
- Clean off the nozzle of the tube with a clean tissue.
Nose medications

• Nose sprays
  • Hold one nostril shut or, if possible, have the child do it.
  • Insert nasal spray in the other nostril and squeeze the bottle as the child breathes in.
  • The child should be upright and mouth should be closed.

• Nose drops
  • Administer one side at a time.

Ear drops

• Have the child lie down with affected ear facing up.
• For children younger than 3, pull the lobe down and back. Look for ear canal to open.
• Look for any discharge, blood or pus. Report to the parent.
• Older children can sit up and tilt head sideways until ear is parallel to the ground.
• Never let the bottle touch the ear.
• Drop the medication on the side of the ear canal.
• Have the child stay still for several minutes.

Topical medicines (skin creams, ointments, patches applied to the skin)

• Gloves and/or applicators should be used when administering topical skin cream medication.
• Standard precautions are to be used when possible exposure to body fluids may occur.
• The dressing, gloves and applicator must be disposed of in a plastic-lined container used specifically for this task. Make sure children cannot access these items.
• Apply the cream or ointment with applicator and cover if instructed.
• Gloves are not required for sunscreen.

*Adapted from American Academy of Pediatrics Healthy Futures Medication Administration Curriculum, Module 3. The complete curriculum can be found at http://www.healthychildcare.org/ParticipantsManual.html.
MEDICATION EMERGENCIES

Most medications have possible side effects. Many children do not experience any side effects when taking medications, but some do. Be aware of the side effects to watch for, and report them to parents if they occur.

Sometimes children can have severe reactions to medications. The more severe reactions may be preceded by puffy eyes, cough, hives or welts, nausea or vomiting, and fatigue. These symptoms should be noted and monitored, and parents should be informed when these symptoms are associated with use of a medication. A more severe reaction may occur with continued use. Listed here are examples of symptoms that mean a child needs immediate medical attention:

- Difficult or fast breathing; child sucks in ribs and doesn’t seem to get enough air; child appears blue around lips.
- High fever (over 104 degrees F).
- Child is confused.
- Seizures or convulsions (fits) in a child with no history of seizures.
- Severe pain.

Dial 911 for emergency help. Post 911 emergency numbers by the phone along with the address and phone number of your early care and education home or facility as these can be forgotten easily in an emergency. When calling for emergency help be prepared to give the operator the following information:

- Your name;
- Child’s name;
- Your address;
- The problem.

INFORMATION ABOUT SPECIFIC ILLNESSES

When children are ill, early care and education providers feel better when they are armed with information about diseases. See OKHS Volume 4: Appendix, Chapter C, “Links to Information on Specific Illnesses” for information about a number of different diseases that may be encountered in early care and education settings. The following information is provided about each disease:
A description of common infectious childhood diseases;

- The incubation period (or the time between exposure to infection and the onset of illness);
- The infectious period (length of time an ill person is contagious and can spread infection to others);
- Ways to limit the spread of infectious diseases.
IMMUNIZATIONS

Oregon law requires that children be immunized against many diseases or have an exemption. The purpose of Oregon’s child care immunization law and rules is to keep children safe from vaccine-preventable diseases. Oregon’s child care immunization law and rules — ORS 433.235-433.284 and OAR 333-050-0010 through 333-050-0140 — are available at http://arcweb.sos.state.or.us/pages/rules/access/numerically.html.

VACCINE-PREVENTABLE ILLNESSES

- **Measles:** Measles is a disease that passes from person to person very easily. It can cause a high fever and rash. Approximately 30 percent of people with measles have one or more other medical problems such as diarrhea, ear infection, pneumonia and seizures. People can die from measles, but it happens rarely. Measles used to be a common childhood disease. This is no longer the case due to immunization. In 2011, there were only three cases of measles in Oregon.

- **Mumps:** Mumps is an illness that can cause swelling of the salivary glands. Up to 20 percent of people with mumps may show no symptoms. About half of people with mumps may only have cold-like symptoms. Serious problems can happen, including infection in the brain and swelling of the testicles or ovaries. Mumps used to be the most common reason children went deaf in childhood.

- **Rubella:** Rubella is a mild disease causing a low fever, rash, swollen glands, and, in adults, joint pain. Up to 50 percent of people with rubella may have no symptoms. However, rubella during pregnancy can cause birth defects in the baby. Problems for the baby can include deafness, eye defects, heart defects, mental retardation and death.

- **Varicella (chickenpox):** Varicella (chickenpox) causes fever and a rash. The rash turns into blisters that crust over. Most cases of chickenpox are mild. However, sometimes an infection occurs that can be serious, causing possible skin infection, pneumonia or problems with the brain. People
who had chickenpox disease can get shingles later in life because the two
diseases are caused by the same virus. Before the vaccine, 11,000 people
with chickenpox needed to go to a hospital, and 100 people died every
year in the United States from chickenpox.

- **Haemophilus influenzae type B (Hib):** Hib disease used to be a
  common reason for brain infection in children under 5 years old. Hib
  infection also can cause pneumonia, deafness and infections of the
  blood, joints and bones. Up to 5 percent of children with Hib disease
die even with medical care. Of children that live, some will have permanent
brain damage. Currently, most children get the vaccine and the disease
is very rare.

- **Diphtheria:** Diphtheria is caused by bacteria that produce a toxin.
  Diphtheria can infect many places in the body, but most infections
happen in the nose and throat. Diphtheria can cause heart failure,
breathing problems, local paralysis and death.

- **Tetanus:** Tetanus is a disease that causes muscle spasms all over the
  body. The muscle spasms can be severe enough to break the spine or
long bones. Tetanus is also called lockjaw. Tetanus is caused by bacteria
that usually enter the body through a wound. Approximately 20 percent
of people who get tetanus die. People who live can get tetanus again.
Almost all cases of tetanus occur in people who have never had shots
or who have not had a booster shot in the previous 10 years.

- **Pertussis:** Pertussis (whooping cough) is a disease that spreads easily
  from person to person. It can be very severe in infants. Sometimes
children cough so hard that it is difficult for them to eat, drink or breathe.
In older children and adults, whooping cough can seem just like a cold
or bad cough. Children can get whooping cough from older children and
adults around them. Serious problems can result including pneumonia,
seizures and death.

- **Polio:** Polio is a disease that can cause paralysis. Up to 95 percent of
infected people have no symptoms of polio. However, polio used to cause
20,000 cases of paralysis every year in the United States. Polio shots
work very well. In fact, the disease no longer exists in the western half of
the world. Polio seen in the United States has been diagnosed in some
travelers from other countries.
• **Hepatitis B:** Hepatitis B is a disease that affects the liver. Hepatitis B can cause acute (short-term) or chronic (long-term) infection. Acute hepatitis B can lead to diarrhea, vomiting, yellow skin and eyes, and pain in the muscles, joints and stomach. Chronic hepatitis B can lead to liver damage (cirrhosis), liver cancer and death. Some people carry hepatitis B in their blood and may not know they are infected. These carriers can pass on the virus, and they can end up having problems such as liver cancer later in life. The younger a person is when getting hepatitis B, the more likely he or she is to become a carrier.

• **Hepatitis A:** Hepatitis A is a disease that affects the liver. The virus is found in the stool of people who have hepatitis A. You can also get hepatitis A by eating food or drinking water that has the virus in it. People who have hepatitis A can get very sick. Some need to be in the hospital. A few may even die. Before the vaccine became available, Oregon had a higher rate of hepatitis A disease than most other states.

• **Pneumococcal disease:** Infection with this disease can cause serious illness and death. The bacteria are spread from person to person through close contact. Before the vaccine, 200 children under age 5 died from this disease every year in the United States. It can cause infection in the covering of the brain. It can also cause blood infection and pneumonia. These bacteria also cause many ear infections in small children. Pneumococcal vaccine is recommended for all children under 5 years of age, but it is not required for early care and education in Oregon.

• **Influenza (flu):** Influenza is a respiratory illness that is usually spread from person to person through coughs and sneezes. Symptoms include fever (usually high), headache, extreme tiredness, dry cough, sore throat, runny or stuffy nose and muscle aches. Nausea, vomiting and diarrhea also can occur and are much more common among children than adults. In rare cases, complications from flu can lead to death. Vaccination against flu each fall or winter is the primary way to prevent this disease. All children and adults are advised to get an annual flu vaccination. Early care and education providers are at high risk for contracting the flu from the children they care for and passing it on to others. It is important for adults who care for children to be immunized against flu. Influenza vaccine is recommended for all children, but it is not required for early care and education in Oregon. Note: Children and staff who have flu-like illness (fever above 100 degrees F with cough or sore throat) should stay home until fever has been gone for
at least 24 hours. If staff or children become ill while at early care and education they should be sent home. For more information, go to http://www.cdc.gov/h1n1flu/guidance/exclusion.htm.

- **Rotavirus:** Rotavirus is a viral infection that is spread through fecal and oral routes on contaminated hands and objects. In infants and young children, it can cause severe diarrhea, vomiting, fever and dehydration. The most severe cases occur in children six to 24 months of age. By the age of five years, 95 percent of all children are infected with rotavirus. Before the vaccine, rotavirus led to between 20 and 60 deaths each year in the United States. The disease can be prevented by routine hand washing and by immunization. Vaccine is recommended for children under 32 weeks of age, but it is not required for early care and education in Oregon.

**WHAT DO I NEED TO DO?**

All children need to have an immunization form, called a Certificate of Immunization Status (CIS) form, filled out and signed by their parent or guardian. You can get blank CIS forms from your local health department. (See this chapter’s Resources section for a list of local health departments.)

On the CIS form the parent must fill in at least:

- The child’s name;
- The child’s date of birth;
- Address;
- The parent’s or guardian’s name;
- The month and year each shot was given;
- The signature of the parent or guardian;
- The date the form is signed.

Before beginning early care and education, a child’s CIS form must show that he or she has received at least one dose of each vaccine given to children of that age (see following table).
Where can I find shot records?

Parents often have a shot record from their child’s doctor listing the shots the child has had. You may also use the ALERT Immunization Information System (IIS). It is a secure, confidential computer system that contains immunization information for people in Oregon. Early care and education providers have a right to access the immunization dates for children in their care. To gain access to ALERT IIS, please contact the ALERT IIS Help Desk at 1-800-980-9431 or by email at alertiis@state.or.us.

Can I just copy the shot record from the doctor?

Oregon law requires that shot information be kept on a CIS form. It is easier for you if you ask the parent to fill out the CIS form using the shot record from the doctor or use an updated CIS form printed out from ALERT IIS.

It is very important that the parent or guardian signs and dates the CIS form when he or she fills it out. The information on the form is not complete without the parent or guardian signature.

Preschools and certified early care and education centers must complete an annual immunization report for the county health department about children in their care. Contact your county health department for more information about this report (see Resources section at the end of this chapter for list of health departments).

<table>
<thead>
<tr>
<th>Age of child</th>
<th>Shots that child must have to start in a program for young children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 2 months old</td>
<td>None</td>
</tr>
<tr>
<td>2 months to 14 months</td>
<td>Diphtheria/tetanus/pertussis (DTaP), polio, Hib, hepatitis B</td>
</tr>
<tr>
<td>15 months to 17 months</td>
<td>Diphtheria/tetanus/pertussis (DTaP), polio, Hib, hepatitis B, measles, mumps, rubella (MMR)</td>
</tr>
<tr>
<td>18 months and older</td>
<td>Diphtheria/tetanus/pertussis (DTaP), polio, Hib, hepatitis A, hepatitis B, measles, mumps, rubella (MMR), varicella (chickenpox)</td>
</tr>
</tbody>
</table>
When do I need to have the CIS completed?

You must have the parent or guardian complete the CIS form before the child can begin attending early care and education. It is very important that the parent or guardian signs and dates the CIS form when filling it out. The information on the form is not complete without the parent’s or guardian’s signature.

Do these rules apply to all children in my care?

Every child in your care — both full-time and part-time, as well as your own children — needs a completed CIS form.

What if parents don’t want their children to have shots?

Parents or guardians who do not want their children to have shots can sign a religious exemption. On the back of the CIS form is a box with a statement for the parent or guardian to read and sign. The parents must also read a brochure about claiming a religious exemption, available at http://www.oregon.gov/DHS/ph/imm/docs/SchRelExemtBrch.pdf. The parents or guardian cannot change the words in the statement. The parents must check the boxes for the vaccines they don’t want their child to receive. As an early care and education provider, you cannot refuse to care for a child because the parent or guardian has signed a religious exemption for the child.

What if a doctor says that a child shouldn’t get shots?

If a doctor says that a child should not get shots, the doctor or the county health department can sign a medical exemption. Parents cannot sign medical exemptions. Information about medical exemptions is on the back of the CIS form. The medical exemption must specify the vaccines that the child cannot receive, how long the exemption is good for, and the reason for the exemption. The county health department needs to review and approve all medical exemptions.

HOW MANY SHOTS DO CHILDREN NEED?

Most children will receive up to 20 shots by the time they are 2 years of age. They will have up to five medical visits just for shots by the time they are 2 years old. It is very important that a child’s CIS form is updated each time the child gets more shots. To update the child’s CIS form, ask the parent or guardian to fill in the dates of the shots that the child got and then have the parent or guardian sign the CIS form again. There are four lines on the CIS form for the
parent to sign. A separate line should be used each time a parent or guardian adds information to the CIS form.

The current immunization schedule that most doctors use is included in the Resources section at the back of this chapter under “Immunizations.” It changes every year. An updated schedule can be printed off the CDC website at [http://www.cdc.gov/vaccines/schedules/index.html](http://www.cdc.gov/vaccines/schedules/index.html).

**How do I know if a child is due for shots?**

It is important to ask parents and guardians often whether their child has received any more shots. If you want to know whether the child needs more shots based on the record you have, you can use Oregon’s Immunization Primary Review Table. You can get a copy of the current table by calling your county health department. A new table comes out every year, usually in late November.

**Why is it important to keep the child’s record updated?**

Every early care and education provider, preschool, kindergarten and school must keep current shot records. If there is ever a case of disease, the county health department may need to see the CIS forms to make sure the children have the vaccine doses needed to be protected. By keeping a child’s record updated, the CIS form can be given to the parent or guardian if the child is changing early care and education providers or is going on to school. Just remember that you have to have the CIS form on file when the child is in your care.

**Keeping track of children without shots**

In case your community ever has an outbreak of a disease that children get shots for, it is important that you know which children in your care haven’t had shots. This includes children who are too young to get shots, and children with a religious or medical exemption. If you care for many children at once, you may want to keep a list of children who have not had shots.
## COUNTY PUBLIC HEALTH DEPARTMENTS

<table>
<thead>
<tr>
<th>County</th>
<th>Address 1</th>
<th>Address 2</th>
<th>City, State, Zip</th>
<th>Phone</th>
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<tr>
<td>Baker County Health Department</td>
<td>3330 Pocahontas Road</td>
<td></td>
<td>Baker City, OR 97814</td>
<td>541-523-8231</td>
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<tr>
<td>Benton County Health Department</td>
<td>530 NW 27th Street</td>
<td></td>
<td>Corvallis, OR 97330</td>
<td>541-766-6838</td>
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<tr>
<td>Clackamas County Health Services</td>
<td>710 Center Street</td>
<td></td>
<td>Oregon City, OR 97045</td>
<td>503-655-8478</td>
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<tr>
<td>Clatsop County Health Department</td>
<td>PO Box 206</td>
<td></td>
<td>Astoria, OR 97103</td>
<td>503-325-8500</td>
</tr>
<tr>
<td>Columbia Health District - Public Health Authority</td>
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<td></td>
<td>St. Helens, OR 97051</td>
<td>503-397-4651</td>
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<tr>
<td>Coos County Health Department</td>
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<td>Crook County Health Department</td>
<td>203 N Court Street</td>
<td>Prineville, OR 97754</td>
<td>Prineville, OR 97754</td>
<td>541-447-5165</td>
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<tr>
<td>Curry County Health Department</td>
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<td>Gold Beach, OR 97444</td>
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<td>541-247-7011 x265</td>
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<tr>
<td>Deschutes County Human Services</td>
<td>2577 NE Courtney</td>
<td>Bend, OR 97701</td>
<td>541-322-7400</td>
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</tr>
<tr>
<td>Douglas County Health Center</td>
<td>621 W Madrone</td>
<td>Roseburg, OR 97470-3093</td>
<td>Roseburg, OR 97470-3093</td>
<td>541-440-3625</td>
</tr>
<tr>
<td>Gilliam County Medical Center</td>
<td>PO Box 705</td>
<td>Condon, OR 97823</td>
<td>541-384-2061</td>
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<tr>
<td>Grant County Health Office and Family Planning Clinic</td>
<td>201 S Humbolt Street, Suite 255</td>
<td></td>
<td>Canyon City, OR 97820</td>
<td>541-575-0429</td>
</tr>
</tbody>
</table>

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**RESOURCES: PREVENTING AND RESPONDING TO ILLNESS (CHAPTER C)**
Harney County Health Office  
323 N Grand  
Burns, OR 97720  
541-573-2271  

Hood River County Health Department  
1109 June Street  
Hood River, OR 97031  
541-386-1115  

Jackson County Health and Human Services  
1005 E Main Street  
Medford, OR 97504  
541-774-8209  

Jefferson County Health Department  
715 SW 4th Street, Suite C  
Madras, OR 97741  
541-475-4456  

Josephine County Department of Health  
714 NW A Street  
Grants Pass, OR 97526  
541-474-5325  

Klamath County Department of Public Health  
403 Pine Street  
Klamath Falls, OR 97601  
541-882-8846  

Lane County Health & Human Services  
125 E 8th Avenue  
Eugene, OR 97401  
541-682-4035  

Lincoln County Human Services Department  
36 SW Nye Street  
Newport, OR 97365  
541-265-4112  

Linn County Department of Health Services  
PO Box 100  
Albany, OR 97321  
541-967-3888  

Malheur County Health Department  
2671 SW 4th Avenue  
Ontario, OR 97914  
541-889-7279  

Marion County Health Department  
3180 Center Street NE, Room 200  
Salem, OR 97301  
541-588-5357  

Morrow County Health Department  
PO Box 799  
Heppner, OR 97836  
541-676-5421  

Multnomah County Health Department  
1120 SW Fifth Avenue -14th Floor  
Portland, OR 97204  
503-988-3674  

Polk County Health Department  
182 SW Academy, Suite 302  
Dallas, OR 97338  
503-623-8175
Tillamook County Health Office
PO Box 489
Tillamook, OR 97141
503-842-3900

Umatilla County Public Health Division
431 SE Third
Pendleton, OR 97801
541-278-5432

Union County Center for Human Development, Inc.
1100 K Avenue
La Grande, OR 97850
541-962-8801

Wallowa County Health Department
758 NW 1st
Enterprise, OR 97828-1527
541-426-4848

Wasco-Sherman County Health Department
419 E 7th Street, Room 100
The Dalles, OR 97058
541-296-4636

Washington County Department of Health & Human Services
155 N First Avenue, MS-5
Hillsboro, OR 97124-3072
503-846-6667

Wheeler County Health Office
PO Box 307
Fossil, OR 97830
541-763-2725

Yamhill County Public Health Division
412 N Ford Street
McMinnville, OR 97128
503-434-7525

*Online directory
http://public.health.oregon.gov/PROVIDERPARTNERRESOURCES/LOCALHEALTHDEPARTMENTRESOURCES/Pages/lhd.aspx
HEALTH ORGANIZATIONS

Centers for Disease Control and Prevention (CDC)
Health, safety and environmental health, as well as communicable disease and emerging diseases (e.g., West Nile virus, SARS, etc.) information
http://www.cdc.gov

Epilepsy Foundation of America
8301 Professional Place
Landover, MD 20785-7223
1-800-EFA-1000 or 301-459-3700
http://www.efa.org/

Immunization Action Coalition
http://www.immunize.org

National Association for the Education of Young Children (NAEYC)
1313 L St. NW Suite 500
Washington DC 20005
1-800-424-2460
http://www.naeyc.org

Oregon Child Care Resource & Referral Network
Click “For Provider/health and Safety”
http://oregonccrr.com/

GENERAL RESOURCES

Preventing illness in early care and education settings

• Books and reference materials
  Lee: The Rabbit with Epilepsy
  D.M. Moss
  Managing Infectious Diseases in Child Care and Schools:
  A Quick Reference Guide
  S. Aronson and T. Shope, editors

• Hand hygiene
  Includes information on the use of hand sanitizers in early care and education settings
• Hand washing
  http://www.cdc.gov/ounceofprevention/
  http://www.dobugsneeddugs.org/daycares/

• Mercury thermometer disposal
  http://earth911.com/recycling/hazardous/mercury/

• Thermy Campaign
  Food safety education
  http://www.fsis.usda.gov/Food_Safety_Education/Thermy/index.asp

• U.S. Agriculture Department Food and Drug Administration Food Safety and Inspection Service publications

Health policies

• Model Child Care Health Policies
  http://www.ecels-healthychildcarepa.org/content/MHP4thEd%20Total.pdf

• Safe N Sound Child Care Health and Safety Tips
  English, Russian, Spanish and Vietnamese
  http://www.oregonchildcare.org/SafeNSound.htm

Child illness and what to do

• Antibiotics
  Oregon AWARE (the Alliance Working for Antibiotic Resistance Education)
  971-673-1111
  Centers for Disease Control and Prevention
  http://www.cdc.gov/getsmart/

• Head lice
  Oregon Public Health Division

• HIV/AIDS
  General
  Centers for Disease Control and Prevention
  http://www.cdc.gov/hiv/
  Questions or counseling
  http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVPrevention/Pages/index.aspx
• **Medication administration**
  American Academy of Pediatrics Healthy Futures Medication Administration Curriculum and resources for medication logs, incident forms, release of information forms, and consent forms and care plans

• **Scabies**
  Red Book from the American Academy of Pediatrics
  141 NW Point Blvd.
  Elk Grove Village, IL 60003-1098
  847-434-4000
  1-847-434-8000 (fax)
  [http://www.aap.org](http://www.aap.org) (search under Journals & Publications)

**Documents and forms to download and print — General**
*(Go to OKHS Volume 4: Appendix — Chapter C.)*

- Asthma Action Plan
- Links to Information on Specific Illnesses
- Medication Administration Form
- Posters
  - Cleaning, Sanitizing and Disinfecting With Bleach
  - Diapering Procedure — English and Spanish
  - How to Handwash (adult)
  - Infant Handwashing — English and Spanish
  - Mixing Sanitizing and Disinfecting Solutions
  - Washing Your Hands (child) — English and Spanish
- Seizure Care Plan
- Special Health Care Plan

**IMMUNIZATIONS**

National Network for Immunization Information: NNii
[http://www.immunizationinfo.org](http://www.immunizationinfo.org)
Oregon ALERT
For access to ALERT IIS
1-800-980-9431 (Help Desk)
alertiis@state.or.us

Oregon Health Authority Public Health Division, Immunization Program
971-673-0300
public.health.oregon.gov/PHD/OFH/IMM/Pages/index.aspx

Oregon’s child care immunization law and rules
http://arcweb.sos.state.or.us/pages/rules/access/numerically.html

Recommended Childhood and Adolescent Immunization Schedule
United States – 2010
http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm

Documents and forms to download and print — immunizations

(Go to OKHS Volume 4: Appendix — Chapter C.)

• Oregon Certificate of Immunization Status
CHAPTER D
PREVENTING AND RESPONDING TO INJURIES AND POISONING
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Young children grow very fast, and their curiosity about new things grows even faster. They have limited skills and experience to make judgments about safety. Because of children’s age, parents and caregivers must take the responsibility for preventing injuries. Preschool children, unlike infants and toddlers, can begin to learn safety behaviors. Here are some ways to help young children learn safety behaviors:

- **Young children like to imitate adults.** A small child may try to imitate his father lighting a cigarette or his mother taking medication. Showing a small child how a match can start a fire may produce undesired results. The child may attempt to repeat what he or she sees. Remember you are a role model and you need to model safe behaviors.

- **Young children have an extremely limited vocabulary.** Most children will not be able to understand words such as “scald,” “pressure” or “prevent.” Carefully choose words that a preschooler can understand, such as “burn” or “push down.”

- **Young children do not always understand the relation between one event and another.** Telling a child not to run into the street after a ball because he or she may get hit by a car is difficult for most young children to understand. Cause and effect should be carefully explained, but you should not expect a young child to change his or her behavior.

- **Young children need constant repetition and reinforcement of a concept.** They need time to understand the relationship and time sequence between one event and another.

- **Young children do not perceive auditory and visual stimuli well enough to react in a self-protective way.** Caregivers must check the early care and education setting for hazards and carefully supervise children.
Injuries are the major cause of death and disability to children in the United States, including children in Oregon. The most common risks to Oregon children ages 0 to 4 include:

- Falls
- Poisonings
- Motor vehicle traffic crashes
- Scald burns
- Airway obstruction

Injuries caused by dog bites and drowning also contribute to hospitalizations in this age group, and injury is commonly caused by unsafe toys and lead poisoning. Fortunately, almost all injuries can be prevented.

You can prevent most injuries that occur with children by:

- Watching and supervising children carefully;
- Checking the early care and education or play settings for hazards;
- Understanding the growth and development of children (certain kinds of injuries/incidents are common at each stage of development);
- Correctly using child safety seats, seat belts and bicycle helmets;
- Staying trained and up-to-date in first aid and age-appropriate CPR.

**PREVENTING COMMON CHILDHOOD INJURIES**

**Falls**

By far, falls are the leading cause of hospitalization among children ages 0 to 4 in Oregon. Babies and toddlers are primarily at risk from falls associated with furniture, stairs and baby walkers. Preschoolers are at risk for falls from playground equipment, out of windows, down stairs, off a bike or tricycle, and off anything that can be climbed.

Use the safety checklist to make sure that your early care and education setting is as safe as it can be. (Refer to “Indoor, outdoor and safety checklists” later in this chapter.)
Ways to prevent falls

• Put babies in a safe place such as a crib or playpen when they cannot be held.

• Use gates on stairways and close doors.

• Avoid baby walkers. According to the American Academy of Pediatrics, baby walkers allow children to get to places where they can pull hot foods or heavy objects down on themselves. A baby walker can also tip over, or the child can fall out of it or fall down the stairs in it.

• Be sure the surface under play equipment is soft enough to absorb a fall.

• Make sure toddlers and children wear bicycle helmets while riding on scooters, bicycles, tricycles, skates or any other wheeled toy.

If a child falls:

1. Assess the fall and assume a serious injury with a fall from a height, a violent collision or blow, or if a child’s helmet is broken.

2. Check the child for life-threatening conditions:
   • Unconsciousness
   • Not breathing or having trouble breathing
   • No pulse
   • Severe bleeding
   • Head, neck or back injuries
   • Shock
   • Possible broken bones

3. Have someone call 911 if life-threatening conditions exist.

4. Do not move the child unless the child is in danger of more injury or needs treatment.

   Note: If a helmet is present, leave it on the child. Removing the helmet could cause more pain and injury.

5. Give CPR or first aid if needed.

6. Treat for shock if indicated.

7. Comfort the child and keep the child from moving.
8. Notify the parents or guardians.

9. Conduct a review of the injury and determine ways to prevent a reoccurrence.

10. Complete the Injury Report Form and have the parent sign it to confirm he or she was notified.

Scald burns

The majority of scald burns to children, especially among those ages 6 months to 2 years, are from hot foods and liquids spilled in the kitchen or carried by adults and spilled onto children. Hot tap water from a sink or bathtub is also to blame for many scald burns among children.

Ways to prevent injury from scald burns

- Check bath and tap water temperatures to make sure they are not too hot (120 degrees F or less).
- Hot liquids, such as coffee, can easily scald a child. Carry coffee and other hot liquids in an insulated cup with a secure lid.
- Check stoves and counters for containers with hot liquids that could be pulled down. Turn pot handles away from counter edge.

If a scald burn occurs:

1. Check the child and call if the burn is severe or other life-threatening conditions exist.

2. Call for:
   - Burns involving breathing difficulty;
   - Burns covering more than one body part;
   - Burns to head, neck, hands, feet or genitals;
   - Burns (other than very minor) to a child;
   - Burns from chemicals, explosions or electricity.

3. Move the child away from the source of the heat.

4. Use lots of cool water or cover burned area with cool, wet cloths to cool the burned area.
5. When the burn is cool, loosely bandage or cover the burned area with a dry cloth to prevent infection and reduce pain.

6. Check for and treat for shock.

7. Notify the parents or guardian and have them contact their medical care provider if 🏥 was not indicated.

8. Comfort and reassure the child.

9. Conduct a review of the injury and determine ways to prevent a reoccurrence.

10. Complete the Injury Report Form 📝 and have the parent sign it to confirm he or she was notified.

Choking

Choking is a common cause of injuries among young children. Children will put anything in their mouths. The federal government has established a safe toy size for kids under 3 years old. A small part should be at least 1-1/4 inch in diameter and 2-1/4 inches long. Any part smaller than this is a potential choking hazard. Have parents check with medical provider if child swallows a foreign object.
Ways to prevent choking

- Keep small items out of children’s reach, such as:
  - Small parts of a toy
  - Broken or deflated balloons
  - Jewelry
  - Batteries
  - Safety pins
  - Unsafe rattles
  - Nails, tacks, screws
  - Crayon pieces
  - Coins
  - Beads
  - Peas and beans
- Leave foods that may cause choking out of the diet until a child can chew and swallow (usually around the age of 4). See section on nutrition in Chapter B for more information on foods that may cause choking.
- Don’t let children run with anything in their mouth (rattle, lollipops, food, pencil).
- Don’t let children lie down while eating.
- Never leave infants alone with a propped-up bottle.

If conscious child (1 to 8 years old) chokes:

1. Try to keep the child calm. Allow the child to cough.
2. If the child can’t cough, talk or breathe, have someone call 911.
3. If the child cannot cough, stand behind the child and give abdominal thrusts until the airway is clear or child goes unconscious.
4. Follow the CPR guidelines.
5. Notify parents or guardian.
6. Conduct a review of the injury and determine ways to prevent a reoccurrence.
7. Complete the Injury Report Form and have the parent sign it to confirm he or she was notified.

If conscious infant (birth to 1 year) chokes:

1. If the infant can’t cough, cry or breathe, have someone call 911.
2. Give five back blows and five chest thrusts until airway is clear or infant goes unconscious.
3. If the infant becomes unconscious, follow CPR guidelines for an unconscious infant.
4. Notify parents or guardian.
5. Conduct a review of the injury and determine ways to prevent a reoccurrence.
6. Complete the Injury Report Form and have the parent sign it to confirm he or she was notified.

Drowning

More than half of infant drownings occur in bathtubs, although toilets and buckets can also be hazardous for this age group. The primary reason infants drown is a lack of supervision. Drowning can happen in less than two inches of water.

- If children are in or around water, adults need to constantly keep them within arm’s reach and visually supervise them.
- Empty out buckets, bathtubs, pails and any other containers of water immediately after use.
- Make sure spas, hot tubs and whirlpools have locked safety covers when not in use.
- Fence pools with self-latching gates. Portable-style wading pools are not allowed in licensed early care and education facilities.
- Lifejacket use should be encouraged during activities around water including swimming pools, beaches, river banks and lakes.
If a child shows signs of drowning:

1. Remove the child from the water.
2. Check the child for life-threatening conditions:
   - Unconsciousness
   - Not breathing or having trouble breathing
   - No pulse
   - Severe bleeding
   - Head, neck or back injuries
   - Shock
3. Have someone call 911 if life-threatening conditions exist.
4. Give CPR or first aid if needed.
5. Comfort the child and keep the child from moving.
6. Treat for shock if indicated.
7. Notify parents or guardian.
8. Conduct a review of the injury and determine ways to prevent a reoccurrence.
9. Complete the Injury Report Form and have the parent sign it to confirm he or she was notified.

It can happen in your own backyard, or your neighbor’s. One false move, a back turned for a minute and next thing you know, it’s a trip to the emergency room with an injured child, or worse.

More children die from injuries in the warm months of spring and summer than at any other time of year. With millions of children home from school ready to enjoy the toys and activities of summer, parents and others looking after children have a particularly challenging job of keeping them safe.

Two hazards are especially worrisome because of their popularity and the carelessness that too often accompanies their use: backyard pools and trampolines.

MOTOR VEHICLE CRASHES

By Oregon law, all children under age 8 and under 4 feet 9 inches tall must be properly secured in an approved child safety seat. A correctly installed and used child safety seat reduces the risk of death by 71 percent for infants, and 54 percent for toddlers. However, it is estimated that the majority of children who are placed in child safety seats are improperly restrained.

Car seat safety — Give your infant seat a checkup!

By Oregon law, all children under 8 years old and under 4 feet 9 inches must be properly secured in an approved child safety seat. That’s because safety seats save children’s lives. But they must be used the right way. To make sure your child is riding in the right seat the right way, always read the instruction manual carefully, or call the Child Safety Seat Resource Center at 503-656-7207 in Portland, or 1-877-793-2608 statewide. The Child Safety Seat Resource Center provides training on installing car seats. It also has information on programs that help pay for infant seats.

Be sure that:

- Infants under 1 year of age and weighing less than 20 pounds always ride rear-facing.
- Infants ride in the middle of the back seat, or to the side if there’s an arm rest. Never place an infant seat in front of an airbag.
- Check to be sure the seat is at a 45-degree angle.
- Thread the seat’s harness straps at or below the child’s shoulders.
- Adjust harness snugly; only one finger should fit between the harness and the child.
- Adjust the safety seat’s retainer clip to underarm level.
- Tighten safety belt so the seat does not move more than one inch from side to side.
- When children outgrow their infant seat, use a rear-facing convertible/toddler seat appropriate for their weight.

Source: Adapted from the Oregon Department of Transportation, December 1999.
Ways to prevent injury from traffic crashes

- Make certain that the child’s safety seat is installed and used correctly or call the Child Safety Seat Resource Center at 503-643-5620 in Portland, or 1-877-793-2608 statewide. To make sure your child is riding in the right seat the right way, always read the instruction manual carefully, or call the Child Safety Seat Resource Center for training on installing care seats.

Read and follow the instructions that come with the safety seat and refer to the vehicle’s instructions on installation. Babies from birth to 12 months and 20 pounds should ride in a rear-facing child safety seat, installed in the back seat of the vehicle. Best practice is to keep the child rear-facing to the upper weight and height limits of the seat. Never place an infant in the front seat of a car with a passenger airbag. Toddlers between the ages of 12 months and 4 years and between 20 and 40 pounds (or until the child reaches the seat’s upper weight and height limits) should ride facing forward in a child safety seat. Children over 40 pounds should ride in a booster seat secured with a lap/shoulder belt until they reach age 8 or a height of 4 feet 9 inches. For questions about seat installation or Oregon child restraint laws, call the Child Safety Seat Resource Center, 1-877-793-2608, or go to http://www.childsafetyseat.org.

- Be sure that each child has a seat belt. You may only have as many children in a car as there are seat belts.

- The back seat of a car is a safer place for children up to 12 years of age.

Infant seats (all rear-facing)

- Oregon law requires that infants from birth through 12 months of age, and a minimum of 20 pounds, ride rear-facing. The child must be both 20 pounds and 12 months of age before turning forward-facing. However, the American Academy of Pediatrics (AAP) recommends that babies remain rear-facing until they weigh the maximum weight limit of the seat. Many infant seats have upper weight limits of 30 pounds, rear-facing. Check the manufacturer’s instructions or the stickers on the side of the seat for weight limits.

- Seats are installed in the back seat of the vehicle at a 45-degree angle.

- Never place an infant in the front seat of a car with a passenger-side airbag.

- Thread the seat’s harness straps at or below the child’s shoulders.
• Harness straps need to be snug and hold the child in the seat.
• Adjust the safety seat’s retainer clip to underarm level on the child.
• Tighten the safety belt or the lower anchors so the child safety seat does not move more than one inch from side to side at the safety belt path.

**Convertible safety seats (rear-facing and forward-facing)**

• Oregon law requires child passengers be restrained in an approved child safety seat until they weigh 40 pounds.
• The AAP recommends that once children outgrow an infant seat, they remain rear-facing to the upper weight limits of a convertible seat (often 30-35 pounds). At that point, the seat can be turned forward facing until the child is at the upper weight limit of the seat, forward-facing (40-50 pounds). Check the manufacturer’s instructions or the stickers on the side of the seat for the weight limits.
• In the rear-facing position, thread the seat’s harness straps **at or below** the child’s shoulders.
• In the forward-facing position, thread the seat’s harness straps **at or above** the child’s shoulders.
• Harness straps need to be snug and hold the child in the seat.
• Adjust the safety seat’s retainer clip to underarm level on the child.
• Tighten the safety belt or the lower anchors so the child safety seat does not move more than one inch from side to side at the safety belt path.

**Booster seats (forward-facing with lap and shoulder belt)**

• Oregon law requires that children ride in a booster seat until they are age 8 or 4 feet 9 inches in height.
• Best practice recommendations are that children should continue riding in a booster seat until the lap and shoulder safety belt fit properly, even if over 8 years of age or 4 feet 9 inches in height.
• Lap and shoulder safety belts are required for booster seats.

**Safety belts**

• A child taller than 4 feet 9 inches or age 8 or older must be properly secured with the vehicle’s safety belt.
• The child is properly secured if the lap belt is positioned low across the thighs and the shoulder belt is positioned over the collarbone and away from the neck.

**If a motor crash occurs:**

1. Stay calm.

2. Check for life-threatening situations and conditions such as:
   - Unconsciousness
   - Not breathing or having difficulty breathing
   - No pulse
   - Severe bleeding
   - Head, neck or back injuries
   - Shock
   - Possible broken bones

3. Call if needed. If possible, stay with the child and send another person to call.

4. Give CPR or first aid if needed.

5. Do no harm. Do not move the child, unless the child is in danger of more injury. If the child is in a car seat, leave him or her there. In most cases a child can be treated while in the seat.

6. Treat the child for shock if indicated.

7. Comfort the child.

8. Notify the parent or guardian.

9. Conduct a review of the injury and determine ways to prevent a reoccurrence.

10. Complete the injury report and have the parent sign it to confirm he or she was notified.
TOY SAFETY — PLAY IT SAFE!

Kids will be kids

Even the smartest kids behave like children. They put everything they can grab into their mouths, their noses, their eyes and their ears. They don’t know that sharp edges or pointed objects can hurt. They also don’t know that small things such as marbles, rubber bands, batteries, a teddy bear’s eyes, or a doll’s button can choke them, or that electricity can burn and shock them.

It’s up to caregivers to protect children when deciding what toys to buy and keep in your early care and education settings.

Buying toys

How can I tell what’s safe? Pay attention to age labeling — It’s a good guide to safety.

Toys are often labeled according to ages of children who can use them safely. For instance, “For ages 3 and over” means that the toy is likely to have small parts on which young children can choke or sharp points or strings of elastics that can injure kids under 3 years old.

Choose non-toxic toys

Toys are occasionally recalled for containing high levels of toxic materials such as lead and other heavy metals. Visit the website at http://www.healthystuff.org to find listings of recalled toys and those that have tested positive for toxic materials. Look in the small print on packaging for “ASTM,” which indicates that a toy meets national safety standards of the American Society for Testing and Materials. Avoid soft-plastic beach balls, squeeze toys and baby books made with vinyl and smelling of plastic, which can contain the toxic additive “phthalates.”

Choose non-toxic art supplies

Paint, clay, glazes and markers can contain toxic materials that pose a risk to children. Look for the circular label from the Arts and Creative Materials Institute to be sure that art supplies are certified non-toxic.

Check out crib toys

Children can get tangled up and even have their breathing cut off by the strings of toys that are draped across a crib. Any toys with strings or elastic can be hazardous to young children.
Be tough on a toy before a child is

Small children have amazing skill in taking things apart. Make sure rattles are strong enough so they won’t come apart. Test buttons, bells and stuffed animal eyes to make sure they won’t pull off. Squeeze toys should not have squeakers or whistles that can be pulled out.

Watch for sharp edges and points

Kids love their toys. But they also love to throw them and leave them where they can fall on them. Avoid toys with glass or easily breakable plastic. They can become instant weapons.

Bike helmets: Don’t leave home without one

Bikes are toys too. In fact they are a major source of childhood injuries. A child old enough to ride needs a helmet.

Darts, lawn darts, projectiles, air rifles and guns

These are so dangerous you should not even think of allowing them anywhere near kids.

How can I tell when small is too small?

The federal government has established a size for safe toys for kids under 3. A small part should be at least the size of this standard — 1-1/4 inches diameter and 2-1/4 inches long. Any part smaller than this is a potential choking hazard. To check size see “Choking” earlier in this chapter.

What if I have a problem with a toy?

Call the Consumer Product Safety Commission toll-free hotline, 1-800-638-2772, or go to http://www.cpsc.gov.

Safe age-appropriate toys

The following is a list of toys that the American Academy of Pediatrics recommends for specific age groups. Use these recommendations when shopping for toys. However, always remember that these are guidelines. Caregivers should continue to watch out for mislabeled toys and always provide proper supervision for younger children.
Newborn to 1-year-old infant

Choose eye-catching toys that appeal to the baby’s sight, hearing and touch such as:

- Large blocks of wood or plastic
- Pots and pans
- Rattles
- Soft, washable animals, dolls or balls
- Bright, movable objects that are out of baby’s reach
- Busy boards
- Floating bath toys
- Squeeze toys

1- to 2-year-old toddler

Toys for this age group should be safe and be able to withstand a toddler’s curious nature:

- Cloth or plastic books with large pictures
- Sturdy dolls
- Kiddy cars
- Musical tops
- Nesting blocks
- Push and pull toys (remember — no long strings)
- Stacking toys
- Toy telephones

2- to 5-year-old preschooler

Toys for this age group are usually experimental and should imitate the activity of adults and older children:

- Books (short stories or action stories)
- Blackboard and chalk
- Building blocks
- Crayons, nontoxic finger paints, clay
- Hammer and bench
• Housekeeping toys
• Outdoor toys: sandbox (with a lid), slide swing, playhouse
• Transportation toys (tricycles, cars, wagons)
• Tape or record player
• Simple puzzles with large pieces
• Dress-up clothes
• Tea party utensils

5- to 9-year-old child
Toys for this age group should help the child promote skill development and creativity:

• Blunt scissors, sewing sets
• Card games
• Doctor and nurse kits
• Hand puppets
• Balls
• Bicycles
• Crafts
• Electric trains
• Paper dolls
• Jump ropes
• Roller skates
• Sports equipment
• Table games

10- to 14-year-old child
Hobbies and scientific activities are ideal for this age group:

• Computer games
• Sewing, knitting, needlework
• Microscopes/telescopes
• Table and board games
• Sports equipment
• Hobby collections

Remember to take a second look at all old toys or hand-me-downs to ensure they are right for your children. It’s also a good idea to reread the labels of old toys, because age recommendations continue to change. If you’re not sure about a toy’s safety, call the manufacturer to find out if there are new safety recommendations.

**Source:** Adapted from “Play it Safe!,” a brochure published by the Association of Trial Lawyers of America and the Johns Hopkins Injury Prevention Center; and, “Toy Safety, Guidelines for Parents,” a brochure published by the American Academy of Pediatrics.

**If a child cuts himself or herself on a toy:**

1. Stay calm.

2. Check the child and call if bleeding is severe or other life-threatening conditions exist.

3. If bleeding is minor, wash the wound with soap and water and bandage. Apply ice over the bandage to reduce swelling and pain.

4. If bleeding is severe, apply direct pressure with a gauze pad or dressing and elevate wound above the level of the heart to slow bleeding. **Note:** Wear latex-free disposable gloves if coming into contact with blood. Dispose of gloves in sturdy leak-proof bag. Wash hands after removing gloves.

5. If blood continues, apply pressure bandage.

6. If direct pressure and a pressure bandage do not stop the flow of blood, call.

7. Notify the parent or guardian and have the parents check with their medical provider to see if follow-up care is required.

8. Comfort and reassure the child and treat for shock, if indicated.

9. Conduct a review of the injury and determine ways to prevent a reoccurrence.

10. Complete the Injury Report Form and have the parent sign it to confirm he or she was notified.
If a child chokes on a toy:
See information earlier in this chapter on what to do if a child or infant chokes.

PREVENTING SUFFOCATION AND REDUCING THE RISK OF SUDDEN INFANT DEATH SYNDROME (SIDS)

Infant sleeping position and SIDS

In 1992, the American Academy of Pediatrics recommended that all healthy infants be placed on their backs to sleep. This was based on numerous reports that babies who sleep on their stomachs have an increased likelihood of sudden infant death syndrome (SIDS).

The “Back to Sleep” campaign was launched in 1994 to promote placing infants on their backs to sleep. As public awareness of the importance of correct sleeping position for infants increased, SIDS mortality rates have decreased.

Q: Is the side position as safe as the back?
A: The side lying sleep position is not as safe for the baby as sleeping on the back. Unless there is a medically verified reason for sleeping in any other position, all infants should be put to bed on their backs.

Q: Should healthy babies ever be placed on their stomachs?
A: Yes, during hours when the infant is awake. Developmental experts advise that allowing babies to lie on their stomachs while they are awake is important for proper development.

Q: Should products be used to keep the babies on their backs during sleep?
A: No. None of the studies used devices for this purpose. No study to date has been conducted on the safety of such products.

Q: Are there any reasons that an infant should be placed on the stomach to sleep?
A: Yes. There may be specific medical conditions that suggest the infant sleep on the stomach. Follow the physician’s instructions.
Q: Should soft surfaces be avoided?

A: Yes. Studies show that soft sleeping surfaces increase the risk of SIDS in infants who sleep on their stomachs. How soft a surface must be to pose a threat is unknown. A standard firm mattress with no more than a thin covering, such as a sheet between the infant and mattress, is advised. The U.S. Consumer Product Safety Commission has also warned against placing any soft, plush or bulky items such as bean bag chairs, pillows and rolls of bedding or cushions in the baby’s sleeping environment. They may contribute to suffocation.

For more information on sleep position and SIDS risk, call 1-800-505-CRIB.

Sources: Information gathered from the “Back to Sleep” brochure sponsored by American Academy of Pediatrics, U.S. Public Health Service, SIDS Alliance and Association of SIDS and Infant Mortality Program.

Ways to prevent suffocation

- When putting babies to sleep, you should always place them on their backs on a firm mattress.

- DO NOT put babies to sleep on chairs, sofas, waterbeds or cushions. Standard adult beds are not safe for babies to sleep on in early care and education settings.

Beginning Dec. 28, 2012, any crib provided by early care and education facilities and family early care and education homes must meet new and improved federal safety standards. These requirements address deadly hazards previously seen with traditional drop-side rails, require more durable hardware and parts, and mandate more rigorous testing. The new standards took effect for manufacturers, retailers, importers and distributors June 28, 2011.

For more information on crib safety in early care and education and posters in English and Spanish, see the Resources section at the end of this chapter, “Crib safety.”

Ways to reduce the risk of SIDS

- Infants should always be put on their backs to sleep on a firm mattress with sheets that fit snugly. The side-lying sleep or stomach position is not as safe for the baby as sleeping on the back.

- Tell each baby’s parents or guardian that you put all infants to sleep on
their back as recommended by the AAP. If the parent asks you to do something different, require a signed note from the child’s pediatrician stating what is recommended for the baby and why.

- Place each baby in his/her own safety-approved crib with a firm mattress and a well-fitting sheet. Do not allow babies or older children to share cribs. Do not put toys and other soft bedding (blankets, comforters, pillows, stuffed animals or wedges) in the crib with the baby.
- Keep babies’ heads uncovered and avoid over-bundling them in clothing and blankets.
- Protect the baby from getting too hot. Set the room temperature at a level that is comfortable for a lightly clothed adult and dress the baby lightly for sleep.
- Keep the early care and education setting smoke-free.
- Support parents who want to breastfeed or feed their baby breast milk.
- Frequently check on sleeping babies.

For more information on sleep position and SIDS risk, call 1-800-505-CRIB.

If a child shows signs of suffocation or is not breathing:

- If the child is unconscious, have someone call 911. If you are alone, give one minute of care using the following process before leaving the child or carrying a small child to the phone.
- Tilt the child's head back and lift the chin to open the airway.
- Look, listen and feel for breathing.
- Check the child’s pulse.
- If the child has a pulse but is not breathing, continue giving rescue breathing.
- Continue to give rescue breaths until medical care arrives, or the child breathes on his or her own.
- Notify parent or guardian.
- Conduct a review of the injury and determine ways to prevent a reoccurrence.
- Complete the Injury Report Form and have the parent sign it to confirm he or she was notified.
PETS IN EARLY CARE AND EDUCATION SETTINGS

Pets can help teach even very young children about kindness, caring and respect. You can help children learn that the animals deserve love, too. Pets have been shown to increase socialization and self-esteem, especially for those who may be shy or withdrawn.

Choose pets carefully by considering the ages of the children. It is important that the temperament, personality and general needs of the animal are appropriate to be with children. Organizations are able to help you select an animal to meet the needs of your early care and education setting. See this chapter’s Resources section on “Pets in early care and education” for contact information.

All wild animals are a potential safety and health risk. Reptiles and baby chicks may carry salmonella and are not acceptable pets for the early care and education setting. See the early care and education center and certified family early care and education home rules for a list of other animals that are not allowed in centers.

Guidelines for early care and education settings that have pets:

- Determine if any children enrolled in your program have pet allergies (see “Asthma” in Chapter C under Managing chronic illness in early care and education).
- Caregivers must always be present when children are around animals to assure the safety of children. Also, it is important that children treat the pet well.
- Children and adults should wash their hands immediately after handling animals or animal wastes, or playing with or handling a pet. Many animals can carry germs such as campylobacter, salmonella and ringworm (see OKHS Volume 4: Chapter C, “Links to Information on Specific Illnesses”). Washing with soap and warm water for at least 20 seconds is needed to prevent illness caused by these germs. Children should not assist in cleaning animal cages.
- Clean up animal waste promptly and dispose of it properly. To dispose of pet waste, flush the waste down the toilet or put it in a plastic bag and in the garbage. Animal litter boxes should not be located in areas accessible to children. Keep the children’s sandbox covered when not in use so neighbor cats won’t think it’s their litter box!
• Animal cages should have removable bottoms for ease of cleaning and should be cleaned regularly when children are not present.

• Live animals should not be in areas used for food preparation, food storage or eating. Animal food supplies should be kept out of reach of children.

• Feed pets away from children. Children may observe pets eating, but they should not interfere.

• Pets must be in good health. Obtain regular preventive veterinary care for the pet such as flea control, de-worming, immunizations and check-ups. Have pet checked by the veterinarian if the animal shows any sign of illness or skin lesion. Keep the animal free of fleas and other parasites.

• Dogs and cats must be vaccinated according to a licensed veterinarian’s recommendations.

• Make sure all dogs have a temperament suitable for children. Don’t assume a small dog is a safe dog. Get obedience training! Potentially aggressive animals must not be in the same physical space as the children or be accessible to children.

• Check with your local health department about whether there are any local ordinances that prohibit certain animals in public settings.

If a child is bitten by an animal:

1. Ensure your own safety while assisting the child.

2. Check the child and call 911 if bleeding is severe or other life-threatening conditions exist.

3. If bleeding is minor, wash the wound with soap and water and bandage it. Apply ice over the bandage to reduce swelling and pain.

4. If bleeding is severe, call 911, apply direct pressure with a gauze pad or dressing and elevate the wound above the level of the heart to slow the bleeding.

   Note: Wear latex-free disposable gloves if coming in contact with blood. Dispose of gloves in sturdy leak-proof plastic bag. Wash hands after removing gloves.

5. If bleeding continues, apply a pressure bandage.

6. If severe bleeding continues, and a pressure bandage does not stop the flow of blood, call 911.
7. Report the incident to the authorities. Do not try to capture the animal. Make note and be able to report the description of the animal, identifying characteristics, and where the animal was last seen.

8. Notify the parents or guardian and have them check with their medical provider to see if follow-up care is required.

9. Comfort and reassure the child and treat for shock, if indicated.

10. Conduct a review of the injury and determine ways to prevent a reoccurrence.

11. Complete the Injury Report Form and have the parent sign it to confirm he or she was notified.

POISON PREVENTION

Poisons that may be present in the early care and education setting:

- Medicines, including vitamins and non-prescription medications
- Cleaning products: chlorine bleach, drain opener, toilet bowl cleaner, oven cleaner, rust remover
- Antifreeze
- Windshield washer solution
- Hydrocarbons: furniture polish, lighter fluid, lamp oil, kerosene, turpentine, paint thinner
- Carbon monoxide
- Pesticides
- Wild mushrooms
- Plants

A poison is any substance that can cause harmful effects in the body. The poison may be swallowed, spilled on the skin, splashed in the eyes, or inhaled. Millions of people are unintentionally poisoned every year, and children under the age of 6 are at the greatest risk. Children ages 1 to 3 are especially at risk of poisonings from medicines and household products, lead and carbon monoxide. Lead poisoning occurs when ingesting or breathing in lead dust or

“The best treatment for a poisoning is to prevent it from happening.”

Child Care Professional Source Book, American Red Cross, Oregon Trail Chapter.
Many poisonings occur when children are hungry or stressed, when there is a change in routine such as a holiday, or when visitors arrive.

Children may know that poisons are “bad,” but they don’t realize that something sweet smelling or tasting can be poisonous. If they are not used correctly, many common products are poisonous to a small child.

Exposure to plants – mushrooms or household, lawn and garden plants – is one of the most common calls to a poison center. Children may also choke from eating plant leaves.

Many plants are not poisonous. Ingestion of many others causes only mild symptoms. Yet there are many plants around us that can cause serious symptoms, or even death, if ingested in moderate amounts.

**Ways to prevent poisoning**

1. Be safe with household poisons or medicines.
   - Be sure to keep household products such as cleaners, chemicals and medicines stored up and away, out of sight and reach, under childproof lock.
   - Keep all household poisons and medicines in their original, labeled, child-resistant containers.
   - Use safety latches on drawers and cupboards.
   - Be as careful with non-prescription medicines as you are with prescription medications.
   - To avoid confusion, do not refer to medications as candy.
   - Do not take medicine in front of children.
   - Keep purses and diaper bags out of children’s reach. Also be aware of visitors’ purses and suitcases. Never leave children alone with cleaning products, other chemical products or medications. Most poisonings occur when the product is in use.
   - Return household and chemical products to safe storage immediately after use. Secure any chemical or hazardous material storage area (cabinet or shelves) to prevent it or any products from falling during an earthquake.

Call the Oregon Poison Center if a child does eat something that could be poisonous, 1-800-222-1222.
• If possible, avoid pesticide use. Good hygiene at your facility will deter many pests. If you use pesticides, store containers in an outbuilding or locked garage.

2. Store flammable products, such as gasoline, in an outbuilding or outside and away from open flames. Use the least hazardous material possible. Attempt to use products with the caution signal word or no signal word rather than products with the danger signal word on the label.

• **Take the time to teach children about poisonous substances.** Contact the Oregon Poison Center for ideas and educational materials.

• Use Mr. Yuk stickers on poisonous products. Teach children that Mr. Yuk means “No.” You can get stickers from the Poison Center.

• Each time a poisonous item is brought into the house/classroom, place a Mr. Yuk sticker on it and talk with children about the item.

3. Learn about plant safety. See “A Guide to Plant Poisoning Prevention and Treatment” in the *OKHS Volume 4: Appendix, Chapter D.*

• Identify all the plants currently in your early care and education setting, playground, home and yard. Poison Center staff cannot identify a plant over the phone. Your nearest garden nursery or OSU Extension office may assist you in identifying your plants.

• Choose plants that are non-poisonous for decorating both indoor and outdoor areas.

• Keep all poisonous plants out of the reach of children and pets.

• Pick and dispose of all mushrooms and toad stools that grow in your yard or playground. All mushrooms and toadstools are considered poisonous. Only a trained mycologist can correctly identify non-poisonous ones.

• As leaves die and fall off (especially house plants), pick them up and dispose of them. They still may contain poisonous chemicals.

• Store seeds and bulbs safely out of reach of children.

• If your child or pet does get into a plant, berry or mushroom, save the rest of the leaf, stem, branch or berry to help identify the plant, and call the Poison Center. See a list of poisonous plants later in this chapter.
If a poisoning occurs (or you think a poisoning may have occurred):

1. Stay calm.

2. Check the child for life-threatening conditions. For example,
   - Unconsciousness
   - Not breathing or having trouble breathing
   - No pulse
   - Severe bleeding

3. Call for life-threatening conditions.

4. Call the Poison Center, 1-800-222-1222, for non-life-threatening conditions.

5. Have the following information ready:
   - Child’s condition, age and weight
   - Product containers or bottles
   - Time that the poisoning occurred
   - Your name and telephone number

6. Follow the instructions that the Poison Center gives you.

7. Notify the parents or guardians.

8. Conduct a review of the injury and determine ways to prevent a reoccurrence.


Source: Adapted from information provided by the Oregon Poison Center.

According to the American Academy of Pediatrics in a 2003 position statement, syrup of ipecac is no longer considered an appropriate remedy for the routine treatment of accidental poisonings. It should be removed from all first-aid kits.
PLANTS IN EARLY CARE AND EDUCATION SETTINGS

Plants beautify our homes. They add color and accent to our lawns and gardens. They feed us. Yet, if not handled properly, they can become deadly poisons.

Exposure to plants — houseplants, lawn and garden plants, mushrooms — is one of the most common calls to a poison center. Children are most often the victims of poisonings due to plants. Children may also choke from eating plant leaves.

Many plants are not poisonous. Ingestion of many others causes only mild symptoms. Yet there are many plants around us that can cause serious symptoms, or even death, if ingested in moderate amounts.

What is the Oregon Poison Center?

- Keep the toll-free number of the Oregon Poison Center near your telephone, and program this number into your cell phone: 1-800-222-1222.
- The Oregon Poison Center is open 24 hours a day each day of the year.
- Nurses trained in toxicology staff the Poison Center.
- Eighty percent of all calls to the Poison Center can be handled at home.
- Call the center if you have a question. They are working for you.

Adapted from information provided by the Oregon Poison Center and the Oregon Trail Chapter of the American Red Cross, Child Care Professional Source Book.
Tips to prevent plant poisoning

Poisonings can be prevented by following some simple suggestions:

- Identify all the plants in your early care and education setting, playground, home and yard today. Poison center staff cannot identify a plant over the phone. Your nearest garden nursery or OSU Extension office may assist you in identifying your plants.
- Choose plants that are nonpoisonous for decorating both indoor and outdoor areas.
- Keep all poisonous plants out of the reach of children and pets.
- Pick and dispose of all mushrooms and toadstools that grow in your yard or playground. All mushrooms and toadstools are considered poisonous. Only a trained mycologist can correctly identify nonpoisonous ones.
- As leaves die and fall off (especially houseplants) pick them up and dispose of them. They still may contain poisonous chemicals.
- Store seeds and bulbs safely out of reach of children.
- If your child or pet does get into a plant, berry or mushroom, save the rest of the leaf, stem, branch or berry to help identify the plant, and call the Poison Control Center.

Poisonous plants

Listed in the following chart are some of the plants that are considered poisonous. They contain a variety of poisons that cause different symptoms. Symptoms may vary from a skin rash to kidney damage. You are not required to remove outdoor shrubs that are on the list. You do need to closely supervise children when they are around plants that are on the list.

Amaryllis
Azalea
Begonia, sand
Bird of paradise
Black nightshade berry
Butterfly weed
Calla lily
Calamondin orange tree
Carnation
Castor bean
Christmas cherry
Cyclamen
Daffodil
Daisy
Daphne
Deadly nightshade
Devils ivy
Dieffenbachia
Dumb cane
English holly, ivy
Elderberry
Elephant ears
Eucalyptus
Eyebane
Firecracker
Foxglove
Geranium
Golden chain
Holly berry
Horse chestnut
Hyacinth
Hydrangea blossom
Iris
Jack-in-the-pulpit
Jequirity bean
Jerusalem cherry
Jimson weed
Juniper
Larkspur
Laurel
Lily of the valley
Mistletoe
Morning glory
Needlepoint ivy
Oleander
Oxalis
Philodendron
Podocarpus
Poison ivy
Poison sumac
Poison hemlock
Potato plant
Pothos
Pyrocantha
Rhododendron
Rhubarb
Skunk cabbage
Snow-on-the-mountain
Spathe flower
String of pearls
Tomato leaves
Tulips
Violet seeds
Wild carrots
Wild cucumber
Wild parsnip
Wild peas
Yew tree
What to do if a child has swallowed a poisonous plant (or come in contact with a poisonous plant):

1. Remain calm.
2. Check the child and call 1-800-222-1212 if life-threatening conditions exist.
3. Call the Oregon Poison Center at 1-800-222-1212.
4. Have the following information ready:
   - Child’s condition, age and weight
   - Product or item swallowed
   - Time that the poisoning occurred
   - Your name and telephone number
5. Follow the instructions that the Poison Center gives you.
6. Notify the parents or guardian.
7. Conduct a review of the injury and determine ways to prevent a reoccurrence.
8. Complete the Injury Report Form and have the parent sign it to confirm he or she was notified.

**LEAD POISONING**

**What every early care and education provider should know**

Lead poisons people, especially children. Approximately one in 22 children in America has high levels of lead in their blood, according to the Centers for Disease Control and Prevention. Lead is a natural metal present in the environment. In the past, lead was used in paint, gasoline, water pipes and many other products. Lead does not break down in the environment. Once lead has been deposited into the environment, it will remain to poison generations of children unless it is controlled or removed. When eaten or inhaled, lead is easily absorbed by the body and can harm a child’s growth and development. Even very small amounts of lead can cause severe and lasting harm to children.
How does lead affect children?

Lead poisoning can cause

- Brain damage and lower intelligence
- Nervous system damage
- Behavior and learning problems
- Impaired speech and language
- Slowed growth
- Kidney and liver damage
- Headaches
- Irritability
- Sleep disorders
- Fatigue
- Constipation
- Poor appetite
- Stomachache and cramps
- Coma, convulsions or death

Signs of lead poisoning are not always obvious. At low lead levels, a child may show no symptoms at all. Many children who are lead-poisoned look and act healthy. Sometimes the vague symptoms may be mistaken for other illnesses. **The only way to be certain that a child has lead poisoning is to get the child’s blood tested.** Early care and education providers can help protect children from lead poisoning by reducing exposure to lead in the early care and education environment, promoting good nutrition and encouraging testing.

What are the causes of lead poisoning?

- **Paint** — Many buildings built before 1978 have lead-based paint inside and outside. Lead paint in good condition poses little risk. Chipping, peeling or cracking lead paint is a common source of ingestible lead and may be a hazard. Lead paint may also be found on older toys, furniture and playground equipment.

- **Dust** — Lead paint dust is the most common source of lead exposure. Dust in an early care and education setting may be contaminated with harmful lead paint dust that you cannot see. Children can get lead
poisoning from breathing in or swallowing lead paint dust. Fine lead dust can be created when painted surfaces rub against each other, such as where windows open and close. Paint dust can gather on household surfaces, in carpets, on toys and other objects that children may put into their mouths.

- **Water** — Most well or city water does not naturally contain lead. Lead in drinking water is an infrequent source of lead poisoning. Lead gets into drinking water from lead pipes or lead solder in household plumbing. Bathing is not a problem because lead does not enter the body through the skin. You cannot see, smell or taste lead, and boiling the water will not get rid of it.

- **Soil** — Dirt and soil can become contaminated with lead due to the breakdown of lead-based paint on buildings and playground equipment. The soil near roads or highways may contain high lead levels from years of exhaust fumes and pollution from cars that once used leaded gasoline.

- **Ceramics and pottery** — Old, handmade or imported ceramics and pottery may contain lead. Lead may leach or flake from improperly fired pottery. Lead is also found in lead crystal and pewter dishware.

- **Hobbies** — Welding, auto repairs, and the making of ceramics, stained glass, bullets and fishing weights are hobbies that use lead.

- **Folk medicines** — Many home remedies, particularly popular in some ethnic communities, may contain lead. Some home remedies may be as much as 75 percent lead by weight. Some of the more common lead-containing remedies are azarcon and greta (Hispanic community), pay-loo-ah (Hmong community), ghasard, bala goli and kandu (Asian-Indian community), and kohl/Alkohl (Arab-American community).

- **Occupational sources** — Many occupations can expose a worker to lead, including building demolition, painting, construction, battery recycling and radiator repair. People who work in a lead environment may bring lead dust into your early care and education setting on their clothes and bodies.

**Why are children at the greatest risk?**

All young children, especially those under the age of 6, are at risk for lead poisoning. Children explore their environment by putting their toys, hands and other objects in their mouths. Children may chew on painted windowsills and railings. In addition, they spend a lot of time on the floor where sources of lead
are likely to be found. Through normal play, they are likely to eat lead that has come from deteriorating paint, paint chips or dust. Young children also absorb lead more easily than adults. Up to 50 percent of the lead a child ingests can be absorbed, compared to only 10 percent in adults. Children, with their rapidly developing bodies and brains, are more vulnerable to lead’s toxic effects than adults. As an early care and education provider, you can use simple ways to protect children from lead.

**What can you do to prevent lead poisoning?**

- Have your pre-1978 early care and education building professionally tested for lead.
- Supervise children carefully.
- Clean up paint chips immediately and keep all paint in good repair.
- Regularly wet-wipe floors, windowsills, porches, window frames and other surfaces.
- Wash children’s hands frequently, especially before meals and after playing outside.
- Wash toys, stuffed animals, bottles, cribs and pacifiers often.
- Remove shoes before entering the home or center to avoid tracking in lead from soil.
- Have children play on grass instead of bare dirt. Provide a sandbox with lead-free sand. Use impact-absorbing surfaces under play equipment.
- Only use non-toxic toys and art supplies.
- Prepare and store foods in containers that do not release lead.
- Use cold water for drinking, cooking or making baby formula. Run the water for 15 to 30 seconds until it feels noticeably colder.
- Serve meals that are low-fat and rich in iron, vitamin C and calcium. A child who gets enough nutrients will absorb less lead. A full stomach will absorb less lead, so provide regular meals and snacks.
- If you are doing or contracting for maintenance or renovation in your facility, use lead-safe work practices. See Resources section for more details.
- Provide information about lead poisoning prevention to parents. Recommend a blood lead test for all children between the ages of 1 and 6 who are at risk for lead poisoning. (See this chapter’s Resources section under Lead poisoning, “LeadLine,” for who to call regarding lead poisoning.)
If a child swallows a leaded object (or you think the child may have swallowed an object containing lead):

- Remain calm.
- Check the child and call if life-threatening conditions exist.
- Call the Oregon Poison Center, 1-800-222-1222.
- Have the following information ready:
  - Child’s condition, age and weight
  - Product or item swallowed
  - Time that the poisoning occurred
  - Your name and telephone number
- Follow the instructions that the Poison Center gives you.
- Notify the parents or guardian.
- Conduct a review of the injury and determine ways to prevent a reoccurrence.
- Complete the Injury Report Form and have the parent sign it to confirm he or she was notified.

PREVENTING AND MANAGING ORAL INJURIES

Infants and toddlers often fall and hurt their mouths as they explore their world. Try to minimize injuries by doing the following:

- Provide safe toys and a safe environment; supervise activities.
- Always keep one hand on the baby on high places such as a changing table, bed, sofa or chair.
- Install gates at top and bottom of stairs.

Early care and education providers should ask families for their dentists’ emergency phone contacts and discuss with them how they want you to handle oral health emergencies. Older children that participate in contact sports should wear a sports mouth guard to protect permanent teeth.
A child with an oral injury needs first-aid treatment. Oral injuries can bleed easily. First examine the area to determine if the injury includes teeth or is limited to the soft tissues and follow these guidelines:

**Toothache**

- Gently rinse the mouth out with warm water to remove dirt or other material from the area.
- Use dental floss to remove any food that might be trapped between the teeth.
- If swelling is present, place cold packs on the face in the area of the swelling. (Do not use heat or place aspirin on the aching gum or tooth tissues.)
- Recommend the child see a dentist as soon as possible.

**Knocked-out tooth**

- *Immediately* place the tooth (if available) in a container of fresh cool milk or water. **Do not** wash or clean the tooth.
- Place cold packs on the face in the area of the injury to minimize swelling.
- Transport the child and tooth to the dentist **within 30 minutes if possible**.
- Primary teeth are not re-implanted (placed back in the jaw), but a dental exam is still necessary. Permanent teeth can reattach themselves if they are placed back in the socket within one hour of being knocked out.

**Broken tooth**

- Gently rinse the mouth out with warm water to remove dirt or other material from injured area.
- Place cold packs on the face in the area of the injury to minimize swelling.
- Transport the child and piece of tooth (if available) to the dentist **within 30 minutes**.

**Possible fractured jaw**

- Gently hold the jaw still by any means (handkerchief, necktie, towel).
- If swelling is present, apply cold packs.
- **Call [ ] . Take the child to a hospital or urgent care center.**
Loosened tooth, tooth knocked into the gum

- Remember that children normally have loose teeth beginning around 5 years of age.
- If there has been an injury causing a loosened tooth or trauma, take the child to the dentist as soon as possible.

Bitten tongue or lip

- Apply pressure to the bleeding area with a clean cloth for five minutes. If bleeding persists, apply pressure for five more minutes.
- If swelling is present, apply cold packs.
- If bleeding does not stop, contact the child’s health care provider or take the child to urgent care or to a hospital if necessary.

Objects wedged between teeth

- Try to remove the object with dental floss. Do not try to remove the object with a sharp or forked instrument!
- If not successful in removing the object, take the child to the dentist.
Use the following checklists to see if your early care and education setting is as safe as it can be. Those items listed under the icon indicate a requirement of certified and/or registered early care and education. Refer to your individual rule book to determine if the icon relates to the type of care you provide. Those items listed under “best practices” are additional measures you can take to make your early care and education safe.

**INDOOR SAFETY CHECKLIST**

**Fire protection**

- Smoke alarms are installed in all sleeping areas and tested monthly.
- You have a fire escape plan and practice fire drills.
- You have a working fire extinguisher with a rating of at least 2-A:10-BC.
- Fireplaces, wood stoves and heaters have been inspected and approved for use by the local building official. Protective barriers make these units inaccessible to children.
- No obstructions are placed in corridors, stairwells or exit ways.

**Protection from electrical hazards**

- Electrical outlets accessible to children are covered with child-resistant covers or are of the childproof type safety tamper proof or resistant type. Shock stops (safety plugs) are installed on all unused outlets.
- Electric appliances are unplugged when not in use and stored so they cannot fall in water and cause an electric shock.

**Best practices**

- The best type of protective outlet covers have interior shunts or shutters that cover the outlet openings automatically when a plug is removed, or a blank cover plate installed over the outlet. Push-in safety...
plugs are a choking hazard and are not recommended for use in an early care and education setting.

- Electrical outlets in bathrooms or by sinks in kitchens in early care and education homes should have ground fault circuit interrupter (GFCI) outlets. The outlet openings need to be covered as described above.

- No electrical devices accessible to children should be located where they can be plugged into an electrical outlet while in contact with a water source.

- Electrical fans, if used, are mounted high on the wall or ceiling or guarded to limit the size of the blade guard opening.

Protection from poisons and other hazards

- Stairways accessible to infants and toddlers have safety gates at both the top and bottom. Safety gates with a straight top edge and rigid mesh screen are best. Gates and enclosures should have the Juvenile Products Manufacturers Association (JPMA) certification to ensure safety.

- All stairways with three steps or more used by children have handrails installed for their use.

- Heavy objects such as bookcases, cubbies and shelving are anchored or secured to prevent them from falling over and injuring children.

- Protective barriers are in place to protect children from any hazardous location.

- Firearms and ammunition are kept under lock. Ammunition is stored separately from firearms. Firearms must remain unloaded.

- Glass doors and low windows are clearly marked for visibility at child’s level (with decals or tape) and made of safety glass for protection from impact.

- Floors are free of splinters, large or unsealed cracks, sliding rugs and other hazards.

- Poisonous plants are out of children’s reach (See Plant section earlier in this chapter).

- Lead-based paint or other toxic materials shall not be used on walls, furnishings, toys or any other equipment, materials or surface, that may be used by children or are within their reach (See section on Lead poisoning earlier in this chapter).
Items of potential danger to children such as cleaning supplies and equipment, matches and lighters, poisonous and toxic materials, paints, plastic bags, aerosols and detergents are:

(A) Kept in the original container or labeled;
(B) Secured by a childproof lock or latch;
(C) Stored in an area not used by children; and,
(D) Stored separately from food service equipment and supplies.

Best practices

- Chemicals used in lawn care treatments should be limited to those listed for “non-restricted use.” The Environmental Protection Agency has a list of restricted chemicals unsuitable for use in an early care and education environment.

- When cleaning agents cannot be stored separately and must be stored in the same room with food, these supplies should be clearly labeled and kept separated from food items in separate cabinets that are inaccessible to children.

- Install carbon monoxide detectors and check batteries often.

Furniture and toys

- Furniture is durable and cleanable or has non-absorbent surfaces, is safely constructed and in good repair.

- Do not use infant walkers.

- Inspect toys often to make sure they are in good repair and cleaned regularly.

- Check [http://www.cpsc.gov](http://www.cpsc.gov) for child products, including cribs and toys that have been recalled. Sign up for the automatic email alerts.

Best practices

- Check them for sharp edges or small parts that may come off, be swallowed and cause choking. Toys are checked before purchase or if brought in by the child.

- Make sure that all pieces of play equipment are designed to guard against a child’s head getting stuck and causing strangulation. The current “Handbook for Public Playground Safety,” U.S. Consumer Product Safety Commission, recommends that dimension to prevent head entrapment should be 3-1/2-inch minimum and 9 inches maximum.
Cribs

- Make sure there are no more than 2-3/8 inches between crib slats so a baby’s head cannot fit through the slats.
- The mattress should be firm and snug-fitting so a baby cannot get trapped between it and the side of the crib.
- Place baby on his or her back to sleep on a firm surface.
- No missing, loose, broken or improperly installed screws, brackets or other hardware should be on the crib or the mattress support.
- There should be no corner posts more than 1/16 inch above the end panels (unless they are over 16 inches high for a canopy) so a baby cannot catch clothing and strangle.
- Make sure there are no cutout areas on the headboard or footboard so a baby’s head cannot get trapped.
- A mattress support should not easily pull apart from the corner posts so a baby cannot get trapped between mattress and crib.
- There should be no splinters, rough edges or tears in mesh or fabric sides.
- Rails should be 26 inches from the top of the railing to the mattress support at its lowest level.

See more crib safety information in this chapter’s Resources section.

Best practices

- Put babies to sleep on firm mattresses with well-fitting sheets. Do not allow babies or older children to share cribs and do not put toys and other soft bedding (blankets, comforters, pillows, stuffed animals or wedges) in the crib with the baby.
- Keep beds and cribs away from windows and drapery cords.

High chairs

- The base is wide so the high chair does not easily tip over.
- The high chair has a latch to keep a child from raising the tray.
- There are straps to prevent a child from sliding out.
- Chairs do not have sharp edges.
- Watertight washable foam pads cover seat, or seat has an easily cleanable surface.
Best practices

- Chairs are equipped with washable waist strap.
- Chairs have footrests to promote stability and a sense of security in the child.

Playpens

- Slats do not have more than 2-3/8 inches of space between them or there is netting with small weave.

Best practices

- Hinges lock tightly.
- Watertight washable foam pads cover the bottom.

Kitchens, bathroom, laundry and diapering areas

- All medicines, including vitamins, are stored in their original containers – out of children’s reach – and kept locked up.
- Cleaning products, medicines and food are stored separately.
- Bleach solution and diapering supplies are stored out of the children’s reach and bleach is kept locked up.
- All garbage, rubbish and wastes shall be inaccessible to children.

Best practices

- Keep hot foods and liquids away from young children.
- Hot water thermostat is set no higher than 120 degrees F.
- Children are carefully watched in the bathroom so that they do not fall into the tub or toilet (and become injured or drown). Consider installing toilet locks.
- Diaper change tables have barriers in place to prevent children from falling from the table. Straps and belts are not recommended as safety devices for this purpose.
- Dispose of all garbage, rubbish and wastes in compliance with the requirements of the Oregon Department of Environmental Quality.
OUTDOOR SAFETY CHECKLIST

Playground

- An adult always supervises children.
- Equipment is free of projections, entrapment, strangulation, pinching, tripping and cutting hazards.
- Climbing equipment has protective surfacing material underneath and throughout the area children use.
- Play equipment is installed and kept in good repair.
- Play equipment is suited to developmental level of children using it.

For more resources, see “Indoor and outdoor safety” in the Resources section of this chapter.

Best practices

- Climbing equipment should be no more than 6 feet 7 inches high.
- Play areas are checked regularly for hazardous objects or situations.
- Equipment should be coated or treated with non-toxic materials.
- Cargo nets, overhead rings or bars are not suited for preschool-aged children.
- Climbing equipment meets the American Society of Testing Materials (ASTM) standards for head injury protection.
- Protective surfacing material under climbing or play equipment should consist of absorbent material such as wood chips or pea gravel, at least six to 12 inches thick/deep depending on the height of the equipment. Commercial products designed especially for this purpose may be used. Grass and dirt are not sufficiently soft or absorbent to be used as protective cushioning under climbing equipment. Because infants and toddlers put pea gravel in their mouths, it is not recommended for use in areas where children less than 18 months of age play.
- Swings do not swing across footpaths. Slides should not face into the center of the playground where the exit feeds into traffic patterns.
- Equipment that collects water (such as a tire) has drainage holes.
- Children remove bike helmets and outerwear with drawstrings before using playground equipment.
- Sandboxes have covers.
Swimming pools, hot tubs, spas and whirlpools

- Pools are completely fenced and have self-latching gates.
- Water in swimming pools meets state or local standards for chlorine and other chemical levels.
- Swimming pools must be licensed by your local health department.
- Swimming pools require the supervision of a certified lifeguard.
- Backyard wading pools or baby pools are not allowed.
- Fish ponds are not accessible to children without supervision.
- Spas, hot tubs and whirlpools have locked safety covers when not in use.

Best practice

- Children are always supervised by an adult trained in CPR in areas where there is any body of water, including swimming pools, built-in wading pools, tubs, pails, sinks or ponds.

TRANSPORTATION CHECKLIST

Cars

- Safety seats and seat belts for infants and children are used correctly every time children travel. See “Car seat safety” in the Resources section at the end of this chapter for more information.

Best practices

- **Infants:** Place infants rear-facing until at least 1 year old and at least 20 pounds. Best practice is to keep the child rear-facing until he or she has reached the upper weight limits of the rear-facing seat. Never place a child rear-facing in the front seat of a vehicle with airbags.

- **Toddlers:** Oregon law requires child passengers be restrained in an approved child safety seat until they weigh 40 pounds. The AAP recommends that once a child has outgrown an infant seat, he or she should remain rear-facing to the upper weight limits of a convertible seat (often 30-35 pounds). At that point, the seat can be turned forward-facing until the child is at the upper weight limit of the seat (40-50 pounds). Check the manufacturer’s instructions or the stickers on the side of the seat for the weight limits.
Children: When a toddler outgrows a convertible seat, place the child in a booster seat until age 8 or the child reaches 4 feet 9 inches. Booster seats must be used with lap and shoulder belts.

Bicycles/tricycles
As of January 2004, Oregon law has required helmets for anyone under the age of 16 using a bicycle (includes tricycles), scooter, inline skates or a skateboard.

- Approved bicycle helmets are used every time children ride bikes.

Best practice
- Use helmets with tricycles, scooters, skates and big wheels to help promote the “helmet habit.”

Source: Adapted from the “Child Care Health Handbook,” Child Care Health Program, Public Health, Seattle & King County, 2001.
BE PREPARED BEFORE INJURIES OCCUR

- Post emergency phone numbers on or near all phones for fire, emergency medical care (911) and Oregon Poison Center (1-800-222-1222); also post your home or facility address. Emergency numbers should be posted directly on portable or cordless telephones.
- Make sure your address can be seen from the street, day or night.
- Make sure you and any staff are trained and up-to-date in first aid and age-appropriate CPR.
- Develop written emergency procedures that include first-aid measures and procedures for minor and serious injuries. Orient all staff to the plan and keep a set of the procedures with the first-aid kit or posted nearby it. Provide a copy of the written emergency procedures for parents.
- Keep signed parental consent forms on file to enable you to provide emergency treatment and to call 911 if needed. Keep a list of each child’s medical history, which should include immunizations, allergies, medications and serious illnesses. This may include special needs action plans for asthma or other care plans completed by children’s health care providers or parents. Parents need to update forms once a year or when any changes in information occur. When away from the early care and education facility, have emergency contact information and medical consent forms with you.
- Keep a stocked first-aid kit in a convenient location that is known to all staff. The kit should be out of reach of children, but easily accessible to staff. Store the kit away from food and food-contact surfaces. Staff should be familiar with and know how to use the contents of the first-aid kit. Assign one person to check it regularly and restock it as necessary.
- A first-aid kit should be placed in every vehicle used for daily transportation or field trips. Your vehicle kit could also include a mobile phone, blanket, flashlight and handwashing supplies. You can call 911 free of charge from any phone booth.
• A portable first-aid kit should be available for field trips and/or playground use. 📚
• Consider any special procedures individual children should need. 📚

YOUR FIRST-AID KIT
Your first-aid kit should include the following:
• First-aid handbook or chart
• Vinyl or non-latex gloves
• Breathing mask
• Cold packs
• Assorted adhesive bandages
• Gauze dressing pads (2- and 4-inch sizes)
• Adhesive tape
• Small scissors
• Sanitary thermometer or temperature-taking device
• Soap towelettes or soap and water
• Chlorine bleach or other supplies to ensure safe clean-up of blood or body fluids
• Plastic bag to collect soiled gloves and used supplies
• Any other supplies needed to conform to written health policies
• Optional: Knuckle fabric bandages, tweezers, elastic bandage, triangular sling bandages, roller gauze bandages (2- and 3-inch widths)

Remember: Ointments, first-aid spray or creams should not be used without the written, signed authorization of a health care provider and parent/guardian. 📚

Syrup of ipecac is no longer recommended for accidental poisoning and should be removed from first-aid kits and discarded. Ipecac syrup has not been found to help and, when it is used, accidental overdose is possible. If you suspect a child has swallowed something poisonous, call the Oregon Poison Center at 1-800-222-1222.
PREVENTING DISEASE TRANSMISSION

Preventing disease transmission while providing first aid is critical. When taking action to control bleeding or provide first aid you may come into contact with blood or other body fluids. A properly equipped first-aid kit can help you deal with an injured person without exposing yourself or the injured person to possible germs. Gloves are recommended for blood contact as an additional precaution against exposure to bloodborne germs.

Good personal hygiene practices, such as washing hands before and immediately after giving care, can also reduce the risk of disease transmission. Antiseptic hand wipes can be useful when running water is not available, but they are no substitute for hand washing. Hand washing should be done even if the person administering first aid was wearing gloves.

GENERAL PRINCIPLES OF FIRST AID

1. Stay calm.
2. Check for life-threatening situations:
   - Not breathing or having trouble breathing;
   - No pulse;
   - Severe bleeding.
3. Do no further harm. Do not move the child, unless the child is in danger of more injury.
4. Call 911 or your local emergency number if needed. If possible, stay with the child and send another person to call.
5. Give CPR or first aid if needed.
6. Treat the child for shock if indicated.
7. Comfort the child. Contact the parent/guardian or other emergency contact.
8. Conduct a review of the injury and determine ways to prevent a reoccurrence.
9. After the incident is over, complete the Injury Report Form.
WHAT YOU NEED TO KNOW

There is enough pressure on a day-to-day basis in early care and education without having to worry about preparing for disasters. But, disasters don’t wait until we’re ready – we have to prepare even when we feel we’re too busy. We can make that easier by breaking the process into pieces. But, please remember that this guide is really just designed to give you some questions. Because each facility has such unique circumstances, the answers are something that you, your staff and your children’s parents are going to have to answer.

It’s important to develop your own plan for responding to emergencies and natural disasters. You can find tools to create a plan in the Resources section of this chapter, “Early care and education crisis/disaster response handbooks.”

Types of emergencies

We all know that there are a variety of disasters, earthquakes, fires and floods. For our purpose we will divide them into either “advanced warning” or “no warning” incidents. The amount of time you have to prepare to respond makes a huge difference in what you can and will do.

• Advanced warning emergencies

Examples of emergencies with advanced warning might be a bad weather forecast, notification of a potentially disruptive protest in your area, or a wildfire that is approaching town. In these cases you have a little time to think about what you are going to do before the incident is upon you. Some decisions that you might need to make are:

• Should you close, or not open at all, ahead of the forecast event?
  ■ What is your action point for deciding to not open or close?
  ■ If you do decide to close, how long will it take for parents to pick up their children?
  ■ If you can’t reach the parents, are there alternative emergency contacts you can reach?
• Do you have facilities to care for children whose parents aren’t able to pick them up? What if you need to provide that care throughout the event?

• Do you stay or do you go? If you do stay open, is the forecast event something that can be weathered at your normal location, or do you and the children need to plan to evacuate to another location?
  - What would be your action point for deciding to evacuate?
  - Do you have arrangements to evacuate? For example, do you have an agreement with another facility or location that you, your staff and the children may go there? How much notice do they need?
  - What would you take with you if you did have to leave?
  - Do you have a system for marking your children as being part of your group?
  - Do the children’s parents know where you might go? How do you let them know if your plan changes?

• **No warning emergencies**

Examples of emergencies with no warning might be a sudden change in the weather, an earthquake or a structure fire at the facility. In these cases you have no time to think about what you are going to do before the incident is upon you. Some decisions that you might need to make are:

• Do you stay or do you go? The event may damage your normal location or make it unsafe.
  - What are your action points for deciding to stay or go?
  - Do you have plans (as above) in place regarding where to go?
  - What do you need to take with you?

• What do you need to be able to provide the children if you must move to another place or while you are sheltered in place (staying where you are until safe to leave)?
  - The basics: food, water, shelter.
  - Emotional: Kids will be scared by the situation. What can you take with you or provide to help them cope?
YOUR DISASTER SUPPLIES

A good place to begin getting prepared is by putting an emergency and disaster supply kit together.

Disaster supply lists


- Anti-diarrhea medicine
- Batteries
- Blankets (compact or space)
- Bleach, unscented
- Books or games
- Bucket
- Can opener (manual)
- Comfort kits for children (see below)
- Copies of important papers (insurance documents, utility account numbers, etc.)
- Crowbar
- Disaster plan (copy)
- Disposable diapers/wipes
- Disposable face masks
- First-aid kit (for disasters)
  - Adhesive bandages
  - Acetaminophen (children’s)
  - Alcohol wipes
  - Anti-diarrheal medication
  - Bandages (roller gauze, elastic)
  - Butterfly adhesive strips
  - Cotton balls
  - Eye drops (saline)
  - First-aid book
• Gauze dressing
• Gloves, disposable
• Medications or equipment for children/staff with special needs
• Pocket CPR mask
• Safety pins
• Sanitary napkins
• Scissors
• Splints
• Tape, 2 inches, non-allergenic
• Tissue
• Thermometer
• Tweezers

❑ Emergency information cards for children
❑ Extra clothing
❑ Eye dropper (for bleach)
❑ Flashlights
❑ Food (three-day supply)
❑ Gloves (heavy material/leather)
❑ Hand sanitizer
❑ Infant care supplies (bottles, formula, baby food, diapers)
❑ Lighter or matches
❑ Money, change and small bills
❑ Office supplies (pen, paper, tape)
❑ Paper towels
❑ Pet supplies (if appropriate)
❑ PineSol® or similar product
❑ Plastic garbage bags (large, one per child for rain protection)
❑ Plastic garbage bags (medium, for toilets)
❑ Plastic kitchen supplies
❑ Pliers
❑ Radio (portable)
Soap
Tarp or tent
Tissues
Toilet paper
Water (three-day supply)
Whistle
Wrench
Other ________________________________
Other ________________________________
Other ________________________________
Other ________________________________
Comfort kits
You may want to have a small comfort kit for each child. Many disaster supply companies sell pre-made kits. Parents can create a kit if you give each a gallon-size zip lock bag and the following list:

Wool socks
Hat
Photo/letter from home
Small toy or book
Mylar (space) blanket
Three-day supply of prescription medication or a copy of the prescription including dose
Granola bar
Bottle of water

Car kits
You never know when a disaster may strike. Have emergency supplies in your car along with a first-aid kit. Consider including the following items:

Flashlight
Batteries
Non-perishable food
Bottled water
Blanket
Comfortable walking shoes
Flares
Booster cables
Small fire extinguisher

Food

Choose a variety of non-perishable foods that require little or no preparation. Rotate food items every six months. Try to select items that the children like to eat and ones low in sugar and salt. Some ideas include:

Commercially canned or processed foods, ready-to-eat meats, fish, pastas, fruit and vegetables
Canned evaporated or powdered milk
Crackers, granola bars, energy bars, trail mixes and cereals
Freeze-dried foods, salmon/beef jerky, dried fruit, such as for camping
Peanut or nut butter (provided no one is allergic)
A personal energy booster for staff such as candy bars, instant coffee, hard candies or tea bags
Infant formula and baby food for babies or other special foods for people with specific dietary needs

Water

Allow a minimum of one gallon per person per day. Include both staff and children in your count. Store your water in a cool place. Put some in your freezer if you have space, where it can help to keep food cold in a power outage.

*Excerpts are from the “Child Care Center Crisis/Disaster Response Handbook,” Multnomah County Emergency Management and Multnomah County Health Department, 2010, which can be found at https://multco.us/sites/default/files/office-emergency-management/documents/crisis_disaster_center_handbook_mc_final_10-19-10.pdf
CHILDREN AND EMERGENCIES

When children are old enough, teach them about emergencies and how to recognize danger signals. Make sure children know what smoke detectors and fire alarms sound like. Explain how to call for help. Even very young children can be taught how and when to call for help. Have the children practice drop, cover and hold (earthquake); stop, drop and roll (fire); and stay low and go (smoke). Explain why, when and what they should do in a disaster. Encourage children to talk about emergencies. Children of all ages can help put together a comfort kit that is comprised of a family photo and a soft toy or blanket.

When an emergency happens, the children will need both verbal and physical reassurance that everything will be OK and that they are safe with you until their family can come for them. How you react in an emergency will influence the children's reactions. Try to remain calm. Remaining calm will reduce the children's fear and anxiety.

Be aware of possible differences in children's ways of taking in information. Evacuations may require making sure that each child gets instructions in a way they can understand.

Preparing for a disaster will take time. The more time and effort you put into planning, organizing and practicing, the more prepared you will be for a disaster. Early care and education staff can limit injuries and damages and return more quickly to normal operations if they plan ahead.
PREVENTING INJURIES

Care seat safety

- **Safe Kids USA**  
  Child Safety Seat Resource Center, 1-877-793-2608  
  [http://www.safekids.org or http://www.safekidsoregon.org](http://www.safekids.org or http://www.safekidsoregon.org)

- **Child Safety Seat Resource Center**  
  503-643-5620 in Portland, or 1-877-793-2608 statewide.

- **Seat installation information or Oregon child restraint laws**  
  Child Safety Seat Resource Center, 1-877-793-2608  
  [http://www.childsafetyseat.org](http://www.childsafetyseat.org)

General injury prevention

- **Raising Safe Kids: One Stage at a Time**  

- **Safe Kids Oregon**  
  [http://www.healthoregon.org/safekids](http://www.healthoregon.org/safekids)

Pets in early care and education settings

Contact your local humane society, animal shelter or dog breeder organizations for education and specific information about pet selection and screening.

Preventing common childhood injuries

- **Oregon Health Authority Injury Prevention and Epidemiology Program**  

- **Oregon Safe Kids**  
  [http://www.safekidsoregon.org/?page_id=45](http://www.safekidsoregon.org/?page_id=45)
**Toy safety**

- **Information on recall of dangerous products**
  U.S. Consumer Product Safety Commission  
  [http://www.cpsc.gov](http://www.cpsc.gov)

- **Injury and hazards’ reporting**
  New tool and resource for parents, families, pediatricians and other health care providers to report injuries or hazards posed by consumer products  

Documents and forms to download and print — Preventing injuries  
*(Go to OKHS Volume 4: Appendix – Chapter D.)*

- Injury Report Form

**PREVENTING SUFFOCATION AND REDUCING THE RISK OF SIDS**

American Academy of Pediatrics  
[http://www.aap.org](http://www.aap.org)

- **A Child Care Provider’s Guide to Safe Sleep**  

- **A Parent’s Guide to Safe Sleep**  
  [http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx](http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx)

- **Back to Sleep, Tummy to Play**  

- **Policy Statement SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment Task Force on Sudden Infant Death Syndrome**  
  [http://pediatrics.aappublications.org/content/128/5/1030.full](http://pediatrics.aappublications.org/content/128/5/1030.full)
Scheduled rest periods and sleep arrangements. Search for “sleep.”

Crib safety

- **Back to Sleep Campaign**
  1-800-505-CRIB (2742)

- **Information specific to early care and education providers**

- **Safe Kids Oregon**
  Two posters (English/Spanish) on crib safety requirements
  http://www.safekidsoregon.org

- **U.S. Consumer Product Safety Commission Crib Information Center**

Factsheet


Healthy Child Care America Back to Sleep Campaign
http://www.healthychildcare.org/sids.html

Reducing the Risk of SIDS in Child Care
A free one-hour online tutorial
http://www.healthychildcare.org

Rules for Child Care Centers
Oregon Administrative Rules, Division 300, Certified Child Care Centers: 414-300-0215, Infant and Toddler Furniture Equipment, 414-300-0300, Infant and Toddler Program Activities, (6).
Safe Sleep for Babies
http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HealthScreening/BabiesFirst/Pages/sids.aspx

Safe Sleep Practices and SIDS/Suffocation Risk Reduction
http://cfoc.nrckids.org/StandardView/SpcCol/Safe_sleep

POISON PREVENTION

Eco-Healthy Childcare
Recognizes early care and education providers who take steps to provide a safe and eco-healthy environment for children. Early care and education facilities that qualify receive a colorful sticker and poster to inform parents and others of their commitment to being eco-healthy

- General information
  http://www.oeconline.org

- Qualifications to be an eco-healthy early care and education provider
  http://www.oeconline.org/our-work/kidshealth/ehcc/index_html

Oregon Poison Center

- General information
  Poisonous materials and how to prevent unintentional poisonings
  1-800-222-1222 for emergencies
  http://www.ohsu.edu/poison/

- Poisonous plants in early care and education settings
  http://www.ohsu.edu/poison/youAndYourfamily/plantSafety.htm?WT_rank=1

Medication safety

- Up and Away
  An initiative of PROTECT in partnership with the CDC
  http://upandaway.org/

Documents and forms to download and print — Plant poisoning prevention
(Go to OKHS Volume 4: Appendix – Chapter D.)

- A Guide to Plant Poisoning Prevention and Treatment
Lead poisoning

- **Childhood Lead Poisoning Prevention Program**
  Information and materials on lead hazards and prevention for early care and education providers, professionals and the public. Brochures, posters and other educational materials on how to protect children from lead poisoning through lead-safe remodeling, healthy lead-safe eating, blood lead screening information; and lead educational materials for children.
  503-731-4025

- **Environmental Protection Agency (EPA) Lead Program**
  Lead poisoning prevention educational materials and publications
  1-800-424-LEAD (5323)
  [http://www.epa.gov/lead](http://www.epa.gov/lead)

- **Lead-Based Paint Program**
  A certified contractor list and materials on lead-based paint hazards, lead abatement and control methods, lead-safe remodeling and risk assessment
  503-731-4500

- **LeadLine**
  Answers questions about local lead programs and services; provides information on reducing lead hazards in the home, upcoming lead poisoning prevention workshops, childhood blood lead screening, and home repair and remodeling. Available in English, Spanish, Russian and Vietnamese.
  **Note:** Service currently only available in Portland metropolitan area, but LeadLine services will soon be statewide.
  1-800-368-5060 statewide or 503-988-4000 in the Portland metro area
  [http://www.co.multnomah.or.us/health/lead/](http://www.co.multnomah.or.us/health/lead/)

- **National organizations**
  - **Centers for Disease Control and Prevention**
    Information about lead poisoning and the Childhood Lead Poisoning Prevention Program
• **Department of Housing and Urban Development**  
  Educational materials and information related to lead-based paint in housing and lead poisoning prevention  

• **National Lead Information Center**  
  Comprehensive list of lead poisoning educational materials and publications for the general public and professionals  
  [www.epa.gov/lead/nlic.htm](http://www.epa.gov/lead/nlic.htm)

• **Oregon Lead Poisoning Prevention Program**  
  Information and educational materials on lead hazards, preventing lead poisoning and list of certified lead paint professionals  
  971-673-0440  
  [http://www.healthoregon.org/lead](http://www.healthoregon.org/lead)

• **Oregon Remodelers Association**  
  Information specialists to answer questions about lead-based paint hazards during housing maintenance, renovation, remodeling and rehabilitation  
  503-788-2274  

**Hazardous materials**

• **Disposal of hazardous materials**  
  [http://www.earth911.org](http://www.earth911.org)

• **Integrated Pest Management Toolkit for Early Care and Education Programs**  
  Funded by the California Department of Pesticide Regulation. In English and Spanish; includes illustrations and information about using integrated pest management (IPM) to improve sanitation, prevent and manage pest problems, and reduce pesticide exposure for children and staff in early care and education programs.  

• **Metro**

  • **Information on common hazardous household products**  
    Including proper use, storage, disposal and safer alternatives  
    503-234-3000  
    [http://www.metro-region.org](http://www.metro-region.org)
• **Guide to hazardous waste**  
  Many common hazards and information about safer alternatives. Metro operates household hazardous waste collection facilities for the safe and legal disposal of unwanted hazardous products. Metro will accept some wastes from businesses.  
  503-234-3000  
  [http://www.metroregion.org/index.cfm/go/by.web/id=24267](http://www.metroregion.org/index.cfm/go/by.web/id=24267)

• **Oregon Department of Environmental Quality**  
  • **General information**  
    1-800-452-4011  
    [http://www.oregon.gov/DEQ](http://www.oregon.gov/DEQ)  
  • **Hazardous consumer products**  
    [http://www.deq.state.or.us/lq/sw/hhw/products.htm](http://www.deq.state.or.us/lq/sw/hhw/products.htm)  
  • **Hazardous waste**  
    [http://www.deq.state.or.us/lq/hw/index.htm](http://www.deq.state.or.us/lq/hw/index.htm)

**INDOOR AND OUTDOOR SAFETY**  
**Handbook for public playground safety**  
U.S. Consumer Product Safety, Publication #325, Washington D.C.  
1-800-638-2772  

**National Recreation and Parks Association**  
U.S. Consumer Product Safety, Publication #325, Washington D.C.  
[http://www.nrpa.org](http://www.nrpa.org)

**FIRST AID AND PREPARING FOR NATURAL DISASTERS**  
**American Red Cross**  
First aid and disaster classes, educational materials and supplies  
[http://www.oregonredcross.org](http://www.oregonredcross.org) (local chapter search)

• **Oregon American Red Cross Chapters**  
  [http://www.redcross.org/find-your-local-chapter](http://www.redcross.org/find-your-local-chapter)
• **Newport District Office ~ Newport, OR**
  308 SW Coast Hwy
  Newport, OR 97365
  541-265-7182
  lincoln@redcross-salem.org

• **Oregon Mountain River Chapter American Red Cross**
  2669 NE Twin Knolls Drive
  Bend, OR 97701
  541-382-2142
  Fax: (541) 382-2405

• **Oregon Pacific Red Cross**
  862 Bethel Drive
  Eugene, OR 97402
  541-344-5244

• **Oregon Trail Red Cross**
  3131 N. Vancouver Ave.
  Portland, OR 97227
  503-284-4247
  info@redcross-pdx.org

• **Southern Oregon Chapter of the American Red Cross**
  60 Hawthorne Street
  Medford, OR 97504
  541-779-3773
  1-800-433-9285
  541-772-7212 (fax)
  info@soredcross.org

• **Willamette Chapter of the American Red Cross**
  **Chapter Headquarters**
  675 Orchard Heights Road NW, Suite 200
  Salem, OR 97304
  503-585-5414
  rc@redcross-salem.org
Early care and education crisis/disaster response handbooks
County Health Department and Multnomah County Emergency Management

- Child Care Center Crisis/Disaster Response Handbook, June 2010. Multnomah
  crisis_disaster_center_handbook_mc_final_10-19-10.pdf

  Multnomah
  http://www.oregon.gov/EMPLOY/CCD/CCD%20Forms/
  CrisisDisasterFHHandbook10-23-2012.pdf

Federal Emergency Management Agency (FEMA) Headquarters
Disaster information and educational materials
500 C Street SW
Washington D.C. 20472
202-646-2500
1-800-480-2520
http://www.fema.gov

- Oregon FEMA
  Emergency Management Division
  Oregon State Executive Department
  595 Cottage Street NE
  Salem, OR 97310
  http://www.oregon.gov/omd/oem

Institute for Business and Home Safety
Educational materials and resources, including a disaster planning toolkit
1-877-580-8885
http://www.ibhs.org

IS-366, Planning for Needs of Children in Disasters course
Published and now available in the FEKC and at the Emergency Management
Institute website.

Guidance for emergency managers and implementers of children’s programs
about meeting children’s unique needs due to a disaster or emergency

Includes the following lessons: 1, course overview; 2, unique needs of
children in disasters; 3, critical components of a child’s world; 4, mitigation;
5, preparedness; 6, response; 7, recovery resources toolkit (downloadable
PDF file).
Course length: 4 hours. CEUs: 0.4 hours.
http://training.fema.gov/EMIWeb/IS/is366.asp
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