OREGON KIDS: HEALTHY AND SAFE

Volume 4 | Appendix

A health and safety guide for early care and education providers

PUBLIC HEALTH DIVISION
Office of Family Health

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 *www.oregonchildcaretraining.org.*

Oregon Kids, Healthy and Safe is a joint project among the following partners:

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CHAPTER A

RESOURCES: INTRODUCTION

Child Enrollment and Authorization

Child's Name ____________	**Date Entered Care** ____________
Child's Nickname ____________	**Age at Entry to Care** ____________
Birthdate ____________	

ALLERGY ALERT: Does child have allergies? ☐ **YES** ☐ **NO** If yes, list all allergies on back side of form

Parent or Guardian Contact Information

Name (first, last)	Relationship	
Street Address	City	Zip
Home phone	Cell phone	
Employer/Work Hours	Work phone	
Name (first, last)	Relationship	
Street Address	City	Zip
Home Phone	Cell phone	
Employer and Work Hours	Work phone	

Required Emergency Contact Information- person other than parent or guardian that is authorized to pick up child

Name (first, last)	Phone	Relationship
Name (first, last)	Phone	Relationship

Non-Emergency Contact Information- person other than parent or guardian that is authorized to pick up child

Name (first, last)	Phone	Relationship
Name (first, last)	Phone	Relationship

Medical/Dental Contact Information

Insurance Provider and Policy Information (if applicable)	
Primary Physician Name	Phone
Dental Provider (if child is school-age. If none, list dental provider for child care facility)	Phone

Parent or Guardian Authorization

Please list any restrictions to permission of the following:

- ○ **My child** may be taken on field trips or excursions by bus or private motor vehicle, as well as on neighborhood walking excursions under required supervision (see special transportation arrangements section on back of form).
- ○ **My child** may participate in swimming or other water activities under required supervision (CCD requires approved lifeguard).
- ○ **My child** may be photographed for publicity or news purposes ☐ On-site ☐ Off-site
- ○ **My child** may be given non-prescribed medication as indicated on the container. This may include sunscreen, children's pain reliever, antibacterial first aid cream, and diapering ointment. Syrup of ipecac may be administered if deemed necessary by the poison control operator. The child's parent or guardian will be contacted prior to administering non-prescription pain relievers. Prescription medications must be current and a permission slip is required per each medication.

In an emergency, the child care facility has my permission to call an ambulance, or take my child to any available physician or hospital at my expense to obtain medical treatment. In most emergencies, 911 is called and the child is transported to the nearest hospital and treated by the on-call physician. The parent or guardian of the child is notified as soon as possible.

Parent/Guardian Signature ____________ **Date** ____________

Continued on back (additional signature and date)

Child Information

Has your child previously been in child care?	If yes, what type of care, and for how long?
Reason for requesting care	

Child General Information- please include all information that will assist us in providing quality care for your child

Likes and Dislikes
Eating Habits and Schedule
Sleeping Habits and Schedule
Play
Fears
Special Words and their Meanings

Child Medical Information

Does your child have allergies?	Has your child had chickenpox?
☐ Yes ☐ No	☐ Yes ☐ No

List all allergies or other health problems, including instructions for providing best possible care in regard to stated conditions. Do any of the medical conditions restrict the child's activities?

Other Children in Home

Name (first, last)	Nickname	Age	Sex
Name (first, last)	Nickname	Age	Sex
Name (first, last)	Nickname	Age	Sex
Name (first, last)	Nickname	Age	Sex

Special Transportation Arrangements

CCD requires a written plan of the transportation arrangements between the child care facility and the parent ofr guardian of the child for extracurricular activities. The following indicates the child care facility's transportation plan:

__________(child) attends__________(school). He/she will be transported/escorted between the child care facility and the school by (check applicable type):____ school bus, ____ Head Start bus,____ child care facility, or ________ will arrive/depart unescorted with my permission. If my child is not at the designated pickup site, or does not arrive as planned, please contact (check applicable type): ____parent or guardian, or______the school , in order to confirm the child's whereabouts, as well as devise a plan as needed to locate the child. My child also has permission to (**specify**, ie: work with teacher after school, attend an extracurricular class or meeting, depart for home at specific time, etc):

____

Parent/Guardian Signature ____________________ **Date** ____________________

Child Care Enrollment
Infant and Toddler Information

To Be Completed by Parent

Per rule 414-300-0040(5) the following information is required prior to admission of each infant and toddler.

Name of child care center/home			Date enrolled
Child's Name	Nickname	Birthdate	Child's age at entry
Name of Parent(s)			Phone (day)

Health

Any special/medical needs?

Any previous medical history?

Any allergies?

Any medications?

Individual Needs

Does child say any words? What do they mean?

What languages are spoken in the home?

What are child's favorite games, toys and things to do?

How do you comfort your child when he or she is upset?

Any information that might be important or helpful to caregivers?

Family

Members of Household	Relationship	Age if Sibling

Any pets?

Over ⇒

TA-805 (09/06)

Typical Daily Schedule

7:00 ____________________

7:30 ____________________

8:00 ____________________

9:00 ____________________

10:00 ____________________

11:00 ____________________

12:00 ____________________

1:00 ____________________

2:00 ____________________

3:00 ____________________

4:00 ____________________

5:00 ____________________

Sleep

Any special sleeping routines?

Does your baby liked to be rocked?

Is your baby always put on his/her back to sleep?

When does your baby usually sleep?

How long is a typical sleep period?

Liquids

☐ Cup ☐ Bottle ☐ Parents on-site

Milk: ☐ Formula ☐ Whole milk
☐ Breast ☐ 2%
☐ Skim

Brand: ____________________

Type: ☐ Powder ☐ Ready to feed

☐ Heated ☐ Room Temp ☐ Cool

Amount/serving:

Juice: ☐ Apple ☐ Orange
☐ grape: ☐ Peach
☐ Pineapple: ☐ Apricot

Any other liquids? ____________________

Foods

What does your child eat?

☐ Baby Food ☐ Table Food

Types/Amount:

____

____

____

____

____

____

____

____

____

____

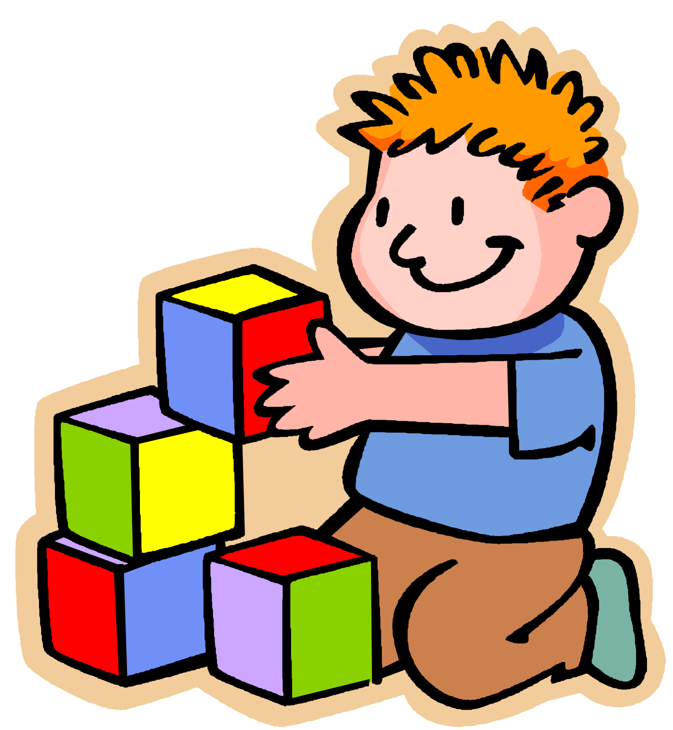
____

____

TA-805 (09/06)

SAFE N' SOUND

CHILD CARE
HEALTH AND SAFETY TIPS



Adapted from Safe N' Sound Child Care Health and Safety Tips
Multnomah County 6/25/2008

Any medical information provided in this pamphlet) or health and safety policy packet) of training is for educational purposes only. The information provided is not a substitute for professional medical care, or a professional medical opinion. If you have a medical problem, please contact your care provider. If a child in care has a medical problem, please have their family contact the child's medical care provider.

Oregon Child Care rules may vary by type of child care. If you have questions about a policy recommendation, please check the rules and/or call the Oregon Child Care Division at 1 800 566-6616

Adapted from Safe N' Sound Child Care Health and Safety Tips
Multnomah County 6/25/2008

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Asthma Triggers

Asthma is a health condition that can make it hard for a child to breathe at times. Asthma affects the airways that carry the air they breathe into their lungs. When a child has asthma, their airways can get irritated and swollen and cause an asthma attack, making it hard to get enough air into and out of the lungs. Their chest may feel tight and they may cough or wheeze. To keep a child with asthma well and avoid breathing problems, many children need to take daily "controller" medicines and only use "rescue" medicines that relieve symptoms when having problems.

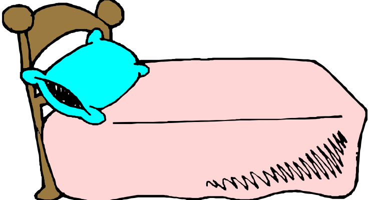
Things that cause asthma attacks are called **"triggers." Asthma triggers are different for each person.** If you know a child in your enter has asthma, discuss the condition with the child's parents to find out what is being done for the child to keep their asthma under control. It is important to limit or reduce the presence of the following asthma triggers in the day care center to prevent asthma attacks and/or reduce the likelihood that other children in the center will develop asthma.

- Tobacco smoke or other smoke
- Animals with fur or feathers
- Dust mites
- Strong smells and sprays
- Pollen
- Mold or mildew
- Being physically active when asthmas is not well managed
- Illnesses that cause a stuffy nose or other problems with breathing
- Breathing cold air

For more information about asthma and asthma triggers call the Oregon Asthma Network at (503) 731-4273 or consult the Environmental Protection Agency website at http://www.epa.gov/asthma/index.html

Adapted from Safe N' Sound Child Care Health and Safety Tips
Multnomah County 6/25/2008

Care of Bed Linen



Proper storage of an individual child's linen includes pillows, covers, and blankets used on cots, mats, and cribs or futons. Good storage practices may reduce spreading illness in the child care setting. The following recommendations may be used as both guidance in adhering to regulations and best practice applications.

- Each child should have their own linen, stored in individual cubbies or approved containers.
- Children should not share personal bedding items.
- Separate these items and avoid contact with other children's personal items. Cots and mats shall be stored so that contamination is eliminated. Vertical stacking of the mats or on spaced hangers is a good practice. Placing a non-absorbent barrier between the mats is also recommended.
- If cots and mats are interchanged between children, a sanitizer shall be applied to the surfaces before the next use. Centers normally apply the sanitizer at the end of the day.
- If a child uses the same mat or cot on a daily basis, labeling of the mat with the child's name is required. Sanitize these cots and mats at least weekly.
- Crib linen is changed before another child uses the crib. Surfaces of the crib are sanitized daily. If the same child uses the crib on a daily basis, label the crib with the child's name, inspect linen daily and change as needed. At minimum, a weekly change of linen is required. Best practice would be a daily change.
- Bedding and linen should be laundered weekly at a temperature of at least 140 degrees Fahrenheit (or with added disinfecting agent such as unscented household bleach) or during the week if additional supplies are needed. Parents should be advised to launder weekly or if the center performs this service, the frequency should be a minimum of once a week.

Adapted from Safe N' Sound Child Care Health and Safety Tips
Multnomah County 6/25/2008

Cleaning, Disinfecting, and Sanitizing

Cleaning will consist of washing surfaces with soap and water, and rinsing with clean water.

Disinfecting/Sanitizing will consist of using bleach/water solution as follows:

Disinfecting	Amount of Bleach *	Amount of Water
Diaper areas, bathrooms and bathroom equipment	1 Tablespoon	1 Quart
Sanitizing	**Amount of Bleach***	**Amount of Water**
Table tops, dishes, mouthed toys, mats, etc…	¼ to ¾ teaspoon	1 Quart

* This guide uses unscented household bleach. Please follow the product label instructions on use. Other approved disinfectors and sanitizers are available. Please check with your health consultant about these products. Solutions should be mixed daily and stored in a cool, dark place out of the reach of children.

- **Tables** used for serving food will be cleaned with soap and water, rinsed, and then sanitized with bleach solution before and after each meal or snack.
- **The kitchen** will be cleaned daily and more often if necessary. Sinks, counters, and floors will be cleaned and sanitized at least daily. Refrigerator will be cleaned and sanitized monthly or more often as needed.
- **Bathroom(s)** will be cleaned daily or more often as necessary. Sinks, counters, toilets, and floors will be cleaned and disinfected at least daily.
- **Furniture, rugs, and carpeting** in all areas will be vacuumed daily. This includes carpeting that may be on walls and surfaces other than the floor.
- **Hard floors** will be swept and mopped (with cleaning detergent) daily and sanitized (with above bleach solution) daily. If floors are soiled with body fluids, disinfect floors according to the policy "General Instructions for the Exposure to Body Fluids".
- **Mouth toys** will be washed and sanitized in between use by different children. A system for ongoing rotation of mouth toys will be implemented in infant and young toddler rooms. Toys that have been mouthed or contaminated (falling on floor, handled by hands not adequately washed) will be placed in a container labeled "soiled toys" that is not accessible to children.
- **Toys** (that are not mouth toys) will be washed, rinsed, sanitized, and air-dried weekly or toys that are dishwasher safe can be run through a full wash and dry cycle.
- **Cloth toys** will be laundered monthly or more often, as needed, for young children. If they cannot be washed in the washing machine, they will be washed in warm soapy water for 1 minute and allowed to air dry. Toys that cannot be washed, sanitized, or laundered shall not be used.
- **Professional steam cleaning** of carpers and fabric furnishings is recommended on a semi-annual frequency.
- **Pacifiers, thermometer, teething toys** shall be cleaned between uses. Pacifiers (and teething toys) shall not be shared.
- **High chairs** are to be treated like dishes. Remove food debris after meals, wash, rinse, and sanitize between uses. Allow chair to dry before storing. High chair safety belt must be washed and sanitized as needed or at least weekly. Protect high chairs from contamination between uses.

Adapted from Safe N' Sound Child Care Health and Safety Tips
Multnomah County 6/25/2008

Diaper Changing and Disposal

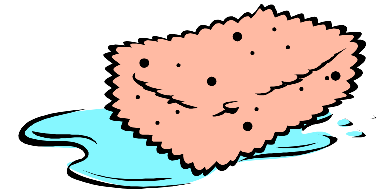
The activities of diaper changing and proper disposal are considered high risk areas in the child care setting. By establishing safe practices, the risk of the spread of disease is minimized. In addition, the child's safety and comfort are important considerations when diapers or pull-ups are changed. The following recommendations follow national standards in diaper changing and disposal.

- Plan ahead with the diaper area set up for changing (supplies within reach including the hand wash sink).
- The diaper changing surface should be nonabsorbent using a pad or disposable paper surface. For in-home care, a towel may be used for one change per child. The surface should not be carpet or a rug that other children play on or have access to. Diaper changing and hand washing sink used following diapering should be in a non-food preparation area.
- Wash your hands before you begin. Remember, through interaction with the child, you may be holding or touching the child. If gloves are worn, put them on at this time.
- Gently pick up the child holding the child away from your body to avoid any soiling on your clothes.
- Place the child on the changing surface, removing clothes if necessary and place soiled (without rinsing) clothes (plastic bagged and tied) or diaper in a plastic lined approved container. Clothing and cloth diapers can be sent home with the parents.
- Clean the child's bottom from front to back with a pre-moistened cloth or a dampened single use disposable towel.
- Discard soiled supplies and if using a disposable glove, remove and dispose of gloves at this time.
- Wash your hands. The sink should be in reach of the diaper change area. Do not leave the child unattended.
- Place a new diaper on the child.
- Wash the child's hands with soap and water. If the child in unable to get to the hand washing sink, a wash cloth moistened with soap and water may be used (for example, with an infant). The wash cloth should then be laundered.
- Return the child to the activity area.
- Clean and disinfect the changing area. Set up for the next change.
- Wash your hands (20 seconds) with soap and water.

Website links: http://www.cdc.gov/parasites/crypto/daycare/prevent.html

Adapted from Safe N' Sound Child Care Health and Safety Tips
Multnomah County 6/25/2008

General Instructions for Exposure to Body Fluids



<u>All blood or body substance</u> should be considered potentially infectious and should be cleaned up in a careful manner.

Blood or body substances on you:

Immediately wash affected area with soap and running water.

- Check area of contamination for cuts or other breaks in skin integrity (i.e. torn hangnails, chapped skin).
- Should you find a cut in your skin repeat the cleansing.
- Notify your supervisor or health care provider.

<u>Surfaces contaminated with blood or body fluids</u>

Clean surfaces soiled with blood, fecal material, or other body secretions with soap and water.

- Wear gloves
- Use enough absorbent material (paper towels, rags) to avoid contact with your skin. This will remove most of the contamination and allow for further clean up.
- Rinse the area with a bleach solution (1 part household bleach to 9 parts cool water – ½ cup bleach and 1 quart cool water.*) Mix bleach water fresh when needed as it loses potency if stored diluted.
- Surface should remain wet from bleach water for 10 minutes.
- Rinse and cleanup remaining material. Rinse with clear water.
- Dispose of all contaminated articles in a plastic bag with the top tied shut.

<u>Clothing contaminated with Blood or Body Fluids</u>

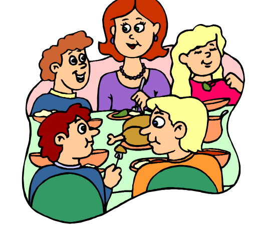
Try to minimize skin contact. If possible remove soiled clothing carefully to minimize further contamination of self.

- Wash any affected area thoroughly with soap and water.
- Change clothing as soon as possible.
- If it is not possible to change clothing, remove and rinse clothing to remove the body substances. Blot dry.
- Place soiled clothing in a plastic bag to be laundered.
- Wash normally using ordinary laundry soap and the temperatures appropriate for the material. Dry cleaning is also safe. No special labeling is necessary.

* This solution is between 5000-5800 ppm according to the National Antimicrobial Information Network

Adapted from Safe N' Sound Child Care Health and Safety Tips
Multnomah County 6/25/2008

Family Style Meal Service



Family style meal service, for age appropriate children, provides beneficial opportunities for social interaction and conversation. In addition, the introduction of the concepts of food, color, quantity, shapes, and temperatures of food are also opportunities for learning. Here are some food safety guidelines that should be considered when planning this activity.

- The table should be cleaned and sanitized.
- Hot food must be kept at 140 degrees F or warmer and cold food held at 41 degrees F or colder until served. Foods should be covered until served.
- Provide separate serving portions for each table.
- Children and teachers shall wash their hands before table setting and serving of food.
- Serving tables, containers, and utensils shall be used for the serving of foods.
- Children shall be in table groups no larger than age group defined ratios.
- Teachers shall supervise and interact with children during the meal service.
- A second serving may be offered to the child, but it is important that the teacher not contact the child's plate or bowl with the serving utensil.
- If a child is "mildly" ill, a provision for serving that child shall be provided.
- Discard any leftover food brought to the table and not eaten.
- Children and staff shall wash their hands after the meal service.
- Clean and sanitize the table after each use.
- For certified homes/child care centers check CCD rules.

Storage and Handling of Food

The proper storage and the safe handling of foods are important practices in preventing contamination and food illnesses in the child care setting. The following are recommended guidelines suggested in creating and maintaining a safe and healthy environment for children in care.

- Accept and use only foods that are from an approved source. Approved in this context shall mean food and beverages that have been processed and inspected by a governmental regulatory agency (USDA, FDA, Oregon Department of Agriculture, or similar agencies).
- Wash hands by using soap and water for at least 20 seconds before food preparation and serving. Hands should be dried using a disposable paper towel. Avoid the use of latex gloves because of possible allergic reactions. Vinyl and polyvinyl food grade gloves may be substituted.
- Do not prepare or served foods if symptoms of illness (nausea, vomiting, diarrhea, etc) are present.
- Storage areas include pantries, shelves and cabinets and refrigeration or freezer equipment.
- Dry product storage of food should be elevated off the floor a minimum of 6 inches or on properly designed storage shelving or platforms. This will include any paper or disposable service items.
- Keep the food preparation and storage area clean.
- Clean, Separate (don't cross-contaminate). Cook and Chill guidelines are followed.
- Refrigerator air temperatures are 41 degrees F. or colder.
- Freezer storage at 0 degrees or colder.
- Cook foods to safe temperatures following Food Service Certificate/Training guidelines. Foods should be checked using a metal stem thermometer.
- Label and date any leftovers, refrigerate and cool quickly using food safety guidelines described in Food Service Certificate Training.
- Discard any food or beverage items that are questionable. "If in doubt, throw it out."
- By following safe storage and food handling in the child care setting environment, children and staff will benefit by avoiding food illnesses caused by mishandling.
- Website links: http//www.fightbac.org/main.cfm
  http//www.cdc.gov/foodsafety/
  http//mchealthinspect.org

Adapted from Safe N' Sound Child Care Health and Safety Tips
Multnomah County 6/25/2008

Hand Washing

Hand washing is probably the single most effective and important way to decrease the spread of communicable diseases. This fact cannot be over emphasized.

Hands must be washed under warm running water with soap for 10 to 20 seconds. Create friction by rubbing hands together both front and back. This friction helps get rid of germs. Dry your hands before turning off the water. Use a single towel or disposable towel to thoroughly dry each hand then turn off the faucet with the paper towel to prevent contaminating your hands with germs that might be on the faucet. The paper towel waste receptacle should be placed close to the door so the door can be opened with a paper towel prior to disposing the towel. If bar soap is used, it must be kept in a soap dish that is dry and clean; if a soap dispenser is used, the dispenser must be kept clean. Limit the amount of jewelry worn as germs and food particles may be trapped under rings, bracelets, and/or watches. Keep fingernails short and clean under nails when washing hands.

Child Care Professionals should wash their hands:

- When arriving at child care or starting the day.
- Before preparing, handling, or serving food or eating.
- After using the toilet, assisting children with toileting, or changing diapers.
- After contact with body fluids or secretions (nasal secretions, saliva, etc.).
- After handling or caring for pets or cleaning their cages.
- Before and after administering any type of medication, or applying ointments or creams.
- After cleaning surfaces or toys.
- Whenever hands are visibly soiled.
- Before leaving work.
- Before and after eating or feeding children.
- After handling trash or taking out the garbage.

Children should wash their hands:

- Upon arrival.
- Before food activities or eating.
- After contact with body fluids.
- Before and after playing outside.
- After contact with body fluids.
- After handling or feeding animals/pets, or handling their cages.
- When their hands are visibly soiled.
- Before leaving child care for the day.

In order for hand washing to be effective against the spread of communicable diseases, hand washing must occur frequently and be a part of the program's curriculum and daily activities.

Adapted from Safe N' Sound Child Care Health and Safety Tips
Multnomah County 6/25/2008

Bathing Infants

Although not a common practice, a policy for bathing infants is required if it is a frequent practice in the child care setting. These recommendations may be used for the times infant bathing occurs.

- Plan ahead. Prepare the area with clean clothing, wash cloth and soap, a clean bassinette and other items needed for bathing.
- Monitor the water temperature. It should not exceed 120 degrees F. An ideal water temperature would be around 104 degrees F. Test the water with your hand before placing the infant in the bassinette. Remember burns may occur quickly on the infant's skin.
- After bathing, return the infant to the normal activity area.
- Clean the area, place the used washcloth and (clothing) in a container for later laundering or to be sent home with the parents.
- Wash the bassinette, rinse, and apply the sanitizer. Store the bassinette in a clean and dust free area.

Adapted from Safe N' Sound Child Care Health and Safety Tips
Multnomah County 6/25/2008

Pets in Child Care Settings

Policy: Exposure of children to infections and injury associated with pets will be minimized. Animals in the home or child care center should be appropriate to the age of children.
Rationale: The feces of any animal may be infectious. Feces of iguanas, turtles, lizards, some birds, puppies, kittens, or any other animal that does not appear active or healthy may be infectious. Some children may be allergic to animal fur or feathers. Aggressive, frightened, or injured animals may bite or unexpectedly jump on children.

It is recommended that:

- All animals will be healthy appearing and friendly. Children will be closely supervised. Loud and rough activity that may frighten, excite or injure animals is not allowed.
- Dogs, cats, and other animals requiring immunizations as recommended by the National Association of State Public Health Veterinarians will be current in those immunizations.
- All animals will be free of fleas, ticks, and skin disorders.
- Animals that are not "house or litter boxed trained" will be kept confined to minimize risk of fecal contamination of the children's environment.
- Children shall not clean cages, aquariums, or litter boxes.
- Animal waste will be cleaned promptly. Waste can be disposed of by flushing waste in the toilet or placing it in a plastic bag and into a garbage container. Avoid disposing of any type of cat litter in the toilet (may clog your waste line).
- If children are allowed to handle pets, they will immediately and thoroughly wash their hands after handling. It is also a good idea to have children wash their hands before handling pets to prevent human illness spreading to pets.
- Providers who clean cages, aquariums, terrariums, litter boxes, interior accidents, and outside play activity areas will immediately and thoroughly wash their hands. Cleaning of cages and animal enclosures will be scheduled after children have the home or center. It is recommended that someone preparing food avoid cleaning the pet environment. Always wash your hands before any food preparation activity.
- Cages, aquariums, terrariums, and litter boxes should not be cleaned in the kitchen or eating spaces. Pet food and other pet supplies should be stored separately from human food. Pet food will be stored in a manner that does not attract rodents or insects.

Oregon Child Care rules may vary by type of child care. Questions? Call Oregon Child Care Division 1 800 556-6616.

Adapted from Safe N' Sound Child Care Health and Safety Tips
Multnomah County 6/25/2008

Restrictable Diseases

Child Care facilities are required to restrict children and providers who are ill with certain diseases. This helps prevent the spread of diseases to others in child care. Any child or provider who has a restrictable disease should not come to the child care facility until a health care provider determines that they are no longer contagious to others. By the time child care providers hear about these diseases, the disease has already been diagnosed by a health care provider. Restrictable diseases include the following:

- Chicken pox
- Diphtheria
- Enterohemorrhagic E. Coli
- Food poisoning or waterborne illnesses
- Hepatitis A
- Measles
- Pertussis (Whooping Cough)
- Rubella
- Salmonellosis (including Typhoid)
- Scabies
- Shigellosis
- Streptococcal infection
- Staphylococcus infection
- Tuberculosis
- Any illness accompanied by diarrhea and vomiting

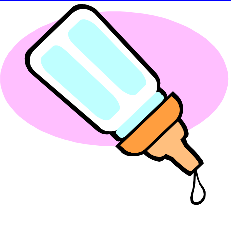
In addition, if any of the following occurs, contact the Communicable Disease Office (see phone number below).

- Whenever there is a single case of meningitis or bacteremia (infection of blood) within the facility.
- Whenever 3 or more children or staff in the facility has diarrhea, vomiting, or other gastrointestinal symptoms during a 7 day period.
- Whenever there are 2 or more cases of diagnosed strep throat among children or staff in a home or classroom in a 7 day period.
- Whenever a child or staff member develops jaundice (yellow discoloration of skin or eyes) or is diagnosed with hepatitis.

Call you county Health Department with any questions or concerns. Contact information can be found at: http://public.health.oregon.gov/ProviderPartnerResources/LocalHealthDepartmentResources/Pages/lhd.aspx

Adapted from Safe N' Sound Child Care Health and Safety Tips
Multnomah County 6/25/2008

Serving of formula, storage, and handling of bottles and feeding infants



Safe handling of formula, breast milk, bottles, and infant foods is necessary to ensure the health and safety of infants in care. The following are some helpful tips. We recommend that child care providers develop a routine policy so that staff consistently follow these practices. We acknowledge that feeding practices vary from culture to culture and must be respected.**

Bottle/Food Preparation Area:

- Before handling or preparing bottles or food, staff should wash their hands.
- Preparation surfaces should be cleaned and sanitized before preparing formula/breast milk.
- Never heat/reheat infant foods, breast milk, or formula in the microwave. Uneven hot spots may occur.
- If a crock-pot is used to warm milk, do not exceed 120 degrees F. Use a clean container (porcelain, stainless, or other suitable material) with heated water and immerse the bottle for 5 minutes. Test the formula or breast milk for temperature before feeding. Never leave bottles in a crock-pot or warm water until another feeding period, because bacteria can grow. Clean and wash the crock-pot or container used as a warmer. The crock-pot should be kept inaccessible to children.

Bottle Labeling and Cleaning:

- Label bottles with child's full name and date prepared. Recheck label for child's name before feeding.
- Used bottles, if brought from home, should be rinsed and returned to the parents at the end of the day.
- At home, bottles, caps, and nipples should be washed in a dishwasher or washed, rinsed and boiled for one minute. Centers should use the commercial dishwasher for sanitizing or boil.

Refrigeration:

- Full bottles should be refrigerated immediately upon arrival at the center or after mixing, unless being fed to an infant immediately (refrigerator temperature should be 41 degrees F or colder).
- Used bottles should not be placed in the refrigerator for later use; discard leftover milk after feeding.
- Bottles should be stored in the coldest part of the refrigerator (avoid placing in the refrigerator door.)

Feeding Practice:

- Infants should be fed on demand, held by a care provider who looks, talks to, and touches infant in nurturing way. Infants should be fed when they exhibit hunger cues (searching for bottle/breast, sucking on hands, bringing hands to mouth, turning to care provider for food, etc.) and feeding ended when infant signals fullness (falling asleep, pushing bottle out of mouth, decreased sucking, relaxing or pulling/pushing away).
- Nipple covers should be used on all bottles. A clean plastic sandwich bag may be used
- Contents of bottle should be discarded after 1 hour of removing from the refrigerator to prevent bacterial growth in milk.
- Infants should be held when fed until they are able to hold their own bottle or can drink from a cup. Bottles should never be propped. Infants able to hold their own bottle should be held or seated while feeding; infants should not be allowed to walk around with food, bottles, or cups.
- Cup drinking and spoon feeding should be introduced by 9 months of age or when it is developmentally appropriate. Wash and sanitize bottles, cups, and tableware after feeding.

Contents of Bottle:

- We recommend breast milk or iron fortified formula for infants 12 months of age or younger.
- Written permission from the child's licensed health provider is required if any infant is to be on pedialyte or on a special diet.
- No honey, or products made with honey, should be given to infants less than 12 months old due to the risk of botulism.

Adapted from Safe N' Sound Child Care Health and Safety Tips
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Formula:

- Ideally, families will provide individually labeled bottles for their child daily. Covered bottles should be brought to the setting each day and returned to the child's family when the child leaves. If formula mixing is required, it is important for the infant's health that it be prepared correctly and stored safely.
- Powdered formula should be dated when opened, stored in a cool, dark place and used before the expiration date. Unused portions should be discarded or sent home 1 month after opening. Providers should use the scoop that comes with the can and not interchange the scoop from one product to another.
- Formula provided by parents or by the facility should come in a factory-sealed container, be the same brand of formula used at home and prepared according to the manufacturer's instructions using water from a source approved by the health department.*
- An open container of ready to feed or concentrated formula must be covered, refrigerated, and discarded after 48 hours if not used.
- Formula prepared in advance must be stored in the refrigerator and consumed within 24 hours or discarded.
- Use water from the food preparation sink. Allow cool water to run from faucet for 1 minute before using.
- If your home is on a well, your water should be tested annually for contaminants. Oregon Child Care rules vary by type of child care. Questions? Call Oregon Child Care Division 1 800 556-6616.
- To prevent burns, do not hold the infant while removing bottle from warm water. After warming, mix gently and check temperature of formula before feeding infant.

Breast Milk:

- Special handling of breast milk is required to eliminate nutritional breakdown of milk and prevent giving the milk to another infant. Breast milk and formula should not be heated above 120 degrees F for more than 5 minutes.
- Breast milk may be stored in a self-contained freezer unit (separate from refrigerator with its own outside door) for up to 3 months or in a freezer compartment inside the refrigerator for 2 weeks. The milk should be labeled with the child's name, date and time milk was expressed, and sealed in a plastic bag or container.
- Breast milk should be thawed using cool running water or thawed under refrigeration. Thawed breast milk should be used within 24 hours and not refrozen.
- If breast milk is freshly pumped, it must be refrigerated immediately and used within 48 hours or put in freezer
- Storage of breast milk in amounts of 2-4 ounces might help reduce waste.
- Discard breast milk if it is in an unsanitary bottle, has been left unrefrigerated for more than 1 hour, or if feeding of that bottle exceeded an hour.
- Breast milk should be stored in 1) hard sided plastic or glass containers with well fitting tops, 2) freezer milk bags that are designed for storing breast milk. Disposable bottle liners are not adequate as they may leak or break if punctured.
- Breast milk should be transported from home to child care setting in a cooler bag with ice packs as long as air temperature is below 86 degrees F. and out of the refrigerator time is less than 2 hours.
- Shake bottle before feeding if refrigerated and thawed to evenly distribute the fat layer.

Information about formula and breast milk preparation/storage was obtained from the Child Care Food Handler Manual.

* Please check with local health department regarding the need for boiling water.
** It is recommended that USDA CACFP participants check with their sponsor regarding infant guidelines.

Symptoms That Require Family Notification and Exclusion

- Diarrhea: more than 1 watery stool or 1 bloody stool, if not caused by dietary changes, medications, or passing hard stool.
- Persistent stomach pain or intermittent pain with fever and/or other symptoms.
- Pink or red conjunctiva (whites of the eyes) with white or yellow mucous (pus) draining from the eye Fever: a child with a fever of 100 degrees F. or more, measured under the arm must be excluded from child care*, especially when fever is accompanied by changes in behavior or other signs of illness such as sore throat, rash, vomiting, diarrhea, or earache, etc. It is recommended that a health provider examine an infant less that the age of 4 months who has an unexplained fever.
- Body rash, especially with fever, itching, sores or changes in behavior.
- Sick appearance and not feeling good: unusually tired, pale, not hungry, confused or irritable, or not being able to keep up with program activities or requires more attention than you can provide without compromising the health and safety of other children in your care.
- Sore throat with fever or swollen glands in the neck or mouth sores with drooling.
- Vomiting two or more times in the last 24 hours.

These symptoms may indicate an illness that may be contagious to others. It is recommended that the family seek advice from their health provider if these symptoms are present. If the child is in care, the child's family should be notified to pick up their child from the care. The child should be separated from others, in the extent possible, until he/she leaves care.**

Following an illness, children will be readmitted to care when they no longer have any symptoms or experience discomfort, or their health provider determines they are no longer contagious to others in care.

Staff members will follow the same exclusion criteria for themselves.

* Refer to Child Care Division rules for Certified Family Child Care Homes and Child Care Centers on exclusion based on fever.
**Note: See OAR 333-019-0010 and Child Care Division regulations for additional restrictable diseases. Refer to Child Care Division rules on isolation of ill children in Child Care Centers and Certified Family Child Care Homes.
Reference: Managing Infectious Diseases in Child Care and Schools A Quick Reference Guide, AAP Department of Marketing and Publications Staff, 2005

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Multnomah County 6/25/2008

Tooth Brushing

- Do not share toothbrushes. The exchange of body fluids that such sharing would foster places toothbrush sharers at an increased risk for infections, a particularly important consideration for persons with compromised immune systems or infectious diseases.
- After brushing, rinse toothbrushes thoroughly with tap water to ensure the removal of toothpaste and debris, allow it to air-dry, and store it in an upright position. If multiple brushes are stored in the same holder, do not allow them to drip or contact each other.
- It is not necessary to soak toothbrushes in disinfecting solutions or mouthwash. This practice actually may lead to cross-contamination of toothbrushes if the same disinfectant solution is used over a period of time or by multiple users.
- It is also unnecessary to use dishwashers, microwaves or ultraviolet devices to disinfect toothbrushes. These measures may damage the toothbrush.
- Do not routinely cover toothbrushes or store them in closed containers. Such conditions (a humid environment) are more conducive to bacterial growth than the open air.
- Replace toothbrushes every 3-4 months, or sooner, if the bristles appear worn or splayed. This recommendation of the American Dental Association is based on the unexpected wear of the toothbrush and its subsequent loss of mechanical effectiveness, not on its bacterial contamination.

Tooth brushing Programs in Schools and Group Settings:

Tooth brushing in group settings should always be supervised to ensure that toothbrushes are not shared and that they are handled properly. The likelihood of toothbrushes cross-contamination in these environments is very high, either through children playing with them or toothbrushes being stored improperly. In addition, a small chance exists that toothbrushes could become contaminated with blood during brushing. Although the risk for disease transmission through toothbrushes is still minimal, it is potential cause for concern. Therefore, officials in charge of tooth brushing programs in these settings should evaluate their programs carefully.

Recommended Measures for Hygienic Tooth Brushing in Schools:

- Ensure that each child has his or her own toothbrush, clearly marked with identification. Do not allow children to share or borrow toothbrushes.
- To prevent cross contamination of the toothpaste tube, ensure that a pea-sized amount of toothpaste is always dispensed onto a piece of wax paper before dispensing any onto the toothbrush. For children less than 3 years of age, use a rice grain size amount of toothpaste.
- After the children finish brushing, ensure that they rinse their toothbrushes thoroughly with tap water, allow them to air-dry, and store them so they cannot contact those of other children.
- Provide children with paper cups to use for rinsing after they finish brushing. Do not allow them to share cups, and ensure that they dispose of the cups properly after a single use.

AMERICANS WITH DISABILITIES ACT (ADA) INFORMATION FOR CHILDCARE PROVIDERS

Childcare Providers are Covered by the ADA

The ADA[1] was passed by Congress to bring Americans with disabilities into mainstream American society. It states that individuals with disabilities have the same right to public and private services as all Americans. The act covers adults and children with many permanent disabilities such as mental retardation, autism, and hearing impairments.[2] As a childcare provider you must be aware of this law. You are required to comply with the ADA because you provide services to the public.[3]

Some parts of the ADA are quite complex, but in simple terms, it requires almost all service providers and businesses to take reasonable steps to serve people with disabilities in their programs. This means that children and adults with disabilities receive the same services that are available to others. Virtually all childcare providers must comply with the ADA. Private providers that serve the public as businesses are covered by Title III of the ADA.

Parents who believe that their children's (or their own) rights under the ADA have been violated by a childcare provider can file a federal lawsuit and/or a complaint with the Bureau of Oregon Labor and Industry (BOLI.)

ADA Reasonable Accommodations for Children with Disabilities

As a child care provider, you cannot refuse to serve children with disabilities or their families simply because the children have disabilities, or because they might require more time or attention from you or your staff. Typical reasonable steps you might be required to take include providing additional training for staff, obtaining information or consultation from a professional with knowledge of the child's disability, reassigning staff responsibilities, hiring additional staff, or making physical changes to accommodate a wheelchair.

A child with autism for instance, might require 1-on-1 assistance during transition times from one activity to another. Even if you are a family child care provider who works alone you can make reasonable accommodations. For example, serving a child with emotional disabilities might require that you follow a behavior plan designed to minimize emotional outbursts or anxiety. A child's parent, teacher or therapist can help you make these types of necessary accommodations.

Under the ADA you cannot charge more to care for a child who has a disability. Similarly, you cannot add charges for serving a child with disabilities unless the additional charge applies equally to children without disabilities. There are exceptions. For instance, courts have decided that you can charge more to serve children with disabilities who wear diapers, but only **if** you charge more for all children who wear diapers. The same principle generally applies to other "extra" charges.

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[1] The Americans with Disabilities Act is Public Law 101-336 and can be found in the U.S. Code at 42 USC 12101 et. seq.

[2] The ADA definition of a disability is a physical or mental impairment that substantially limits one or more major life activity. Temporary impairments such as broken arms and colds are not covered by the ADA.

[3] Centers that are operated by religious organizations are not generally subject to ADA requirements. Title II of the ADA applies to government agencies and other groups or businesses (including childcare providers) who receive government money.

The law related to this sort of thing is probably more complicated than something you want to look at without legal help, but in simple terms:

1. You cannot charge extra for anything that affects only children with disabilities;

2. You cannot refuse to serve a child with disabilities unless the extra costs and changes involved are so large that they will put you out of business or fundamentally alter your program.

Limits of ADA Responsibilities

The ADA does **not** require you to serve children with disabilities if doing so would directly threaten the safety of others, even with modifications or added extra staffing to make the situation safe. Also, the ADA does not demand that you make modifications that would fundamentally change the nature of your program or impose an undue financial burden upon you. Whether the modifications needed to serve a particular child would fundamentally alter the nature of your program or impose an undue burden are complex questions that you should not take on without legal advice.

Three indicators that you may need legal advice are:

1. Making decisions about whether you can serve a child with disabilities based on your general beliefs or past experience with a disability rather than specific facts about the child;

2. Changing or ignoring written policies or changing the way you have done things in the past when a child with disabilities wants to enter your program (for example, changing your process for an initial interview);

3. Adding a charge that affects only children with disabilities even if the explanation for it does not specifically mention disabilities.

Additional Resources

A more detailed set of questions and answers about childcare and the ADA is available at http://www.ada.gov/childq%26a.htm or through the U.S. Department of Justice ADA website at www.ada.gov. DOJ also operates a toll-free ADA hotline at 800-514-0301 (voice) or 800 514 0383 (TDD) that will answer specific questions about the ADA.

The Inclusive Childcare Program operated by the Oregon Council on Developmental Disabilities is a statewide resource that can provide information and materials on the ADA and child care. The program may also have other resources to help you serve children with disabilities. You can contact the program toll-free at 866-837-0250.

BANANAS HANDOUT

Inclusion – Caring for Children with Special Needs

One of the strengths of our community is its diversity. People from different cultural and racial backgrounds, people from different family units, as well as individuals with disabilities all live here. The mandate of the Americans with Disabilities Act (ADA), a federal civil rights law passed in 1990, is to provide people with disabilities access to all community services – including child care. The purpose of this Handout is to help you, the child care provider, include children with disabilities or special needs in your program; this is called inclusion, or inclusive child care.

The Child With Special Needs

A child with special needs is one who, because of physical or emotional reasons, requires some special care. The kinds of disabilities children may have vary greatly, ranging from children with allergies or developmental delays, to a child suffering from a terminal illness. The most important thing to remember is that all children are individuals and should be respected. Following are some basic ideas to keep in mind when caring for children with special needs:

- Children with disabilities are more like other children than they are different. They need the same emotional support all children do and a safe, nurturing environment with caregivers who respect their individual developmental needs.
- All children should be encouraged to help themselves as much as they can. A balance is necessary: allow freedom and choices and offer assistance when needed.
- Children like to follow some kind of routine – include exercise, play, good food, and fresh air in your program.
- All children benefit from an individualized approach while learning to participate in group activities.

A quality program, where staff understand the principles of child development, will have the necessary foundation to meet the needs of all children, including those of children with special needs.

Inclusion

All parents at some time need child care and this includes parents who have children with disabilities. The ADA prohibits discrimination against children with disabilities by any child care center or family child care home. Under this law, a licensed child care provider must evaluate the needs of each individual child seeking to enroll or already enrolled and must make and document every **reasonable accommodation** to include and serve that individual.

When a parent seeks to enroll a child with a disability in your child care program, this offers a valuable opportunity for you to expand your skills as a professional caregiver. As with any child, it is your job to find out (from the parent) the individual strengths, challenges and needs of the child's care. Then, find out and develop a plan for how your program will make accommodations to fully include this child.

Begin by thinking about the main activities of your program, such as snack or mealtime, outdoor play, creative play and toileting. Next, put yourself in the shoes of the child you are enrolling: how inviting or playful is each setting to him or her? You will find that most adjustments or accommodations you need to make are not very difficult, such as rearranging some furniture so that a child with a walker can move freely, or training staff to administer an inhaler for a child with asthma. You should be able to fully include most children by making such reasonable accommodations as required by the ADA. Unless admitting a child with a disability requires extreme changes that significantly alter your program, you should be able to fully include the child.

Everyone benefits from inclusive child care programs. The child who has special needs benefits from time spent with typically developing children through learning, playing and friendship. All children learn the importance of diversity, tolerance and relationships. Parents also benefit from an early childhood program that reflects a diversity of strengths, needs and a commitment to include all children.

BANANAS Child Care Information & Referral • 5232 Claremont Ave., Oakland, CA 94618 • 658-7353 • www.bananasinc.org

Caring For A Child with Special Needs

A careful interview and a visit with the family will help you learn how you can provide a safe and positive environment for each child. It is usually more helpful to know a child's strengths and challenges rather than a medical diagnosis to meet his or her needs. Consider asking the parents the following questions.

- What kinds of activities does your child enjoy? What does she do well?
- How does your child communicate her needs?
- How does your child get around (walking, crawling, with braces, or a walker, etc.)?
- What other group experiences has your child had? How does she interact with other children and/or adults?
- Is your child on a special diet and how does she eat?
- Does your child need help with toileting or diapering? If so, what type is needed?
- Is your child taking any medication or receiving any medical treatments? What do I need to know about the medication or treatment?
- What are your child's special needs?
- What are your social or educational expectations for your child in care? Can you help me get a sense of what you want for your child?
- Are there other health professionals, special education, or early intervention programs (for children ages 0-3) that are helping you and your child? Do you think their staff would be willing to work with me in the child care setting with your consent? Can I get your written consent to contact them?
- What, if any, special skills or training will I or my staff need?

These questions can help determine what accommodations are needed, but cannot be used to screen out a child. Ongoing communication between parents and providers is essential. In order to be adaptable and make necessary accommodations, you may need to meet regularly with the child's parents.

Over time, as you get to know the child, you may identify other needs. Please refer to the Early Warning Signs list in BANANAS' Child Care Providers' Guide to Identifying and Caring for Children with Special Needs, $3 per pamphlet. Call 658-7353 for more information.

Making Accommodations In Your Policies

The ADA requires that you attempt to provide care for a child with special needs by drawing on your knowledge of child development and by obtaining information from the parent on the needs of each child. Following is a list of ways that providers can develop their inclusive child care programs as they comply with the ADA:

- Develop admissions policies that do not discriminate against children with disabilities and do not charge more to the parents of a child with special needs.
- When hiring staff, ask about their experience with caring for individuals with disabilities.
- Make reasonable modifications to the policies, practices and procedures of your program. This means significant attempts must be made to include a child with disabilities into the program. Care providers could include language of their policies to this effect. For example: Rainbow Day Care is "fully accessible" or, "our teachers have experience in caring for children with disabilities."
- Provide resources for effective communication between caregiver and child. For example, providing large-print books, using picture cards, or learning some sign language.
- Comply with physical access requirements.

Making Accommodations In Your Program

Many of the accommodations children need can be easily planned and put into practice. Following are brief descriptions of general disabilities and some sample accommodations. Some children may have one identified special need, other children may have multiple disabilities.

Communication/Language – A child with a disability in this area may have difficulty speaking or understanding speech. Expressing needs or understanding rules and instructions may be difficult and frustrating for this child. Repeat what the child says and add missing words, or ask the child to repeat what you are saying. Build on what the child says by adding new information.

Developmental – A child who is developmentally delayed grows and develops more slowly than other children. Physical, mental and emotional development may all be affected by the disability. Use simple words to teach new concepts and repeat as often as needed. Make sure to break tasks and information into simple, small steps that are easier to grasp. Give clear, simple directions, providing structure and consistency. Label objects with pictures and words.

Emotional/Behavioral – A child with this disability may need help learning how to relate to others and how to follow daily routines. Tell the child of upcoming changes ahead of time to help the child deal with transitions: "We're almost done with snack time. In a little while, we'll all go outside to play." Provide the child with a safe emotional outlet for anger or fear. For example, tell an angry child that it is **not** OK to hit another person, but it **is** OK to hit a pillow.

Hearing – A child with a hearing impairment may have significant hearing loss or be deaf. Make direct eye contact with the child so she knows you are talking to her and can see your lips and/or signs. Set up play space so it is visibly accessible to all children; blink the lights to signify transitions in the day.

Learning – Children with a learning disability may need help because they learn in different ways. For instance, a child who has difficulty remembering may need very detailed, step-by-step instructions. Because learning in traditional ways is frustrating for some children, they may act out with other, challenging behavior. Provide activities that appeal to children with different learning styles. The more visually inclined children will enjoy looking at picture books. Those who learn through touching will prefer hands-on activities, like finger-painting, or helping in the garden.

Physical – A child with a physical disability may have limited movement or require adaptive equipment such as braces, a walker or wheelchair. Rearrange furniture, install a grab bar in the bathroom, or set up a temporary or permanent wheelchair ramp for children who would benefit from an easier entry to the program.

Special Health Care Needs – This child may require specialized care for a health problem such as asthma, diabetes, epilepsy, sickle cell anemia, or for a terminal illness. Learn from the parent or other providers in the child's life how to use an asthma nebulizer, or how to check the child's blood glucose level.

Vision – Children who are visually impaired cannot see well or are blind. They will rely more on hearing and touch to learn. Provide large print or Braille books, audiobooks and toys that offer auditory and sensory stimulation (noises and textures). Store toys so children can reach them independently.

For more information about your responsibilities under the ADA, contact BANANAS (or your local resource and referral agency). In some cases, additional training may be helpful or necessary to you as a professional caregiver. Classes and workshops are available from a variety of organizations. Contact your Professional Growth/Career Advisor for information on training opportunities on disabilities and inclusion issues. You can also visit the provider page of our website, **www.bananasinc.org**, to view our current listings of Professional Growth opportunities.

Getting Help

As a child care provider, advice and assistance are available to you from many sources:

Parents – Share your observations with them, consult them and keep in close contact. Ask them about strategies they use at home, and what agencies or individuals work with their child, especially those who may be able to help you. Ask for a copy of a child's **Individual Family Service Plan** (IFSP) for children 0-3, or **Individual Education Plan** (IEP) for children older than 3, or other plans that will help you learn more about what the child is learning, or what skills he is working on. See if the parents will grant permission (written consent) to contact members of the child's "team."

Consultants – BANANAS has a Warmline (658-7353) staffed with counselors who can help parents and providers with questions on developmental or behavioral issues. In addition, a mental health specialist is available to provide on-site consultations for children ages 0-5.

Agencies – Seek out services that work with the families of children with special needs. Staff at BANANAS can help you find the right organizations.

Written Materials – You may want to read more about the child's disability, but remember that each child is an individual and that parents really are the experts on their child(ren).

Because caring for children with special needs depends on the particular child with a particular disability, much of what you will be learning is O.J.T. (On the Job Training). But don't worry. BANANAS is here to offer advice and support, and to help you plan and find resources you need to work with all children in your care. BANANAS also has a reference library of books, videos, and children's books on child care and inclusion.

Other Support and Resources

Family Resource Network (FRN) provides resources and support to Alameda County families whose children, birth to 22 years, have disabilities or special health care needs. With offices at BANANAS, FRN also assists professionals who are working with a child or family, or who have concerns about a child's development. They offer workshops, classes, and support groups. All FRN staff members are parents of children with disabilities and understand the services children and families need.

This organization also maintains a lending library containing adult and children's books and videos on disabilities. It publishes a comprehensive directory in English and Spanish of special resources for families in need, free for parents, $4 for providers. All services are free and available in English, Spanish, and Vietnamese. Call 547-7322 or visit **www.frnoakland.org** for more information.

Child Care Law Center (CCLC) works to ensure quality, affordable child care for all children. CCLC produces and distributes publications on a wide range of legal issues related to child care. Following are some on inclusion of children with disabilities available in English, Spanish and Chinese.

- Questions and Answers About the Americans with Disabilities Act: A Quick Reference (Information for Child Care Providers)
- ADA Title III Flowchart: When Are You Required to Admit a Child with a Disability?
- Caring for Children with Special Needs: The Americans with Disabilities Act (ADA) and Child Care – a manual that covers multiple aspects of what the law requires of child care providers and how to integrate children with special needs into child care programs most effectively
- Can I Provide This Type of Health Procedure In Licensed Child Care? – a manual that addresses health-related procedures allowed in California child care programs

CCLC has other relevant publications as well. Call (415) 394-7144 to download or order any publications or visit **www.childcarelaw.org.**

The following organizations also provide information on caring for children with disabilities:

- California Early Start Library, managed by Early Source Resources:
  (800) 869-4337, **www.dds.ca.gov/earlystart.**
- Child Care Plus+ Center on Inclusion in Early Childhood:
  (800) 235-4122, **www.ccplus.org.**
- Exceptional Parent Magazine
  (877) 372-7368, **www.exceptionalparent.com.**
- Healthy Young Children – A Manual for Programs by the NAEYC:
  (800) 424-2460, **www.naeyc.org.**
- National Information Center for Children and Youth with Disabilities (NICHCY):
  (800) 695-0285, **www.nichcy.org.**

Children's Book Resources

The books you choose for your program and read to children should reflect the diversity of the world around us. Following are some resources:

- **Special Needs Project** offers listings of good books about disabilities:
  (800) 333-6867, **www.specialneeds.com**.
- **Jason & Nordic Publishers** present award-winning Turtle Books for children with disabilities, their families and friends:
  (814) 696-2920, **www.jasonandnordic.com**.
- **Garlic Press** includes books and resources on sign language:
  (541) 345-0063, **www.garlicpress.com**.
- **Ten Quick Ways to Analyze Children's Books for Bias Against People with Disabilities.** Call BANANAS for a copy of this manual, or to review our library of good children's books about people with disabilities:
  (510) 658-7353, **www.bananasinc.org**.

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Emergency Information Form for Children With Special Needs

Last name:

American Academy of Pediatrics

Date form completed By Whom	Revised	Initials
	Revised	Initials

Name:	Birth date: Nickname:
Home Address:	Home/Work Phone:
Parent/Guardian:	Emergency Contact Names & Relationship:
Signature/Consent*:	
Primary Language:	Phone Number(s):

Physicians:

Primary care physician:	Emergency Phone:
	Fax:
Current Specialty physician: Specialty:	Emergency Phone:
	Fax:
Current Specialty physician: Specialty:	Emergency Phone:
	Fax:
Anticipated Primary ED:	Pharmacy:
Anticipated Tertiary Care Center:	

Diagnoses/Past Procedures/Physical Exam:

1 .	Baseline physical findings:
2.	
3.	Baseline vital signs:
4.	
Synopsis:	
	Baseline neurological status:

*Consent for release of this form to health care providers

Diagnoses/Past Procedures/Physical Exam continued:

Medications:

1.
2.
3.
4.
5.
6.

Significant baseline ancillary findings (lab, x-ray, ECG):

Prostheses/Appliances/Advanced Technology Devices:

Management Data:

Allergies: Medications/Foods to be avoided	and why:
1.	
2.	
3.	

Procedures to be avoided	and why:
1.	
2.	
3.	

Immunizations

Dates					
DPT					
OPV					
MMR					
HIB					

Dates					
Hep B					
Varicella					
TB status					
Other					

Antibiotic prophylaxis: Indication: Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: **Print Name:**

Last name:

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Inclusive Child Care Program

DHS High Need Child Care Rate Information for Parents and Child Care Providers

Introduction to the Inclusive Child Care Program (ICCP)

We are a program of the Oregon Council on Developmental Disabilities. We do a variety of things related to child care for children and youth who have disabilities, emotional or behavioral disorders, or special health care needs.

ICCP staff are not part of the Oregon Department of Human Services (DHS) Child Care Program. DHS refers children to ICCP. Our job is to evaluate whether the child requires an individualized High Need Rate for safe and healthy child care.

What is the DHS High Need Rate?

The DHS High Need Rate is for children and youth who meet these two criteria:

1) The child has disabilities or other special needs; AND
2) The child requires an exceptionally high level of care and supervision compared to others the same age.

The High Need Rate can be different for each child. The amount depends upon the child's specific abilities and needs. The ICCP assessment helps determine how much the rate will be.

How is the High Need Rate different from the Special Needs Rate?

Most children who have disabilities, emotional/behavioral disorders, or special health care needs can receive appropriate care at the DHS *Special Needs Rate*. Parents can request the Special Needs Rate by completing DHS Form # 7486 and returning it to the family's caseworker.

The *High Need Rate* is for the small number of children whose care and supervision needs are so high that they may not be able to receive appropriate care at the Special Needs Rate.

What are the steps in the High Need Rate assessment process?

Here are the steps:

1) DHS makes the assessment referral to ICCP. A parent, a provider or a family's caseworker can contact us to ask about the referral process.

2) After ICCP receives the referral, we contact parents and providers to arrange the assessment. Usually this is a face-to-face meeting with the parent and provider. We will come to the child care setting or the parent's home.

3) At the meeting we will ask questions about the child's needs in child care. We record the information on the High Need Child Care Rating Scale.

4) We will ask for supporting documentation. This may be an Early Intervention plan, special education plan, mental health evaluation, or other information from professionals who are the familiar with the child's abilities and needs. The assessment will not be complete until we have received and reviewed this information.

5) After the assessment meeting, we review notes from the meeting and the supporting documents. We use this information to score the High Need Child Care Rating Scale.

6) We submit a recommended rate to DHS for approval. This will include a recommend start date for the High Need Rate. In some cases we may recommend that a High Need Rate is not needed.

7) DHS will notify us when the rate is approved or not approved. We then contact parents and providers to explain the rate and payment process. We will also write a plan for the rate and send it to parents and providers for their approval.

8) DHS will also notify someone at the local branch that the rate is approved. The local branch will make each monthly High Need Rate payment.

What if the High Need Rate payment doesn't arrive?
ICCP staff are not directly involved in the DHS payments. We have information on the payment system, so parents and child care providers are welcome to contact us if there are repeated payment problems.

Questions? Call 1-866-837-0250 or 971-673-2286 in the Portland metro area.

The Oregon Department of Human Services Child Care Program
Special Needs Rate and High Need Rate:

How are they different?

1. How much is the rate?

Special Needs rate	High Need rate
The DHS *Special Needs Rate* is a fixed amount for all children in a specific geographic area and type of care. For example, in some areas the special needs rate for all children in registered family child care is $2.50 per hour or $455 for a monthly rate. The DHS Parent and Provider Guides list the specific amounts for each area and type of care.	The *High Need Rate* is different for each child. The ICCP assessment is used to determine the amount. The *High Need Rate* is added to Special Needs Rate. The total provider payment is the Special Needs Rate + the High Need Rate.

2. Who authorizes the rate?

Special Needs rate	High Need rate
A family's DHS caseworker can authorize the *Special Needs Rate*.	Someone in the DHS Central Office must approve *High Need Rate.* The approval can only take place after ICCP completes the assessment.

3. How is the rate paid?

Special Needs rate	High Need rate
DHS pays the *Special Needs Rate* through the regular invoice to DHS Direct Pay Unit (DPU), just like the other DHS child care rates.	DHS pays the *High Need Rate* with a separate check. The child care provider sends in one invoice. The second check should arrive within two weeks after the regular payment.

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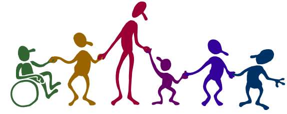
The Inclusive Child Care Program



Inclusive Child Care Program
Targeted Populations Supplemental Subsidy

Information for
Parents and Child Care Providers

Introduction to the Inclusive Child Care Program (ICCP)

We are a program of the Oregon Council on Developmental Disabilities. Our purpose is to support child care for children and youth who have disabilities, emotional or behavioral disorders, or special health care needs. This includes helping eligible families with higher costs of care.

The Targeted Populations Supplemental Child Care Subsidy

The Oregon Child Care Division Targeted Populations Program assists children and families that are at higher risk of not finding appropriate child care. The Division has an agreement with ICCP to provide Targeted Population supplemental subsidies for children and youth who meet these three criteria:

- Are aged birth through 17 years of age;
- Have disabilities, emotional or behavioral disorders, or special health care needs;

and

- Require higher levels of care and supervision than others the same age. This may include extra supports or accommodations in the child care setting.

We call the subsidy "supplemental" because it is added to the parent payment. The supplemental subsidy is different for each child. The amount depends upon things the provider must do to meet the child's specific care and supervision needs. We complete an individualized assessment to identity these needs. The assessment includes information from parents, child care providers, and professionals who know the child's abilities and needs.

How much do parents pay?

Parents pay the provider's customary fee, or a fee that is comparable to local child care rates for a child the same age. The supplemental subsidy is added to the parent payment. It pays for those things that are necessary to safe, stable care and that cannot reasonably be covered within typical child care rates. The subsidy is paid directly to the child care provider.

Which families are eligible for the supplemental subsidy?

To be eligible for the subsidy families must meet both of these criteria:

- Family income is less than 85% of Oregon's median income. For a family of 4 this is $4,789 per month or $57,464 per year. The amount goes up or down depending on family size.

- Parents will use child care while they are employed or attending post-secondary education programs.

Which child providers can receive the subsidy?

Each family chooses their child's provider. This may be a child care center, a registered or certified family child care provider, or an individual. All providers must comply with applicable Child Care Division rules. Providers who are exempt from those rules must undergo a criminal records check, and comply with health and safety requirements.

Questions? Call 1-866-837-0250 or 971-673-2286 in the Portland metro area.
Email: contact.iccp@state.or.us

What are the steps in the supplemental subsidy process?

The steps are:

1) Families apply to the Inclusive Child Care Program (ICCP) for the subsidy. A parent, a child care provider or a family service provider can contact us to ask about the application process.

2) After ICCP receives the application, we contact parents and providers to arrange the assessment. Usually this is a face-to-face meeting with the parent and provider. We will come to the child care setting or the parent's home.

3) At the meeting, we will ask questions about the child's needs in child care. We record the information on the High Need Child Care Rating Scale.

4) We will ask for supporting documentation. This may be an Early Intervention plan, special education plan, mental health evaluation, or other information from professionals who are the familiar with the child's abilities and needs. The assessment will not be complete until we have received and reviewed this information.

5) After the assessment meeting, we review notes from the meeting and the supporting documents to score the High Need Child Care Rating Scale. The score provides the guideline for the amount of the supplemental subsidy. The amount may also depend on specific accommodations that the provider must make for the child.

6) If the supplement is approved, we create and send the necessary payment paperwork to the child care provider.

7) We will write a plan for the supplemental subsidy. Parents and providers will review, make changes if needed, and give final approval to the plan.

8) Each month the provider sends an invoice to ICCP. We review and authorize the amount due, then forward the invoice to the Child Care Division for payment.

4/7/2009

Health and Safety Notes
California Childcare Health Program

Including Children with Special Needs: Tips for Child Care Providers

The following suggestions are intended to help include children with disabilities and other special needs in your care. It is important to remember that children are children first and each child is different, regardless of whether or not he or she has a disability. When considering adaptations and modifications, it may be helpful to take into account the severity of the disability, the child's age and the child's developmental level. Each child with special needs requires a "Special Care Plan" to identify how you will meet the child's individual needs in your program. A sample special care plan is available at the CCHP Web site at www.ucsfchildcarehealth.org, or by by calling the Healthline at (800) 333-3212.

Developmental delays

- Teach in small steps.
- Give clear directions, speaking slowly, clearly and using only a few words.
- Move the child physically through the task, so she can feel what to do.
- Stand or sit close to the child so you can help as needed.
- Help the child organize his world by providing structure and consistency and by labeling things with pictures and words.
- When moving from one activity to the next, let the child know ahead of time and allow plenty of time for the transition
- Work closely with other agencies and personnel who provide specialized services (such as early interventionists, therapists and psychologists). These specialists are a great resource for answering questions and brainstorming when problems arise.

Speech and language delays

- Be a good listener and observer.
- Engage infants and toddlers in back and forth conversations by reading their sound, gestures, facial expressions and body language.
- Give directions using as few, simple words as possible and in complete sentences.
- Talk about what you or the child is doing as you do it.
- Use everyday activities such as singing songs, reading books and dramatic play to encourage language development.
- Encourage the child to talk about what she or he is doing by asking specific questions.
- Repeat what the child says and add missing words, or ask the child to repeat what you are saying.
- Expand the child's language skills—build on what the child says by adding new information.
- Praise the child's efforts at communicating even if he or she doesn't do it exactly right.

Visual disabilities

- Use lots of communication during activities such as dressing and eating to help the child orient to the activity.
- Think about the physical space of the room: be wary of sharp edges on tables, curled up edges of rugs and other potential hazards.
- Once you've found an arrangement of furniture that works for the room, try not to change it too much as the child may rely on furniture to help navigate the room.
- Give specific directions and use descriptive language.
- Call children by their names. Address them directly, not through someone else ("Juan, do you want some banana?" not "Do you think Juan wants some banana?").
- Avoid glaring lights. Increase or decrease the room lights gradually and try not to change the light suddenly.
- Display simple, clear, uncluttered pictures that are easy to see.
- Avoid standing with your back to windows: the glare may make you look like a silhouette.
- Encourage hands-on and sensory experiences such as touching, holding, exploring, tasting, smelling and manipulating.
- Ask first if the child needs assistance—try not to assume you should help.

Physical/neurological issues

- Consider the physical space: are there any obstacles that prevent the child from moving safely in the area?

Are the pathways wide enough to accommodate special equipment such as walkers or wheelchairs?
- Know the child's strengths and needs so that independence is realistically encouraged and supported.
- Assist the child with activities she or he may not be able to do alone, such as kicking a ball.
- Ask any therapists involved with the child to show you proper positioning techniques and how to use and care for any special equipment.
- If you are having difficulty with positioning, feeding, etc., consult with the child's parents or guardians for suggestions they have found helpful at home.
- Give all staff opportunities to hold and position the child to ensure everyone is comfortable.
- Help other children understand why "Lauren can't walk" and emphasize what Lauren can do.
- Try to experience the disability yourself so that you can better understand the child's perspective.
- Work closely with other agencies and personnel who provide specialized services such as early interventionists and therapists.
- Ensure that the child's positioning is similar to what other children in the class are doing whenever possible (such as floor time).
- If the child is unable to use playground equipment, schedule some other outdoor activities that the child with a disability can participate in such as blowing bubbles, flying kites, etc.

Deaf or hard of hearing children

- Find out from the parents/guardians the degree of the child's hearing loss and what that means for the child.
- Ask the child's parent or guardian how to use and care for the hearing aid or other special equipment.
- Support the child socially.
- Be sure you have the child's attention before giving instructions.
- Speak in full sentences, at normal speed, to the child's face—and smile.
- Use visual cues such as pictures or gestures as you talk.
- Encourage the child to let you know when he or she doesn't understand by using a special signal.
- If the child doesn't understand at first, rephrase your comment rather than repeating it.
- If the child uses sign language, learn some simple sign language symbols.
- Provide opportunities for the child to talk.

Social/emotional/behavioral issues

- Try not to change activities abruptly. Warn the child of any changes in schedule ahead of time.
- Provide routine and structure for the child. Use cues such as timers, bells and lights.
- Allow the child time to practice new activities away from the group or allow withdrawn children to watch new activities first.
- Seat the child close to you. Give occasional physical and verbal reassurances and encouragement.
- Let the child bring a familiar object when entering new situations or beginning a new activity.
- Help the child make choices by limiting the number of choices available.
- Allow the child to have a safe emotional outlet for anger, fear or frustration.

Techniques for managing behavior

- Ignore negative behavior when you can.
- Notice and praise positive behavior as much as possible. Focus on what the child can do and accentuate the positive.
- Acknowledge the child's feelings.
- Children follow your example: model the kind of behavior you want to see in them.
- Prevent problems when possible by considering how the schedule, structure and physical space support your goals for children.
- Help children to talk about, act out and understand their strong feelings and behaviors.
- Follow through with realistic consequences.
- Be aware of what behaviors are your "hot buttons" and work with other staff to make sure you have the support you need. Seek additional help if the behavior persists or you feel the need for support.
- Give children reasonable choices.
- Provide developmentally appropriate activities in a safe, nurturing environment.
- Give the child enough time to comply with your request.
- Develop a plan for how you will handle difficult behavior the next time.
- Try to be consistent with the way the child's family and culture handles behavioral issues and their social and emotional goals for the child.
- Remember to have fun with the children!

Resources

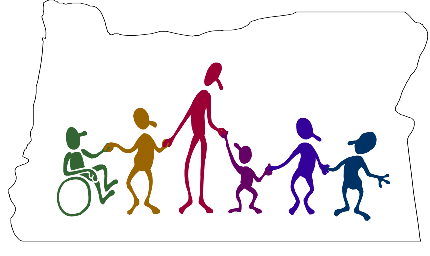
National Network for Child Care at www.nncc.org.

Circle of Inclusion at www.circleofinclusion.org.

By Pamm Shaw, MS, Disabilities Specialist (rev. 04/2003)

California Childcare Health Program • 1950 Addison St., Suite 107 • Berkeley, CA 94704-1182
Telephone 510-204-0930 • *Fax* 510-204-0931 • *Healthline* 1-800-333-3212 • www.ucsfchildcarehealth.org

The Inclusive Child Care Program



No matter what their abilities or needs, all children are children first.

The goals of the Inclusive Child Care Program are:

1) To support access to appropriate child care for families of children with disabilities, emotional/behavioral disorders, or special health care needs; and,

2) To help all children be in inclusive child care settings with their peers.

The Inclusive Child Care Program serves children, families, child care providers and communities through:

- ***Child care subsidies***. The program coordinates subsidies that can help with costs of accommodations or supports that are necessary for safe, healthy child care for some children.

  Families may be eligible when parents are employed, students, or receiving child care assistance through the Oregon Department of Human Services. Family income must be less than $4,789 per month for a family of 4. Eligible children and youth may be birth to 17 years of age and need a higher level of care and supervision.

- ***Individualized planning*** to support stable child care placements.

- ***Training and Consultation*** to support child care providers in their efforts to include children with diverse abilities and needs.

- ***Information on community, state and national resources*** that support inclusive child care.

How is "inclusive child care" different?

It isn't. Inclusive child care just means that children and youth with and without with disabilities, emotional/behavioral disorders, or special health care needs are ***all*** together in child care or out-of-school time programs. It also means that ***all*** children and youth participate in ***all*** of the setting's daily routines and activities.

All child care and out-of-school time programs have the potential to be fully inclusive.

The Inclusive Child Care Program serves children and families throughout Oregon.

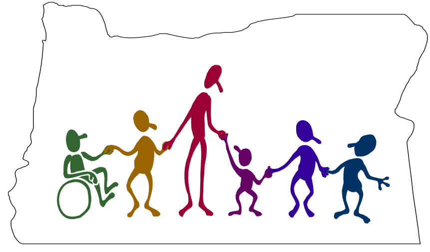
To make referrals or for more information, please contact:

Inclusive Child Care Program
Portland: 971-673-2286
Toll free: 1-866-837-0250
Email: inclusivecc@oregonchildcare.org
Mailing Address: 600 NW 14th Ave., Suite 100,
Portland, OR 97209

The Inclusive Child Care Program is a program of the Oregon Council on Developmental Disabilities through funding from the Oregon Employment Department Child Care Division, the Oregon Department of Human Services, and the Oregon Commission on Children and Families.

9/10/08

Programa Inclusivo de Cuidado de Niños



Sin importar sus capacidades o necesidades, todos los niños son niños primero.

Objetivos del Programa Inclusivo de Cuidado de Niños:

1) Apoyar a las familias para que tengan acceso a cuidado apropiado para niños con discapacidades, desórdenes emocionales o de conducta, o necesidades especiales de cuidado de la salud; y,

2) Ayudar a que todos los niños estén con sus pares en ambientes de cuidado de niños inclusivos.

El Programa Inclusivo de Cuidado de Niños sirve a niños, familias, proveedores de cuidado de niños y comunidades a través de:

- ***Subsidios para cuidado de niños.*** El programa coordina subsidios que pueden ayudar a cubrir los costos de las adaptaciones o apoyos que ciertos niños necesitan para recibir un cuidado seguro y saludable.

  Las familias pueden ser elegibles si los padres trabajan, estudian o reciben ayuda para cuidado de niños del Departamento de Servicios Humanos de Oregón. Los ingresos familiares deben ser menores a $5,067 por mes para una familia de 4. Los niños y jóvenes son elegibles desde que nacen hasta los 17 años de edad y deben necesitar un nivel más alto de cuidado y supervisión.

- ***Planificación individualizada*** para apoyar ubicaciones estables en cuidado de niños.

- ***Capacitación y consultoría*** para apoyar a los proveedores de cuidado de niños en sus esfuerzos para incluir a niños con diversas capacidades y necesidades.

- ***Información sobre recursos nacionales, estatales y de la comunidad*** que apoyan el cuidado de niños inclusivo.

El "cuidado de niños inclusivo", ¿es diferente?

No, no lo es. El Cuidado de Niños Inclusivo sólo significa que niños y jóvenes con o sin discapacidades, desórdenes emocionales o de conducta, o necesidades especiales de cuidado de la salud, están ***todos*** juntos en programas de cuidado de niños o en programas de fuera del horario escolar. También significa que ***todos*** los niños y jóvenes participan en ***todas*** las rutinas y actividades diarias del lugar donde reciben cuidados.

Todos los programas de cuidado de niños y los programas de fuera del horario escolar pueden llegar a ser completamente inclusivos.

El programa Inclusivo de Cuidado de Niños asiste a niños y familias en todo el estado de Oregón

Para hacer derivaciones o para más información, llame al:

Programa Inclusivo de Cuidado de Niños
Portland: 971-673-2286
Sin cargo: 1-866-837-0250
Correo electrónico: inclusivecc@oregonchildcare.org
Dirección postal: 600 NW 14th Ave., Suite 100,
Portland, OR 97209

El Programa Inclusivo de Cuidado de Niños es un programa del Consejo de Oregón para Discapacidades de Desarrollo, con financiamiento de la División de Cuidado de Niños del Departamento de Empleo de Oregón, el Departamento de Servicios Humanos de Oregón y la Comisión de Niños y Familias de Oregón.

3/09

Oregon Department of Human Services

CHILD ABUSE REPORTING PHONE NUMBERS

by county

Revised 11-14-08

County	Daytime phone numbers	Office hours	After hours phone numbers
Baker	541-523-6423 local 800-646-5430 toll free (Main office numbers)	Monday through Friday 8 am to 12 noon & 1 to 5 pm	911 or local law enforcement agency: Baker County Sheriff 541-523-6415 Baker City Police 541-523-3644
Benton	541-757-5019 local 866-303-4643 toll free (Dedicated child abuse hotlines)	Monday through Friday 8 am to 5 pm	911 or local law enforcement agency: Benton County Sheriff 541-766-6858 Corvallis Police 541-766-6925 Philomath Police 541-929-6911
Clackamas	971-673-7112 local (Dedicated child abuse hotline)	Monday through Friday 8 am to 5 pm	971-673-7112 local (Dedicated child abuse hotline) Calls are forwarded to Multnomah County hotline
Clatsop	877-302-0077 toll free (Dedicated child abuse hotline)	Monday through Friday 8 am to 5 pm	911
Columbia	877-302-0077 toll free (Dedicated child abuse hotline)	Monday through Friday 8 am to 5 pm	911
Coos	541-756-5500 local 800-500-2730 toll free (Main office numbers)	Monday through Friday 8 am to 5 pm	541-756-5500 local 800-500-2730 toll free (Main office numbers) Calls are forwarded to Belloni Ranch
Crook	541-693-2700 local (Dedicated child abuse hotline)	Monday through Friday 8 am to 5 pm	911
Curry	541-247-5437 local (Main office number)	Monday through Friday 8 am to 5 pm	911
Deschutes	541-693-2700 local (Dedicated child abuse hotline)	Monday through Friday 8 am to 5 pm	911

CHAPTER B

PROMOTING HEALTHY GROWTH AND DEVELOPMENT

CHILD DEVELOPMENT

This outline for child development gives suggestions to help children learn. Remember that children develop at varying rates. Children with different cultural backgrounds or with multiple languages may differ in their time periods for development. 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 had the same concerns, and your interest may help them decide to visit their health care provider and find out more. Developmental milestones and activities that will encourage development are listed in the table below:

Birth to 3 months	Ways to encourage development
Muscle skills • Moves arms and legs equally well. • When on stomach, ability to raise and control head improvements. • When on back, eyes follow bright objects or person's face from side-to-side. • Stares at objects held about 8–10 inches in front of him or her (likes human faces and bright colors best). • Likes high contrast (black and white) and bright colors (oranges, reds, yellows).	**Muscle skills** • Place infant in different positions when awake. • Put on stomach and place brightly colored toys 8–10 inches in front of face, or make soft noises in front of head. • Sit infant up, either hold or put in infant seat. Be sure back and head are supported. Sitting up gives infant a chance to watch activities occurring around him/her. • Place brightly colored mobiles and pictures around infant's area.

Birth to 3 months	Ways to encourage development
• Slowly develops more head control when in sitting position. • Movements not yet well coordinated; startles to loud sound or sudden change of position. • Cannot yet control hands.	
Language skills • Makes some noises other than crying (coos). • Can hear well, likes human voice.	**Language skills** • Talk to infant as much as possible when changing diapers, feeding, playing. Talk, then wait, giving infant time to respond. • Respond to infant's laughs, coos, sounds with pleasure! Be expressive.
Social and emotional skills • Comforts when talked to, held and cuddled. • Sucking brings comfort. • Crying usually means hunger, loneliness, wet, cold, hot, other discomfort. • Cries to let you know needs — comforts when needs are cared for such as food, dryness, warmth, loving. • Trust begins to be developed when you respond to infant's	**Social and emotional skills** • Provide the same caregiver as much as possible. Infants bond well to only a few people. This bonding is critically important to developing feelings of trust and security. • Be aware of infant's moods. Babies, like adults, like to play and eat when they are awake and alert. When infants are sleepy or fussy they do not like eating or being handled.

Birth to 3 months	Ways to encourage development
need — infant in turn quiets, looks with eyes, smile.	• You cannot spoil infants at this age — they need lots of love and attention. • When an infant cries, check to see if she or he is hungry, wet, too cold or hot or uncomfortable. If so, take care of that. If still fussy, try the following ways to comfort: *Let infant bring hand to mouth — some infants quiet by sucking on their hands or fingers. Bring your face about 10 inches from his/her face. Talk to infant in a soft, steady voice. If these measures don't work after about two minutes, pick up the infant, swaddle (wrap snugly with a blanket) and hold close or rock or walk; this gives a feeling of closeness and warmth*. • Provide quiet time when infant is not over stimulated. Feeding can be the most important social and learning time for infants; pay close attention to them when you feed them. • Spend lots of time holding each infant and looking at him/her. Your face and smile are very important to an infant.

Birth to 3 months	Ways to encourage development
Sexuality skills • Total body exploring. • Infants are born with the ability to feel pleasure in their genitalia and other erogenous zones. Boys' penises have erections and girls' vaginas lubricate from birth.	**Sexuality skills** • Do not be alarmed by or discourage babies touching all parts of their bodies. Babies will touch and play with their genitals, just as they do with everything else in their world.

3 to 6 months	Ways to encourage development
Muscle skills • Gains more muscle control. • Rolls over, begins to sit (first with support, gradually more on own). • Reaches for object; holds object in hand; can bring hands together (like clapping); looks for object that goes out of sight. • Vision improves; can see more clearly. • By 5–6 months, can find mouth with hands. • By 6 months, can find mouth with hands. • By 6 months transfers object from one hand to another.	**Muscle skills** • Provide lots of time for sitting up (support head and back until good head control is complete). • Have brightly colored toys within reach; use toys that child can hold with hands. • Give toys with different textures (e.g., soft and rough).

3 to 6 months	Ways to encourage development
Language skills • Makes a variety of sounds, coos, may begin babbling. • Turns eyes in the direction of sound (especially voice).	**Language skills** • Pronounce words properly when you talk or sing to children. • Use expressive language (happy voice, laughter, etc.). • Respond to infant's coos and babbles with similar sounds.
Social and emotional skills • Smiles. • Makes eye contact. • Shows signs of attachment to important caregiver(s) (father, mother or usual child care provider). • Responds differently to different people.	**Social and emotional skills** • Have the same person care for the same baby as much as possible; this helps her or him learn to trust and develop relationships with others. • Cry begins to be different for hunger, discomfort, wanting attention, etc. Child still needs attention when he/she cries — you still can't spoil him/her!
Thinking skills • Responds to environment: Laughs, looks at objects making sounds. • Begins to explore body.	**Thinking skills** • Provide interesting toys — rattles, squeeze toys, stuffed animals with noisemakers inside. Provide toys that can be reached for and held — crib gym, soft toy above crib to kick. • Provide time for being near other infants and adults.

3 to 6 months	Ways to encourage development
Sexuality skills • Learning to love through attachment with caregivers. • Curious about surroundings and self. ***Note:*** *Babies at this age put objects in their mouths. Check all toys to be sure they don't have small pieces that could be swallowed. Hanging toys over cribs must be high enough so infant can't pull them down and become strangled by the cord. See section on SIDS about safe bedding and security objects.*	**Sexuality skills** • Do not be alarmed by or discourage babies touching all parts of their bodies. Babies will touch and play with their genitals, just as they do with everything else in their world. • Physical closeness is essential for babies and children. Infants cannot learn to speak unless spoken to and, likewise, cannot learn how to love and show affection unless they are hugged, tickled and kissed. • Provide security objects and activities, such as imaginary friends, blankets, favorite toys, and thumb sucking; they are sources of comfort and affection for babies.

6 to 9 months	Ways to encourage development
Muscle skills • Sits alone without support, has good head control. • Able to get from lying to sitting. • Can pull self to stand up; may take a step while holding on. • May crawl. • Reaches out and grasps objects (rattles, toys).	**Muscle skills** • Provide a safe environment so infant can creep, crawl and explore. • Have lots of toys of different shapes, textures, and colors. Be sure toys are safe (no small pieces or sharp edges). • Provide finger foods infant

3 to 9 months	Ways to encourage development
• Looks for object that goes out of sight. • Beginning self-feeding with finger foods and cup.	won't choke on (children progress on solid foods at different rates; start out with crackers and then move on to small foods such as Kix® or Cheerios®). • Let infant begin feeding self; try to use cup with small amounts of fluids.
Language skills • May say "dada or "mama" but does not connect these words with specific people. • Imitates speech sounds and noises. • Turns and looks in the direction of sounds. • Likes musical sounds, squeaky toys.	**Language skills** • Talk to infant, use descriptive words to comment on infant's activities. • Praise when infant makes sounds. • Imitate sounds made by infant. • Provide squeaky or musical toys.
Social and emotional skills • Begins to be shy or uneasy with strangers. • May show strong preference or attachment to one or two people. • Enjoys games like "pat-a-cake," "peek-a-boo," hiding a toy and then having it reappear. • Smiles at self in mirror.	**Social and emotional skills** • Continue to provide the same caregiver as much as possible. • Play games like "peek-a-boo" or making toys disappear and then immediately come back. • Provide floor time with infant.

3 to 9 months	Ways to encourage development
Thinking skills • Spends much of daytime awake and alert. • Recognizes familiar people and objects. • Is developing memory.	**Thinking skills** • Continue using toys suggested for 3 to 6–month-olds. Try rotating them so some "new" toys become available each week. • Introduce toys such as pots, pans, and other household items to 6–9 month olds. • As infant begins creeping or crawling, provide large, safe area to explore.
Sexuality skills • Learns receptive language about body parts.	**Sexuality skills** • Use accurate words to name all body parts, including genitalia.

9 to 12 months	Ways to encourage development
Muscle skills • Can get from lying down to sitting position; sits well alone. • Creeps and crawls. • Pulls self up to a standing position, may take several steps while holding on. • Can use thumb and fingers to grasp and hold objects. • Holds cup and spoon. • Has good hand-to-mouth coordination.	**Muscle skills** • Think about safety — as babies gain mobility they get into lots of new areas. • Provide safe area with enough space for creeping and crawling. • Let child pull self up to stand. A railing of low furniture can encourage "cruising." • Give toys like spoons, plastic containers and cups, balls,

9 to 12 months	Ways to encourage development
	large blocks, pots and pans. • Play with a large soft ball — allow child to roll it, throw it, catch it. • Be sure toys cannot fit into infant's mouth — choking is a big risk at this age. • Have outside playtime in a safe play area. • Allow time for child to feed self and explore food.
Language skills • Initiates sounds like clucking, lip smacking. • Uses words such as "dada," "mama." • May understand one or two simple commands. • Begins to understand "no-no."	**Language skills** • Always take time to talk with child (while playing, bathing, changing diapers). • Use "adult" talk, not "baby" talk. • Make sounds the child can copy. • Begin using simple commands and show child what your words mean (e.g., say "sit down," "come here" while using hand gestures). • Describe what you see when walking, playing (e.g., "The leaves are green.").

9 to 12 months	Ways to encourage development
Social and emotional skills • May still show fear with strangers; attaches to main caregiver(s). • Very responsive to adult's smiles, voice, eye contact and play. • Recognizes self in mirror.	**Social and emotional skills** • Continue to provide the same caregiver as much as possible. • Play with child — show how toys work. • Talk, smile, laugh and have fun! • Allow child to play with open-ended toys so they are successful.
Thinking skills • Remembers toys, people. • Curious about objects — likes to put things in and out of containers. • Likes to pull a cover off a toy he/she has seen hidden.	**Thinking skills** • Provide toys that are right for the age and challenge the child to learn (e.g., "In and out" toys, "push-pull" toys, stacking cones, music boxes, jack-in-the-boxes). • Give child time and opportunity to learn to do things for him/herself, such as feed self.
Sexuality skills • Similar to younger ages.	**Sexuality skills** • Continue with activities described for younger ages.

1 to ½ years	Ways to encourage development
Muscle skills • Walks well by self. • Stoops for an object. • Walks backward. • Climbs steps. • Turns pages of a book. • Stacks a few blocks. • Begins interest in holding a fat pencil or crayon and scribbling. • Holds cup. • Eats with spoon; may still eat with hands.	**Muscle skills** • Provide safe play areas — frequently check for small objects that can be swallowed or sharp, dangerous objects. • Provide both big muscle activities (climbing — outdoor play) and quiet play. • Provide play with crayons, large paper, finger paints. • Go on field trips (zoo, parks) to give varied experiences.
Language skills • Uses one word at a time. • Learning new words rapidly; vocabulary increasing — should know at least 10 words (mama, dada, bottle, etc.). • May make sounds that are not understandable to others.	**Language skills** • Talk to child — be descriptive whenever possible. Use language to describe lots of things — if you are talking about snow, say that snow is cold and white. • Encourage child to talk by asking open-ended questions. • Encourage child to say words rather than always pointing. • Read books to child. • Label areas in environment.

1 to ½ years	Ways to encourage development
Social and emotional skills • Likes to copy adults (pretends to do housework). • Curious and very interested in exploring. • Developing sense of independence. • Removes some clothing (socks, pants). • Remembers people and objects even when they are not in sight.	**Social and emotional skills** • Let child help with simple household tasks (like dusting, clearing dishes, setting table). • Put on clothes that are easy to remove so child can undress and be more independent. • Give honest, simple explanations when you leave the child. E.g., when parent/guardian drops off him or her at child care, the child should say goodbye. • Follow through on what you say. Be consistent.
Thinking skills • Looks for objects that have been hidden. • Will try different ways to solve problems until learns what works. • Imitates (copies) others. • Increasing ability to remember.	**Thinking skills** • Give building toys (blocks, Legos®). • Let children spend time together (won't play together, but will play side by side). • Talk about what happened yesterday.
Sexuality skills • Enjoys affection. • Language developing for body parts. • Explores body, including genitalia.	**Sexuality skills** • Provide physical affection and security objects as for younger ages. • Do not be alarmed by or discourage infants from

1 to 1/2 years	Ways to encourage development
	touching all parts of their bodies. Infants will touch and play with their genitals, just as they do with everything else in their world.

1 1/2 to 2 years	Ways to encourage development
Muscle skills • Skills increasing (walks, runs, climbs steadier, jumps). • Stacks more blocks. • Can copy a straight line. • Kicks and throws a ball. • May be able to pedal a tricycle. • Gains more control over bladder and bowel movements.	**Muscle skills** • Have safe play area outdoors and indoors for using large muscles (running, climbing, throwing, jumping). • Allow tricycle riding supervised and in safe area, with helmet. • Supervise coloring and painting. • Good toys and games are blocks, toys to climb on, play house, dress-up toys, colorful picture books. • Can begin toilet training.
Language skills • Vocabulary explosion. • Inquisitive. • Begins to combine two words. • Can name some parts of body (ears, eyes, etc.) or point to them appropriately.	**Language skills** • Play sound games (e.g., "a cow goes moo"); play naming games (e.g., "show me your nose"). • Sing, tell short rhymes. • Encourage talking (same as for 1 to 1-1/2-year-olds).

1 1/2 to 2 years	Ways to encourage development
• Can name pictures of common objects (cat, dog, man, house). • Can follow simple one-step directions (bring the book to me). • Should know about 270 words (either say or understand). • Likes singing and rhymes.	
Social and Emotional skills • Children play side by side not really interact with each other — may do the same activity near others — no real idea of sharing. • Begins to dress self — puts on simple clothing. • Still likes to copy adults. • Developing independence — beginning to say "no" when asked to do things or asked questions. • Exploring concept of ownership.	**Social and Emotional skills** • Let children begin to play with each other — expect mostly individual play but they do enjoy being near one another. • Don't punish if refusing to share. • Whenever possible, give child choices so that he/she has an opportunity to exert control over situations (set your limits clearly before giving a child the choice).
Thinking skills • Increasing problem-solving skills. • Begins to play make believe/ pretend.	**Thinking skills** • Provide picture books with large, bright pictures. • Draw murals, large paintings and tell stories about these.

1 1/2 to 2 years	Ways to encourage development
Sexuality skills • Begins to see self as a boy or a girl. • Continues to explore body parts and to talk about genitalia and bodily functions during toileting.	**Sexuality skills** • Use correct words for body parts and functions. • Avoid using words like "dirty," "naughty," or "stinky" to describe genitalia or waste products.

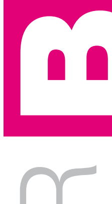
2 to 3 years	Ways to encourage development
Muscle skills • Running and stopping, stepping up, squatting. • Stands on one foot. • Jumps in place with both feet. • Rides tricycle. (Helmets are recommended.) • Throws ball overhand. • Stacks more blocks, up to eight cubes; builds bridges.	**Muscle skills** • Have safe play area outdoors and indoors for using large muscles (running, climbing, throwing, jumping). • Allow tricycle riding supervised, in safe area with helmet. • Supervise coloring and painting. • Good toys and games are blocks, toys to climb on, play house, dress-up toys, colorful picture books.
	Gross motor • Play with balls. • Allow toilet training to proceed at child's pace.

2 to 3 years	Ways to encourage development
Language skills • Follows two-step directions (e.g., "Get the book and put it on the table"). • Names five to six body parts on himself/herself. • Takes part in simple conversation. • Answers simple "What?" and "What do?" questions. • Uses two- to three-word sentences regularly. • Uses plurals. • Asks lots of questions.	**Language skills** • Singing. • Wordless books encourage children to tell the story; adult listens, adds details or pronounces correctly what child says. • Read books aloud, at least one every day. • Encourage children to recount everyday events and details.
Social and emotional skills • Helps with simple tasks, like picking up toys. • Dresses with supervision. • Separates from mother easily. • Plays interactive games (tag). • Asserts own individuality. • May be negative or demanding. • Likes rituals. • Likes to feed himself or herself (but still spills).	**Social and emotional skills** • Model social skills. • Help child to use words to solve social problems. • Ignore negative behavior whenever possible. • Allow choices about many daily events. • Encourage to express feelings verbally. • Simple turn-taking games like tag, musical chairs, Simon says. • Label feelings with words.

2 to 3 years	Ways to encourage development
Thinking skills • Making choices. • Establishing individuality. • Beginning to grasp cause-and-effect relationships.	**Thinking skills** • Simple puzzles. • Books with interesting age-appropriate stories. • Art projects with many textures, colors, large paintings.
Sexuality skills • Sense of shame develops. • May masturbate to quiet self. • Begins to explore others. • Learning differences and similarities between genders.	**Sexuality skills** • Talk with children about privacy and that genitals are private parts of the body. • Teach children they have the right to not have private parts of the body touched. • Describe genitalia using proper language.

3 to 4 years	Ways to encourage development
Muscle skills • Uses good balance to jump, run, throw and climb. • Balance on one foot for five seconds, hop on one foot. • Starts learning to catch. • Walks tiptoe. • Draw up, down, around and sideways using a crayon. • May be dry at naptime and night time, or not.	**Muscle skills** • Continue to allow toilet training to proceed at own pace. • Allow for plenty of free play time out of doors. • Provide with safe climbing structure, tricycles. • Allow for messy art play.

3 to 4 years	Ways to encourage development
Language skills • Uses plurals, past tense, pronouns and prepositions. • Uses speech that is easily understood. • Asks a lot of "why" and "what" questions. • Recognizes colors. • Gives first and last name.	**Language skills** • Same as for 2 to 3-year-olds. • Answer questions straightforwardly and simply. • Focus on topics of interest to the child to increase vocabulary. • Ask questions about art projects, block structures, dramatic play.
Social and emotional skills • Enjoys playing with other children. • Waits her or his turn some of the time. • Dresses partly; undresses completely. • Can ask for help if she needs it. • Likes to learn and follow directions.	**Social and emotional skills** • Allow for lots of "make believe" play with dress-up box, home corner, etc. • Encourage development of cooperative skills. • Encourage children to clean up. • Encourage development of feelings of sympathy for others. • Model social skills. • Encourage children to recognize feelings. (e.g., "You look happy playing with Joe"). • Tell children what to do more than what not to do.



3 to 4 years	Ways to encourage development
Thinking skills • Has attention span of about 10 minutes. • May know shapes. • Can count objects. • Learns to classify objects by color, form, size, etc.	**Thinking skills** • Practice counting. • Allow to make choices about activities. • Encourage to problem solve with guidance. • Develop classification skills by making collections of similar objects for children to sort and compare — buttons, small plastic objects, spools, lids, etc. • Provide group time for singing and telling stories.
Sexuality skills • Genital manipulation is common. Sense of guilt and privacy developing. • Very curious about how babies develop. • Developing values and attitudes toward different genders.	**Sexuality skills** • Give children the opportunity to learn about male and female body parts. • Provide a variety of images about gender and roles. • Use gender inclusive language

4 to 5 years	Ways to encourage development
Muscle skills • Hops on one foot; balances on one foot for 10 seconds. • Climbs down steps, alternating feet. • Toilets without help. • Puts on clothing with some help; laces shoes but does not tie shoes. • Draws three-part stick person. • Cuts on line with scissors.	**Muscle skills** • Continue to provide opportunities for plenty of large muscle activity. • Reinforce progress in self-help skills (toileting, dressing). • Teach and model healthy habits. For example, hand washing; good eating habits; covering nose and mouth when coughing/sneezing. • Encourage self-expression through creative activities, drawing, painting and dramatic play. • Provide child-size scissors, left-handed if needed, larger-size crayons.
Language skills • Tells stories; mixes fact and fiction. • Tries out silly words and sounds. Trying “four-letter” words is typical; should be dealt with calmly. • Has vocabulary of nearly 1,500 words; sentence length of four to five words. • Uses adjectives; uses past tense correctly.	**Language skills** • Teach child correct use of the telephone. • Encourage child to tell stories, real and make-believe — start story and have child choose ending. • Involve child in planning activities and sharing his/her ideas for events: holiday decorations, meal preparation, outings. Reinforce and encourage child’s progress

4 to 5 years	Ways to encourage development
• Understands common opposites (bid/little; hot/cold). • Uses these sounds correctly: m, n, ng, p, f, h, w, y, k, b, d, g, r.	in speech skills: e.g., "I like the way you described your new dress." • Read daily to child. Ask questions about events in story.
Social and emotional skills • Uses verbal skills instead of reacting physically (hitting, grabbing) most of the time. • Verbally expresses anger, frustration, and jealousy. • May be bossy; brag about accomplishments and berates others. • May have imaginary playmates and real worries and fears. • Plays better in a group; shares and waits turn more easily than a younger child. • Separates easily from parent/guardian or primary caregiver.	**Social and emotional skills** • Encourage healthy expression of feelings. • Provide acceptable outlets for anger — using words, deep breathing. • Provide opportunities for role playing through puppets and dress-up clothes. • Avoid power struggles. Give clear, simple rules and consequences. Give only acceptable choices. Use terms such as "It's time to …" or "The rule is …" • Encourage positive peer support by using "buddy system" — pairing more outgoing child with shy child. • Help identify and distinguish between real and imaginary fears. • Model good table manners and common courtesy. • Be aware of transitions — provide warning times (e.g., "After our snack….")

4 to 5 years	Ways to encourage development
Thinking skills • Has longer attention span; stays with one activity at least 10–15 minutes. • Understands some time concepts: noontime, early in the morning, after nap. • Identifies crosses, triangles, circles and squares. • Thinks of imaginary conditions (e.g., “suppose that…” “what if…” “I hope that…”)	**Thinking skills** • Use calendars, clocks and other visual markers to teach time concepts: e.g., “When both hands are on the 12, it will be lunch time.” • Reinforce staying with task. • Provide simple, honest answers to their why, what, where questions. • Continue to teach problem-solving skills through stories, games and situations as they occur.
Sexuality skills • Sex play is common and, like other play, is a normal expression of curiosity. Undressing, playing doctor and playing house are typical of preschool children and help them understand gender differences. It is usually limited to peers, although young children may want to touch their parent/guardian’s sexual organs. It is important to remember that childhood sex play for young children is primarily motivated by the “need to know,” and not by sexual/erotic feelings.	**Sexuality skills** • Do not panic or create a scene if you find children undressed or engaged in sex play. Talk with them about privacy. • If you suspect that one child is coercing the other, explain firmly that one never pushes other people to look at or touch private parts. • Answer questions factually and respectfully.

5 to 6 years	Ways to encourage development
Muscle skills • Catches a bounced tennis ball, two out of three tries; throws ball well. • Draws a six-part figure with more details. • Sews with large needle and yarn or thread. Ties a bow. • Walks backward and forward with heel and toe one inch apart in straight line. • Dances and marches to music. • May ride bicycle instead of tricycle (reinforce use of bicycle helmet).	**Muscle skills** • Provide adequate space for large muscle activities — throwing and catching balls. • Provide ample materials for using small muscles — cutting, pasting, drawing and sewing. • Encourage rhythm activities; provide simple musical instruments — drums, cymbals. • Provide building and carpentry experiences. • Encourage child's interest in printing letters, own name.
Language skills • Defines objects by their use — eat with fork; swim in lake. • Tells what common objects are made of — door made of wood; spoon made of silver, plastic. • Has vocabulary of approximately 2,000 words and sentence length of six or more words. • Uses all types of sentences, some complex (e.g., "I can go in the house after I take off my muddy shoes"). • Uses most all speech sounds correctly (possible exceptions: t, v, l, th, j, z, zh).	**Language skills** • Continue encouraging new vocabulary through reading longer stories, poetry. Define new words and concepts. • Provide field trips to explore child's neighborhood — post office, fire station, library). • Encourage use of reference books — help child look up answers to questions and special interests, dinosaurs, snakes. • Listen to child. Give positive verbal and nonverbal feedback.

5 to 6 years	Ways to encourage development
Social and emotional skills • Has sense of humor; plans surprises and jokes. • Prefers own age group for play, plays cooperatively, and likes to conform. • Expresses sympathy for others, protects younger children. • Displays pride in abilities and possessions. • Expresses thoughts and feelings through dramatic play with a variety of toys. Copies behavior of significant adults and peers. • Beginning to resolve conflicts; considering the other child's feelings.	**Social and emotional skills** • Give child message that he/she is loved and valued (e.g., "I'm glad you're here today"). • Reinforce cooperative group behaviors. • Model appropriate coping skills and expression of feelings. • Encourage responsibility for small chores. • Provide opportunities for child to help younger or less-skilled child. • Provide clear rules and consequences.
Thinking skills • Has longer attention span– over 15 minutes. Remembers previous experiences better. • Counts objects to 10. Identifies nickels, dimes and pennies. Group items according to shape, size, color, function. • Follows three-step direction (e.g., "Get your coat; put it on; and then stand by the back door"). • States full name, age and sex.	**Thinking skills** • Play games that have a few clear directions (board games, checkers). • Provide opportunities for simple science experiments (magnets, water-ice/steam). • Present relevant problems or use actual situations to let children provide possible solutions. • Provide variety of objects for counting games.

5 to 6 years	Ways to encourage development
• Does more complex problem solving. • Is interested in why and how things work.	
Sexuality skills • Develops modesty. • Society has strong effect (TV, peers, child care).	**Sexuality skills** • Provide privacy with toileting.

DEVELOPMENT OF SCHOOL-AGE CHILDREN

This section describes typical development of children 6 to 12 years of age. Some additional developmental tasks are included: personal care, tension-stress behaviors, fears, and ethical sense/moral skills. [Suggested activities that can be provided in school age care settings to promote development for this group are given. This section is still being developed]

6 years	Ways to encourage development
Muscle skills • Constant activity — often just unable to sit still. • Always in a hurry — "speed" is the benchmark of 6. • Tires easily — may have frequent illnesses. • More aware of hand as tool — often returns to finger feeding. • Loves art projects. • Uses knife to spread butter or jam on bread. • Cuts, folds, pastes paper toys, sews crudely with pre-threaded needle. • Has frequent accidents at mealtime — spilled milk, food on clothes. **Language skills** • Verbal — likes to explain things. • Very talkative, boisterous, enthusiastic language.	• The adult should 'be there' for children as a coach and facilitator. • Keep gender stereotyping out of your activities. Recognize that boys may enjoy cooking in the kitchen and girls may enjoy wood working. Keep activities open to both sexes. • Involve children in making and enforcing the rules. • Allow, whenever possible, for children to structure their own time as they need lots of time to them selves. • Making things is very important — Woodworking, paper mache, ceramics, puppet making and weaving are popular activities that encourage children to delight in the process as well as the final product. • Completing projects is very important. Child care providers can break down larger projects into several smaller projects.

6 years	Ways to encourage development
• Describes objects in picture rather than simply naming them. • Defines common object such as fork, chair or cup in terms of their use. • Loves jokes and guessing games. • Vision is at full maturity. • Begins to create whole sentences usually by letter naming and phonics (e.g., "I like to eat candy" means "I like to eat candy"). • "Predictable" books and "easy" chapter books are still important. Obeys triple commands in succession. **Social and emotional skills** • Wants to be first. • Sometimes a "poor sport" or dishonest — may invent rules to win. • Competitive but can share and cooperate with others. • Friends their own age are important. • Imitates adults. • Can be bossy; may tease or be critical of others.	• Handle competition lightly with large doses of encouragement.

6 years	Ways to encourage development
• May occasionally have temper tantrums. • Easily upset when feelings are hurt. • Tremendous capacity for enjoyment; likes surprises, parties, treats. • Doing well is very important even though there is lots of testing of rules. • Is more independent, probably related to influence of school. **Thinking skills** • Develops the concept of numbers. • Knows the difference between morning and afternoon. • Learns best through discovery. • Enjoys the process of creating more than the product. • Attempts to accomplish more than is capable. • Dramatic play is central to learning. • Cooperative play is elaborated. • Representative symbols more important. • Spatial relationships and functional relationships better understood.	

6 years	Ways to encourage development
• Beginning to understand the past when tied closely to present. • Beginning to develop an interest in skill and techniques for their own sake. • Draws a man including neck, hands and clothes. **Personal care** • Can dress and undress; may need help with dressing. • Usually requires, but resists, help with bathing. • Needs reminding to wash before meals. • Plays exuberantly in bathtub but needs help to get clean. • Leave clothes wherever they are removed. • Takes responsibility for toileting, but may have to dash; accidents are rare but extremely disturbing, often related to over-excitement. **Tension-stress behaviors** • May bite nails, lower lips. • Taps foot. • May return to temper tantrums.	

6 years	Ways to encourage development
• Stutters. • Thumb sucking and finger sucking my increase. **Fears** • Is often quite fearful. • Fears loud noises — doorbell, telephone, animals, bird or insect noises. • Fear of the supernatural — witches, ghosts. • Fears large animals. • Fears imagined unseen person, that is, under the bed, inside the closet, in the cellar. • Fears elements — fire, thunder, lightening, water. • Fears being lost. **Ethical sense and moral skills** • Unable to put the rules of the game above the desire to win — will break the rules, even those made by the child. • Is too uncertain of self to lose gracefully. • Tattles on others who cheat.	

6 years	Ways to encourage development
Sexuality • Increased interest in the opposite sex. • Strong interest in the origin of babies. • Interested in how an infant gets out and if it hurts. • Giggles at sound of urine stream — name-calling involves words dealing with elimination. • Has marked interest in and awareness of sex differences. • Mutual investigation by both sexes. • May take part in mild sex play or exhibitionism. • Lots of questions regarding bodily functions.	

7 years	Ways to encourage development
Muscle skills • Printing often small. • Brushes and combs hair without adult help. • Uses table knife for cutting — may need help with difficult cuts. • Pincer grasp low on pencil at point. • Written work often tidy, neat. • More cautious when approaching new tasks. • Repeats tasks in order to master them. **Language skills** • Vocabulary development expands rapidly. • Correct spelling emerges slowly. • Good listener. • Precise talker. • Likes one-to-one conversation. • Interested in the meaning of words. • Likes to write and send notes. • Interested in codes and deciphering them. • Attempts to write stories with beginning, middle and end.	**Same as for 6-year-olds.**

7 years	Ways to encourage development
Social and emotional skills • Boys tend to play with boys and girls with girls. • Takes part in group play. • Spends a great deal of time alone; does not require a lot of companionship. • Sometimes moody. • Needs structure and security. • Often doesn't like to make mistakes or risk making mistakes. • Sensitive to others' feelings but sometimes tattles. • Strong dislikes and likes. • Often relies on teacher for help. • Likes to help and have choices. • Tends to be less resistant and stubborn. **Thinking skills** • Can copy a diamond. • Can count by multiples of two, five and 10. • Beginning to grasp basic ideas of addition and subtraction. • Begins to use elementary logic.	**Same as for 6-year-olds.**

7 years	Ways to encourage development
• Notices when parts are missing from a picture. • Is developing concept of time; reads ordinary clocks and watches to the nearest quarter-hour. • Can name day, month and season. • More mechanical in reading; often does not observe end of sentences; skips words like "it," "the" and "he." • Likes to review learning. • Can classify spontaneously. • Likes being read to. • Wants to discover how things work and loves taking things apart. • Growing ability to reflect on various situations and events. • Enjoys working alone; works more slowly and carefully. • Erases constantly; wants work to be perfect. **Personal care** • Must be reminded to wash hands before meals. • Spends lots of time in bath and self-care activities. • Able to get self fairly clean without help.	**Same as for 6-year-olds.**

7 years	Ways to encourage development
• Still drops clothes on floor. • May need encouragement to go to bed; may still take favorite toy to bed. **Tension-stress behaviors** • Has very few tension outlets. • Fidgets. • Wriggles loose teeth. • Blinks. • Scowls. • Attempts to decrease old tension-reducing habits and attempts to control those that remain. **Fears** • Continues to have many fears. • Fears the dark, attics, cellars, may interpret shadows as ghosts, witches. • Is very stimulated by mass media. • Worries about self – concerned that things may be too difficult, that second grade might be too hard, that people may not like him or her; fear bodily harm or being late for school. • May fear trying something new.	**Same as for 6-year-olds.**

7 years	Ways to encourage development
Ethical sense and morality • Has good intentions but may become distracted. • May make up alibis. • Is becoming conscious of right and wrong in self and others. **Sexuality** • May want a new baby in family. • Knows that having babies can be repeated. • Is very interested in pregnancies. • Has less interest in sex. • Takes part in some exploration and experimentation and sex play, but less than 6-year-old. • Tends to be modest in front of opposite sex.	**Same as for 6-year-olds.**

8 to 9 years	Ways to encourage development
Motor skills • Movement more fluid and graceful. Much more limber. • Always moving: jumping, skipping or running. • Likely to overdo. Experiences difficulty in quieting down after recess. • Numerous injuries and somatic complaints. • Increased smoothness and speed in fine motor control. • Often is able to use cursive writing. • Makes use of common tools such as hammer, saw and screwdriver. • Uses household and sewing utensils. • Helps with routine household tasks such as dusting and sweeping. **Language skills** • Loves vocabulary, language and information. • Talkative; attempts to explain ideas. • Language is often descriptive. • Listens, but is so full of ideas generally has difficulty recalling what has been said.	**Same as for 6 and 7-year-olds**

8 to 9 years	Ways to encourage development
• Baby talk sometimes re-emerges. • "Dirty" jokes emerge. • Age of negatives: e.g., "I hate it," "I can't," "boring." • Exaggerates often. • Uses graffiti. **Social and emotional skills** • Is more social and humorous. • Generally more cooperative at home. • Assumes responsibility for share of household chores. • Goes about home and community freely, alone or with friends. • Likes to compete and play games. • Begins to show preference for friends and groups. • Plays mostly with groups of own sex but is beginning to mix. • Compares self to others. • May tend to be more critical of self. • Is afraid of failing a grade; is ashamed of bad grades. • Usually likes school; wants to answer all the questions.	**Same as for 6 and 7-year-olds**

8 to 9 years	Ways to encourage development
• May begin hero worship; may display prejudices. • Often has strong social feeling; shows empathy and sympathy. **Thinking skills** • Can give similarities and differences between two items from memory. • Counts backward from 20 to 1; understands the concept of reversibility. • Makes change for a quarter. • Grasps the concepts of parts and whole (fractions). • Understands the concepts of space, cause- and-effect, nesting (puzzles) and conservation (permanence of mass and volume). • Can classify objects by more than one quality. • May wake up early just to read; reads classic books but also enjoys comics. **Personal care** • Needs no help in bathing or dressing. Able to dress self completely, including tying shoelaces. • Prefers to select own clothes.	**Same as for 6 and 7-year-olds**

8 to 9 years	Ways to encourage development
• Needs to be reminded to brush teeth. • Is frank about likes and dislikes. • Still needs to be reminded to go to bed. • May get up early to have time to “mess around” before going to school. • May still like to be tucked in. **Tension-stress behaviors** • Cries with fatigue. • May return to earlier patterns such as blinking or rubbing eyes or biting nails. • Stamps feet. • Fiddles. • Grumbles and mutters. • Feels dizzy; has other somatic complaints. **Fears** • Has fewer and more reasonable fears. • Worries less. • Has fears that relate to personal awkwardness. • Fears school failure. • Has scary dreams, but quiets easily.	**Same as for 6 and 7-year-olds**

8 to 9 years	Ways to encourage development
Ethical sense and morality • Willing to evaluate self and family. • Recognizes own weaknesses; may make self-effacing remarks. • Can and is willing to accept blame for own actions. • Attempts to be honest and fair. **Sexuality** • Is quite modest. • Has an increased awareness of sexuality. • Majority at this age know about menstruation. • Has increasing interest in father's part in reproduction. • May discuss sex with friends. • Is interested in details of own organs and functions. • May begin sex swearing. • Some 9-year-old girls begin pubertal changes. • Boys may be more hesitant to discuss sexuality with parents/ guardians.	**Same as for 6 and 7-year-olds**

10 to 12 years	Ways to encourage development
Muscle skills • Very active — plays team sports with much improved abilities. • Needs more sleep — necessary for growth. **Language skills** • Enjoys conversations with adults and peers. • Peer vocabulary — slang emerges. • Imitated adult language patterns. • Loves to debate. • May talk constantly on the telephone. **Social and emotional skills** • Is very fond of friends — talks about them constantly. • Chooses friends more selectively — may have a best friend. • Is more diplomatic. • Likes family and demonstrates affection toward caregivers. • Sports and clubs are of great interest. • Has the ability to weigh the pros and cons of an argument.	• Provide open-ended materials. • Arrange the environment to encourage children to spread out, explore and be messy. • Provide sufficient storage space for projects and creations that cannot be completed in one day. • Allow creations to remain in place for several days so children can continue using them and perhaps expand on them. • Implement a daily schedule that includes large blocks of time when children are free to organize their own games and activities without adult involvement. • Ensure sufficient amount of time for children to make and follow through on their plans. • Materials and equipment should be displayed and stored to encourage autonomy. • Encourage children to express their ideas and feelings. • Introduce children to the activity of brainstorming to practice using as a problem solving tool. • Respectfully respond to children's ideas for projects and activities.

10 to 12 years	Ways to encourage development
• Beginning interest in the opposite sex. • Cliques and gangs may develop; strong desire to belong. **Thinking skills** • Increased ability to think abstractly. • Prefers new tasks and experiences to reflection on or revision of previous work. • Can establish and modify rules, develop hypothesis. • May show emerging ability in particular skill or content area. • Very interested in current events, politics, social justice, pop culture and materialism. • Interested in science and the environment. • Seeks reality in social and physical relationships. • Is often open and uninhibited in classroom. • Research and study skills advance with increased organization and discipline. • Responds to magazine, radio and other advertising. • May occasionally write short letters to friends or relatives on	• Help children understand it takes hard work and practice to develop their talents. • Call attention to sensory experiences. • Ask open-ended questions that encourage children to think about things in new ways. • Model creativity by sharing your own interests, taking risks and solving problems.

10 to 12 years	Ways to encourage development
own initiative. • Reads for both practical information and own enjoyment. **Personal care** • Concerned with personal appearance and cleanliness. • Bathes frequently and prefers showers. • Is concerned about wearing clothes that are in vogue. • Rapid growth often necessitates a new wardrobe. • Enjoys shopping for clothes; however, needs to be reminded to take better care of clothing. • Girls may try to look glamorous — may want to wear lipstick and make-up. May become overly concerned with body changes such as weight gain and change in shape of body — eating disorders may emerge. • Spends time decorating room and less time keeping it clean. • Is able to perform more complex chores and tasks. • Raises pets.	

10 to 12 years	Ways to encourage development
• Cooks and sews small projects. **Tension-stress behaviors** • Has numerous mannerisms that may appear when tired. • Often expresses frustration by withdrawal. • May display sudden, uncontrolled outburst of anger, frequently ending in tears. • May snuggle up to mother in private. • May have increased motor activity such as blinking, grimaces and scowling. • May yell or hit. **Fears** • Afraid to be alone. • May still be afraid of the dark. • Concerned about well-being of primary caregiver. • Worries about school, parents/ guardians' well-being, own health. **Ethical sense and morality** • Can extract the moral from a story.	

10 to 12 years	Ways to encourage development
• Very concerned about how people treat one another. • Is concerned about fairness. • Knows what is right but does not always do what is right. • Is more tolerant of self than others. • Is truthful about the "big" things; believes that it is okay to lie with a good reason (to protect a friend). • More of an adult personality.	
Sexuality	
• Is aware that intercourse happens apart from conception . • Understands prenatal development and the birth process. • Views sex as less "dirty." • Girls are often more open to discussing sex and sexuality issues with parents/guardians than boys in this age group.	Continue to discuss privacy, boundaries and appropriate touch

Source: Adapted from the Child Care Health Handbook, by the Child Care Health Program, Public Health, Seattle & King County [year]. *Caring for Children in School-Age Programs Volume II by Derry G. Koralek, Roberta L. Newman, Laura J. Colker, Teaching Strategies, Washington, DC 1995 pages13-15*. Ages and Stages: Developmental Descriptions & Activities Birth Through Eight Years written ad illustrated by Karen Miller, Telshare Publishing Co., Inc. 1985.

Marketing to Kids
-Talking Points-

- Television ads have a direct influence on what children choose to eat and drink.
- The majority of foods and drinks marketed to kids are for products high in calories and low in nutrients – clearly out of balance with promoting a healthy diet.
- Marketing approaches have become sophisticated, moving far beyond television advertising to include the Internet, advergames, and strategic product placement.
- Marketers are targeting younger and younger kids, all the way down to infants, in an attempt to establish brand-name preference as early as possible.
- Efforts to change current marketing practices, diet trends and the prevalence of overweight and obesity will take action on many levels. Raising parents' awareness that their kids are targets of junk food marketing – and that parents have the power and the responsibility to make good food decisions for their children - is a first step.

Did You Know?

- Kids view more than 40,000 ads per year on TV alone.
- 44% of the ads kids see on TV are for candy, snacks and fast food.
- Advertisers count on your kids to "nag" and "pester" you into purchasing their products.
- Kids younger than 8 years old don't understand the idea of "selling" a product and accept advertising claims at face value.
- Kids younger than 6 years old have difficulty distinguishing advertisements from regular TV shows and movies.
- Advertising to kids is a $385 billion/year industry. The alcohol, tobacco, and prescription drugs industries only spend a total of $20.9 billion/year.
- Several European countries forbid or limit advertising aimed at kids.

Provided by The Nutrition Council of Oregon

Advertising to Children and Adolescents: Resources and Reports

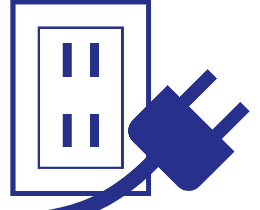
Institute of Medicine – ***Food Marketing to Children and Youth: Threat or Opportunity, 2006***
This report explores what is known about current food and beverage marketing practices, the influence of these practices on the diets of children and youth, and public and private recommendations and strategies that can be used to promote healthful food and beverage choices in children and youth.
http://www.iom.edu/CMS/3788/21939/31330.aspx

American Academy of Pediatrics – ***Children, Adolescents and Advertising, 2006***
Exposure to advertising may contribute to childhood and adolescent obesity, poor nutrition, and cigarette and alcohol use. This revised policy statement published in the December 2006 issue of *Pediatrics*, the American Academy of Pediatrics (AAP) calls on pediatricians to become aware of the effects of advertising on children's behavior and to work with parents, schools, and community groups to ban or limit advertising aimed at children. The policy statement supports media education as an effective approach to lessen the effects of advertising on children and adolescents.
http://www.commercialalert.org/pediatricsadvertising.pdf

Kaiser Family Foundation Report – ***Food for Thought, 2007***
The study combines content analysis of TV ads with detailed data about children's viewing habits to provide an estimate of the number and type of TV ads seen by children of various ages.
http://www.kff.org/entmedia/7618.cfm

The Future of Children: Markets and Childhood Obesity Policy **(Princeton – Brookings publication)**
One journal article of an entire publication focused on Childhood Obesity, *Markets and Childhood Obesity Policy* examines the childhood obesity epidemic from the perspective of economics; both the possible causes and possible policy solutions that work through markets.
http://www.futureofchildren.org/information2826/information_show.htm?doc_id=355339

YOU HAVE THE POWER



5 Steps to Guide Your Child's TV Time

Time spent watching TV takes time away from reading, playing and being active.

Watching a lot of TV can be bad for children's health and can affect children's weight. Children who watch more TV tend to weigh more.

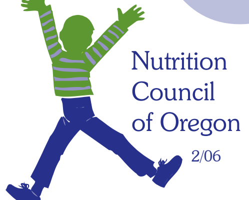
1. **Be a good role model**
   Eat healthy food, be active, and limit how much TV you watch.

2. **Choose when the television is on**
   Limit TV time and stick to it!

3. **Keep TV's out of kids' bedrooms**
   It's too hard to know what they're watching and when it's on.

4. **Turn off the TV during meals**
   Focus meal time on talking with each other.

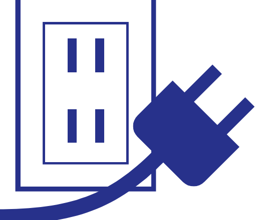
5. **Get active!**
   Get your kids moving! Go for a walk, turn on the music and dance, give them chores… the activities are endless!



How much TV should kids watch?

- **2 years and younger: none**
- **Older than 2 years: no more than 2 hours a day**

USTED TIENE EL PODER



5 pasos para controlar el tiempo que su hijo pasa frente al televisor

El tiempo gastado en mirar televisión quita tiempo de leer, jugar y estar activo.

Mirar mucha televisión puede ser malo para la salud de los niños y puede afectar su peso. Los niños que miran más televisión tienden a sufrir de sobrepeso.

1 Sea un buen ejemplo a seguir - Coma comida sana, esté activo y limite la cantidad de televisión que mira.

2 Decida cuándo estará prendido el televisor - Limite el horario para ver televisión, y cúmplalo.

3 No ponga televisores en las habitaciones de los niños - Es demasiado difícil saber qué están mirando y cuándo está prendido.

4 Apague el televisor durante las comidas Enfoque el horario de las comidas para conversar en familia.

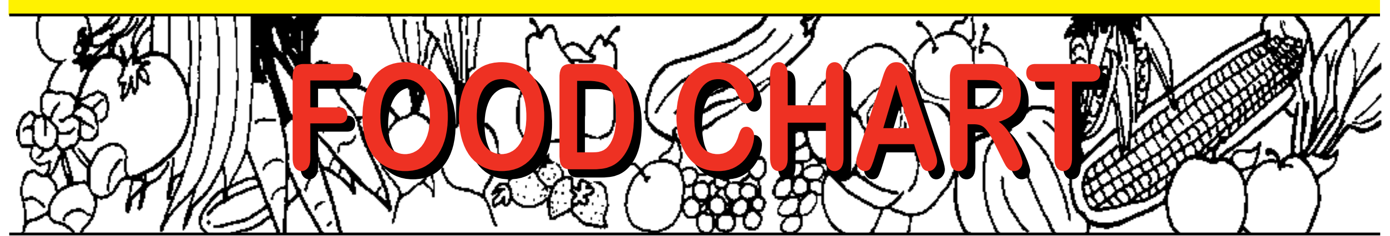
5 ¡Esté activo! ¡Haga que sus hijos se muevan! Vayan a caminar, pongan música y bailen, encárgueles tareas... ¡las actividades son inagotables!

Nutrition Council of Oregon

2/06

¿Cuantás horas de televisión deben mirar los niños?

- **2 años o menor: 0 horas**
- **Mayor de 2 años: no más de 2 horas al día**



Age:	1 and 2 years	3 through 5 years	6 through 12 years
BREAKFAST			
Fluid milk	½ cup	¾ cup	1 cup
100% Juice or fruit or vegetable	¼ cup	½ cup	½ cup
Bread or bread alternate	½ slice*	½ slice*	1 slice*
or cold dry cereal	¼ cup (or ⅓ oz.)	⅓ cup (or ½ oz.)	¾ cup (or 1oz.)
or cooked cereal	¼ cup	¼ cup	½ cup
SNACK Select two of the following four components**			
Fluid milk	½ cup	½ cup	1 cup
100% Juice or fruit or vegetable	½ cup	½ cup	¾ cup
Meat or meat alternate	½ ounce	½ ounce	1 ounce
Bread, bread alternate, or cereal	½ slice*	½ slice*	1 slice*
LUNCH/SUPPER			
Fluid milk	½ cup	¾ cup	1 cup
Meat or poultry or fish	1 ounce	1½ ounce	2 ounces
or cheese	1 ounce	1½ ounce	2 ounces
or cottage cheese, cheese food, or cheese spread	2 ounces (¼ cup)	3 ounces (⅜ cup)	4 ounces (½ cup)
or egg	1	1	1
or cooked dry beans or peas	¼ cup	⅜ cup	½ cup
or peanut butter, soynut butter or nut or seed butters.	2T.	3T.	4T.
or peanuts, soynuts, tree nuts or seeds	½ oz. = 50%	¾ oz. = 50%	1 oz. = 50%
or yogurt***	½ cup (4 oz.)	¾ cup (6 oz.)	1 cup (8 oz.)
Vegetables &/or fruits (2 or more)	¼ cup Total	½ cup Total	¾ cup Total
Bread or bread alternate	½ slice*	½ slice*	1 slice*

* or an equivalent serving of an acceptable bread alternate such as cornbread, biscuits, rolls, muffins, etc., made of whole-grain or enriched meal or flour, or a serving of cooked enriched or whole-grain rice or macaroni or other pasta products.

** for snack, juice may not be served when milk is served as the only other component.

*** or any equivalent quantity of any combination of the above meat/meat alternates.

This Institution is an equal opportunity provider.

USDA CHILD AND ADULT CARE FOOD PROGRAM

What is the USDA Child and Adult Care Food Program?

The program reimburses child care centers, school age programs, Head Start programs, and family child care providers for part of the cost of meals and snacks they serve to children, and it ensures that well-balanced, nutritious meals are served. The program also provides nutrition education to providers and children. The Child and Adult Care Food Program (CACFP) is a federally-funded program. Your tax dollars return to your community when you participate in the program.

How do children benefit?

Research has shown the importance of good nutrition and quality child care to the development of cognitive abilities.

The food program's proven track record makes it an important resource for helping to ensure a healthy and productive future for Oregon's children.

What programs are eligible?

- CCD licensed non-profit and public child care centers, school age programs, Head Start programs, and preschools
- Some CCD licensed for-profit centers that serve low-income children
- CCD registered and certified family child care providers
- Some AFS-listed family child care providers

How do I sign up with the food program?

For more information, call (503) 947-5902 or visit the website: *www.ode.state.or.us/search/results/?id=209*

Child care centers will work directly with the Oregon Department of Education Child Nutrition Program (ODE CNP).

Registered and certified family child care providers will work with a local “Family Day Care Home Sponsor”. ODE CNP staff will help providers locate a local sponsor.

Is the paperwork difficult?

Family child care providers are required to keep simple records, including attendance, meal count forms, and menus. Sponsors provide training and assistance with the paperwork.

Child care centers are required to keep records including attendance, meal count forms, menus, receipts, and some additional records. The ODE CNP provides training and assistance with the paperwork.

What do I need to feed the children to be reimbursed for meals?

Meals must meet simple requirements. You must serve a variety of foods and your sponsor will provide you with detailed information. A sample breakfast could be: Milk, Banana, and Cereal. You can request recipe and menu ideas, a list of foods that count on the program, and an easy-to-read food chart that shows the meal requirements (*http://www.ode.state.or.us/services/nutrition/cacfp/pdf/food-chart.pdf*).

What kind of meals do I need to serve if I’m not on the USDA Child and Adult Care Food Program?

The Oregon Child Care Division requires its approved child care centers and registered and certified family child care providers to provide, or ensure availability of, meals and snacks that meet the USDA guidelines.

In child care facilities where sack lunches and snacks are brought from home, the program also needs to ensure these meals and snacks meet the USDA food requirements.

How much money will I receive?

Family child care providers are reimbursed for meals based on income factors. The reimbursement rates change each year. Your sponsor will provide you with the current rates.

Centers are reimbursed based on the income of the children in care.

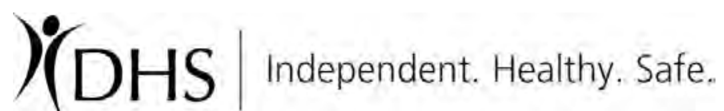
For current rates visit the ODE CNP website:
http://www.ode.state.or.us/services/nutrition/cacfp

When will I receive the money?

Approximately four weeks from the time you submit records.

It's time to eat!

Food for your baby



Feeding your baby

- Around **six months of age**, most babies are ready to try solid foods, starting with single vegetables, fruits and infant cereals with smooth textures.

- Offer your baby only one new food every five to seven days. After they have been eaten separately, then you can mix two foods together.

- If you are buying baby food, look for single ingredient foods. Avoid baby food dinners, desserts and those that have additives and fillers.

- Around **eight to ten months**, babies are able to pick up and hold food. They can handle a variety of soft food in small pieces.

- Let your baby decide what she likes and dislikes. Sometimes it takes a few tries before your baby will like a new food. Just because you don't like it does not mean that your baby won't!

- By **ten to twelve months**, babies will be able to eat most soft table foods, as long as they are cut into bite size pieces.

- Eat with your baby and make feeding time fun and relaxed.
  Your baby will like eating at the table with the rest of the family.

Making your own baby food is easy

Homemade baby food is good for your baby. It will help your baby get used to the foods your family eats, and you always know what is in it!

Did you know that you can help your baby get a good start with solids using the foods and utensils you already have at home?

Try these simple steps:

1. You will need a clean fork, potato masher, food processor or blender.
2. To make sure your fresh fruits and vegetables are clean and safe, scrub them, peel off the skin and remove stems, pits and seeds.
3. Prepare meats by removing bones, skin and visible fat.
4. Cook hard or tough foods until soft.
5. Cool to room temperature.
6. Mash, puree or blend food by adding small amounts of cooking water, breast milk, or formula until mixture is smooth.

Even if you like your foods sweet or salty, your baby will prefer the natural flavor of foods - avoid adding sugar, salt or syrups to baby's food.

Never use honey in your baby's food - honey can make your baby very sick.

Keeping your baby food safe

The safest way to feed your baby is to put the amount of food your baby will eat into a small bowl. Throw away anything that is left over in the bowl.

Feeding your baby directly from the container will cause the food to spoil quickly.

Storing

- If you have any baby food leftover, you can store it in the refrigerator for up to two days in a container with a tight-fitting lid.
- If you want to keep your baby food longer, you can then put the container in the freezer.
- One good way to store baby food in individual portions is to freeze it in an ice cube tray. Once it is frozen, transfer the cubes to a plastic bag and return them to the freezer.

Oregon WIC Program • www.oregon.gov/DHS/ph/wic/

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57-709-ENGL (04/2009)

February is National Children's Dental Health Month

National Children's Dental Health Month is celebrated every February to raise awareness about the importance of oral health - especially the oral health of our children.

Developing good habits at an early age and scheduling regular dental visits helps children get a good start on a lifetime of healthy teeth and gums.

Whether you're a member of the dental team, a school administrator, teacher, health educator or a parent, there are a variety of online resources that can help you with oral health presentations and fun ideas for the classroom- including coloring and activity sheets that can be used as handouts.

The links below can help get you started in the celebration of National Children's Dental Health Month. (Please note: the sites listed do not constitute an endorsement by the Oregon Department of Human Services).

American Dental Association - Downloadable puzzles, games, & coloring pages http://www.mouthhealthy.org/en/

Apples4theteacher. com- Dental Health coloring pages make great practice activities for toddlers, preschool, and elementary children.
http://www.apples4theteacher.com/coloring-pages/dental-health/

Colgate Kids World- Provides oral health games and activities for children of all ages.
http://www.colgate.com/app/Kids-World/US/HomePage.cvsp

DLTK's Crafts for Kids- Coloring activities, books, and other crafts are listed for NCDHM.
http://www.dltk-kids.com/crafts/miscellaneous/dental_health_month.htm

Dental Health - AskERIC lesson teaches first graders how to brush and floss their teeth.
http://www.eduref.org/cgi-bin/printlessons.cgi/Virtual/Lessons/Health/Body_Systems_and_Senses/BSS0008.html

Dental Health Activity Sheets - Various activities from the Canadian Dental Association.
http://www.cda-adc.ca/en/oral_health/faqs_resources/teaching_resources/index.asp

Healthy Teeth - An oral health education database featuring simple activities and experiments as well as easy to understand text for grades 3 to 6.
http://www.healthyteeth.org/index.html

Open Wide and Trek Inside!- Beyond the traditional "brushing and flossing" curriculum, this module focuses on the science of the oral environment, and major scientific concepts relating to oral health for grades 1 and 2.
http://science-education.nih.gov/customers.nsf/ESDental?OpenForm&CS_21=false&

Teacher Vision™ Healthy Teeth - Dental health is demonstrated using a simple experiment which allows youngsters to understand why their teeth can become stained.
http://www.teachervision.fen.com/teeth/lesson-plan/2552.html?for_printing=1

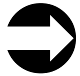
Tooth Tally Project - First grade classes may participate in Wilburn Elementary Tooth Tally Project by counting, collecting data, sorting, and graphing the number of baby teeth lost by the children.
http://www.educationworld.com/a_curr/curr386.shtml

What Causes Tooth Decay? - Helps elementary school students understand the causes and implications of tooth decay.
http://www.reachoutmichigan.org/funexperiments/quick/eric/toothdecay.html

The **Oral Health Program** seeks to improve the oral health of Oregon citizens across the lifespan. We work to decrease the number of children with decayed, filled or missing teeth, increase the number of children with preventive dental sealants in their permanent molars and increase the percent of people served by fluoridated community water systems.

Oregon Department of Human Services
Public Health Division
Oral Health Program
800 NE Oregon Street, Suite 825
Portland, Oregon 97232
www.oregon.gov/DHS/ph/oralhealth/

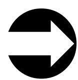
School-based Dental Sealant Program
INFORMATION FOR TEACHERS



Before students get dental sealants:

- Send home the permission form and parent fact sheet. These forms come stapled together.
- Collect the completed permission forms.
- Show your class the "Seal in a Smile" DVD that was sent to your school. This fun, 4 minute video shows kids what to expect so they won't feel nervous about getting sealants.

- Consider these curriculum ideas related to kids' oral health:
  - **American Dental Association**
    Downloadable puzzles, games and coloring pages.
    http://www.ada.org/353.aspx
  - **Open Wide and Trek Inside!**
    Beyond the traditional "brushing and flossing" curriculum, this module focuses on the science of the oral environment and major concepts relating to oral health. For grades 1-2. http://science-education.nih.gov/supplements/nih2/oral-health/default.htm
  - **Healthy Teeth**
    Features simple activities and experiments, and easy to understand text. For grades 3-6.
    www.healthyteeth.org/index.html



What happens when the dental team arrives:

- The dental team brings in portable equipment and sets up in the location chosen by your school.
- **Screening**: The entire class comes into the screening area. It takes about 1 minute to screen each child, about 20 minutes for a whole class.
- **Sealants**: Your school's sealant coordinator will come to your class to escort the first child to the treatment location. When the treatment is done, that child will return to class and send another child to the treatment location. The treatment takes about 15-30 minutes.

This document can be provided upon request in alternative formats for individuals with disabilities. Other formats may include (but are not limited to) large print, Braille, audio recordings, Web-based communications and other electronic formats. Call 971-673-1376 (voice) or call 1-800-735-2900 (TTY) to arrange for the alternative format that will work best for you.

Oregon Health Authority

8/10/2010

CHAPTER C

PREVENTING AND RESPONDING TO ILLNESS

LINKS TO INFORMATION ON SPECIFIC ILLNESSES

Some illnesses are infectious enough that the person should not be allowed in early care and education settings with other children and staff. Oregon Administrative Rules list diseases that are "restrictable." Those are illnesses that require exclusion from child care until the person is no longer infectious. Oregon administrative rules regarding restrictable communicable disease can be found at: *http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_333/333_019.html*

Check the following alphabetical list of web links for information on both restrictable and non-restrictable diseases. Restrictable illnesses are marked with the restrictable disease icon.

Acquired immune deficiency syndrome (AIDS) and HIV infection
http://www.cdc.gov/hiv/

Campylobacter (symptom: diarrhea)
www.cdc.gov/nczved/divisions/dfbmd/diseases/campylobacter/

Chickenpox (varicella)
http://public.health.oregon.gov/diseasesconditions/diseasesaz/chickenpox/pages/facts.aspx

Colds
www.cdc.gov/getsmart/antibiotic-use/URI/colds.html

Cryptosporidium (symptom: diarrhea)
www.cdc.gov/parasites/crypto/gen_info/index.html

Cytomegalovirus
www.cdc.gov/cmv/index.html

Diphtheria
http://www.cdc.gov/diphtheria/clinicians.html

Escherichia coli (E.Coli)
http://www.cdc.gov/ecoli/index.html

Fifth disease
www.cdc.gov/parvovirusB19/fifth-disease.html

Flu (influenza)
http://public.health.oregon.gov/diseasesconditions/communicabledisease/diseasesurveillancedata/influenza/pages/index.aspx

Giardia (symptom: diarrhea)
www.cdc.gov/parasites/giardia/

Hand, foot, mouth disease
www.cdc.gov/hand-foot-mouth/index.html

Haemophilus influenza type B (Hib)
http://www.cdc.gov/hi-disease/clinicians.html

Hepatitis type A
www.cdc.gov/hepatitis/ChooseA.htm

Hepatitis type B
www.cdc.gov/hepatitis/B/index.htm

Hepatitis type C
www.cdc.gov/hepatitis/C/index.htm

Herpes simplex
www.healthychildren.org/English/health-issues/conditions/skin/pages/Herpes-Simplex-Virus-Cold-Sores.aspx

Impetigo
www.healthychildren.org/English/health-issues/conditions/skin/pages/Impetigo.aspx

Lice
www.healthychildren.org/english/tips-tools/symptom-checker/pages/Lice-Head.aspx

Measles
www.cdc.gov/measles/index.html

Meningitis (meningococcal infection)
www.cdc.gov/meningitis/index.html

Molluscum contagiosum
www.cdc.gov/ncidod/dvrd/molluscum/faq/daycare.htm

Mononucleosis
www.healthychildren.org/English/health-issues/conditions/infections/pages/Mononucleosis.aspx

MRSA (methicillin-resistant staphylococcus aureus)
http://www.cdc.gov/mrsa/index.html

Mumps
www.cdc.gov/mumps/about/mumps-facts.html

Pink eye (conjunctivitis)
www.cdc.gov/conjunctivitis/

Pinworms
www.cdc.gov/parasites/pinworm/index.html

Ringworm of the scalp or body
www.cdc.gov/nczved/divisions/dfbmd/diseases/dermatophytes/

RSV (respiratory syncytial virus)
www.cdc.gov/rsv/about/faq.html

Roseola infantum
http://kidshealth.org/parent/infections/skin/roseola.html

Rubella (German measles, three-day measles, light measles)

www.cdc.gov/Features/Rubella/

Salmonellosis
www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001339/

Scabies
www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001833/

Scarlet fever and strep throat (streptococcal infections)
www.cdc.gov/Features/ScarletFever/

Shigellosis
www.cdc.gov/nczved/divisions/dfbmd/diseases/shigellosis/

Staphylococcal skin infections (also see MRSA)
http://public.health.oregon.gov/diseasesconditions/diseasesaz/staph/pages/facts.aspx

Strep throat – See scarlet fever
http://kidshealth.org/parent/infections/bacterial_viral/strep_throat.html

Streptococcal infections
www.cdc.gov/ncidod/dbmd/diseaseinfo/groupastreptococcal_g.htm

Tuberculosis (Tb)
www.cdc.gov/tb/

Typhoid
www.cdc.gov/nczved/divisions/dfbmd/diseases/typhoid_fever/

Whooping cough (pertussis)
www.cdc.gov/pertussis/

Medication Authorization

________________________staff members may administer ____________________________
Center medication

to my child____. The dosage to be given
Child's Name

is _____________________________ and shall be given at_____________________________.
Dosage Amount Time of day

This medication is to be given from ____and
First date of medication authorization

ending on____ .
Last date of medication authorization

Parent Signature____________________________________ Date______________________

Verification Log

Date	Time	Amount	By Whom

Asthma Action Plan

ENGLISH

PROVIDER INSTRUCTIONS

At initial presentation, determine the level of asthma severity

- Level of severity is determined by both impairment and risk and is assigned to the most severe category in which any feature occurs.

At subsequent visits, assess control to adjust therapy

- Level of control is determined by both impairment and risk and is assigned to the most severe category in which any feature occurs.
- Address adherence to medication, inhaler technique, and environmental control measures.
- Sample patient self-assessment tools for asthma control can be found at **http://www.asthmacontrol.com/index.html** **http://www.asthmacontrolcheck.com**

Stepwise approach for managing asthma:

- Therapy is increased (stepped up) if necessary and decreased (stepped down) when possible as determined by the level of asthma severity or asthma control.

Asthma severity and asthma control include the domains of current impairment and future risk.

Impairment: frequency and intensity of symptoms and functional limitations the patient is currently experiencing or has recently experienced.

Risk: the likelihood of either asthma exacerbations, progressive decline in lung function (or, for children, reduced lung growth), or risk of adverse effects from medication.

ASTHMA MANAGEMENT RECOMMENDATIONS:

— Ensure that patient/family receive education about asthma and how to use spacers and other medication delivery devices.

— Assess asthma control at every visit by self-administered standardized test or verbal history.

— Perform spirometry at baseline and at least every 1 to 2 years for patients $\geq$ 5 years of age.

— Update or review the Asthma Action Plan every 6 to 12 months.

— Perform skin or blood allergy tests for all patients with persistent asthma.

— Encourage patient/family to continue follow-up with their clinician every 1 to 6 months even if asthma is well controlled.

— Refer patient to a specialist if:

- there are difficulties achieving or maintaining control
  OR
- step 4 care or higher is required (step 3 care or higher for children 0-4 years of age) OR
- immunotherapy or omalizumab is considered OR
- additional testing is indicated OR
- if the patient required 2 bursts of oral systemic corticosteroids in the past year or a hospitalization.

HOW TO USE THE ASTHMA ACTION PLAN:

Top copy (for patient):

- Enter specific medication information and review the instructions with the patient and/or family.
- Educate patient and/or family about factors that make asthma worse and the remediation steps on the back of this form.
- **Complete and sign the bottom of the form and give this copy of the form to the patient.**

Middle copy (for school, childcare, work, etc):

- Educate the parent/guardian on the need for their signature on the back of the form in order to authorize student self-carry and self-administration of asthma medications at school and also to authorize sharing student health information with school staff.
- **Provide this copy of the form to the school/childcare center/work/caretaker or other involved third party. (This copy may also be faxed to the school, etc.)**

Bottom copy (for chart):

- **File this copy in the patient's medical chart.**

FOR MORE INFORMATION:

To access the August 2007 full version of the NHLBI Guidelines for the Diagnosis and Treatment of Asthma (EPR-3) or the October 2007 Summary Report, visit **http://www.nhlbi.nih.gov/guidelines/asthma/index.htm.**

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My Asthma Plan ENGLISH

Patient Name: ______________________

Medical Record #: ______________________

Provider's Name: ______________________ DOB: ______________________

Provider's Phone #: ______________________ Completed by: ______________________ Date: ______________

Controller Medicines	How Much to Take	How Often	Other Instructions
		______ times per day EVERY DAY!	❑ Gargle or rinse mouth after use
		______ times per day EVERY DAY!	
		______ times per day EVERY DAY!	
		______ times per day EVERY DAY!	

Quick-Relief Medicines	How Much to Take	How Often	Other Instructions
❑ Albuterol (ProAir, Ventolin, Proventil) ❑ Levalbuterol (Xopenex)	❑ 2 puffs ❑ 4 puffs ❑ 1 nebulizer treatment	Take ONLY as needed (see below — starting in Yellow Zone or before excercise)	NOTE: If you need this medicine more than two days a week, call physician to consider increasing controller medications and discuss your treatment plan.

Special instructions when I am *doing well*, *getting worse*, *having a medical alert.*

GREEN ZONE

Doing *well.*

- No cough, wheeze, chest tightness, or shortness of breath during the day or night.
- Can do usual activities.

Peak Flow (for ages 5 and up):
is ______ or more. (80% or more of personal best)

Personal Best Peak Flow (for ages 5 and up): ______

PREVENT asthma symptoms every day:

- ☐ Take my controller medicines (above) every day.
- ☐ Before exercise, take _____puff(s) of ________________
- ☐ Avoid things that make my asthma worse. (See back of form.)

YELLOW ZONE

Getting *worse.*

- Cough, wheeze, chest tightness, shortness of breath, or
- Waking at night due to asthma symptoms, or
- Can do some, but not all, usual activities.

Peak Flow (for ages 5 and up):
______ to ______(50 to 79% of personal best)

CAUTION. Continue taking every day controller medicines, AND:

- ☐ Take___puffs or___one nebulizer treatment of quick relief medicine. If I am not back in the ***Green Zone*** within 20-30 minutes take ___more puffs or nebulizer treatments. If I am not back in the ***Green Zone*** within one hour, then I should:
- ☐ Increase______________________________
- ☐ Add______________________________
- ☐ Call______________________________
- ☐ Continue using quick relief medicine every 4 hours as needed. Call provider if not improving in ______days.

RED ZONE

Medical Alert

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone.

Peak Flow (for ages 5 and up):
less than _________(50% of personal best)

MEDICAL ALERT! Get help!

- ☐ Take quick relief medicine: _____puffs every _____minutes and get help immediately.
- ☐ Take ______________________________
- ☐ Call ______________________________

Danger! Get help immediately! Call 911 if trouble walking or talking due to shortness of breath or if lips or fingernails are gray or blue. For child, call 911 if skin is sucked in around neck and ribs during breaths or child doesn't respond normally.

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may self carry asthma medications: ❑ Yes ❑ No self administer asthma medications: ❑ Yes ❑ No (This authorization is for a maximum of one year from signature date.)

______________________________ ______________________
Healthcare Provider Signature Date

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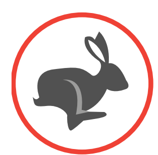
Controlling Things That Make Asthma Worse

❑ **SMOKE**
- Do not smoke. Attend classes to help stop smoking.
- Do not allow smoking in the home or car. Remaining smoke smell can trigger asthma.
- Stay away from people who are smoking.
- If you smoke, smoke outside.

❑ **DUST**
- Vacuum weekly with a vacuum with a high efficiency filter or a central vacuum. Try to make sure people with asthma are not home during vacuuming.
- Remove carpet if possible. Wet carpet before removing and then dry floor completely.
- Damp mop floors weekly.
- Wash bedding and stuffed toys in hot water every 1-2 weeks. Freeze stuffed toys that aren't washable for 24 hours.
- Cover mattresses and pillows in dust-mite proof zippered covers.
- Reduce clutter and remove stuffed animals, especially around the bed.
- Replace heating system filters regularly.

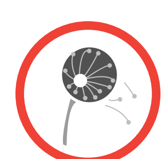
❑ **PESTS**
- Do not leave food or garbage out. Store food in airtight containers.
- Try using traps and poison baits, such as boric acid for cockroaches. Instead of sprays/bombs, use baits placed away from children, such as behind refrigerator.
- Vacuum up cockroach bodies and fill holes in with caulking or copper wool.
- Fix leaky plumbing, roof, and other sources of water.

❑ **MOLD**
- Use exhaust fans or open windows for cross ventilation when showering or cooking.
- Clean mold off hard surfaces with detergent in hot water and scrub with stiff brush or cleaning pad, then rinse clean with water. Absorbent materials with mold may need to be replaced.
- Make sure people with asthma are not in the room when cleaning.
- Fix leaky plumbing or other sources of water or moisture.



❑ **ANIMALS**
- Consider not having pets. Avoid pets with fur or feathers.
- Keep pets out of the bedroom of the person with asthma.
- Wash your hands and the hands of the person with asthma after petting animals.

❑ **ODORS/SPRAYS**
- Avoid using strongly scented products, such as home deodorizers and incense, and perfumed laundry products and personal care products.
- Do not use oven/stove for heating.
- When cleaning, keep person with asthma away and don't use strong smelling cleaning products.
- Avoid aerosol products.
- Avoid strong or extra strength cleaning products.
- Avoid ammonia, bleach, and disinfectants.



❑ **POLLEN AND OUTDOOR MOLDS**
- Try to stay indoors when pollen and mold counts are high.
- Keep windows closed during pollen season.
- Avoid using fans; use air conditioners.

❑ **COLDS/FLU**
- Keep your body healthy with enough exercise and sleep.
- Avoid close contact with people who have colds.
- Wash your hands frequently and avoid touching your hands to your face.
- Get an annual flu shot.

❑ **WEATHER AND AIR POLLUTION**
- If cold air is a problem, try breathing through your nose rather than your mouth and covering up with a scarf.
- Check for Spare the Air days and nights and avoid strenuous exercise at those times.
- On very bad pollution days, stay indoors with windows closed.

❑ **EXERCISE**
- Warm up before exercising.
- Plan alternate indoor activities on high pollen or pollution days.
- If directed by physician, take medication before exercise. (See Green Zone of Asthma Action Plan.)

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My Asthma Plan ENGLISH

Patient Name: ______________________

Medical Record #: ______________________

Provider's Name: ______________________ DOB: ______________________

Provider's Phone #: ______________ Completed by: ______________ Date: ________

Controller Medicines	How Much to Take	How Often	Other Instructions
		_____ times per day **EVERY DAY!**	❑ Gargle or rinse mouth after use
		_____ times per day **EVERY DAY!**	
		_____ times per day **EVERY DAY!**	
		_____ times per day **EVERY DAY!**	
Quick-Relief Medicines	**How Much to Take**	**How Often**	**Other Instructions**
❑ Albuterol (ProAir, Ventolin, Proventil) ❑ Levalbuterol (Xopenex)	❑ 2 puffs ❑ 4 puffs ❑ 1 nebulizer treatment	Take ONLY as needed (see below — starting in Yellow Zone or before excercise)	NOTE: If you need this medicine more than two days a week, call physician to consider increasing controller medications and discuss your treatment plan.

Special instructions when I am *doing well*, *getting worse*, *having a medical alert.*

GREEN ZONE

Doing *well.*

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Peak Flow (for ages 5 and up):
is ______ or more. (80% or more of personal best)

Personal Best Peak Flow (for ages 5 and up): ______

PREVENT asthma symptoms every day:

- ☐ Take my controller medicines (above) every day.
- ☐ Before exercise, take _____ puff(s) of ________________
- ☐ Avoid things that make my asthma worse. (See back of form.)

YELLOW ZONE

Getting *worse.*

- Cough, wheeze, chest tightness, shortness of breath, or
- Waking at night due to asthma symptoms, or
- Can do some, but not all, usual activities.

Peak Flow (for ages 5 and up):
______ to ______(50 to 79% of personal best)

CAUTION. Continue taking every day controller medicines, AND:

- ☐ Take___puffs or___one nebulizer treatment of quick relief medicine. If I am not back in the ***Green Zone*** within 20-30 minutes take ___more puffs or nebulizer treatments. If I am not back in the ***Green Zone*** within one hour, then I should:
- ☐ Increase______________________________
- ☐ Add______________________________
- ☐ Call______________________________
- ☐ Continue using quick relief medicine every 4 hours as needed. Call provider if not improving in ______days.

RED ZONE

Medical Alert

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone.

Peak Flow (for ages 5 and up):
less than _________(50% of personal best)

MEDICAL ALERT! Get help!

- ☐ Take quick relief medicine: _____puffs every _____minutes and get help immediately.
- ☐ Take ______________________________
- ☐ Call ______________________________

Danger! Get help immediately! Call 911 if trouble walking or talking due to shortness of breath or if lips or fingernails are gray or blue. For child, call 911 if skin is sucked in around neck and ribs during breaths or child doesn't respond normally.

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may self carry asthma medications: ❑ Yes ❑ No self administer asthma medications: ❑ Yes ❑ No (This authorization is for a maximum of one year from signature date.)

______________________________ ______________________________

Healthcare Provider Signature Date

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SCHOOL AUTHORIZATION FORM
To be completed by Parent/Guardian and turned in to the school

ENGLISH

AUTHORIZATION AND DISCLAIMER FROM PARENT/GUARDIAN: I request that the school assist my child with the asthma medications listed on this form, and the Asthma Action Plan, in accordance with state laws and regulations.

❑ **Yes** ❑ **No**.

My child may carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications:

❑ **Yes** ❑ **No**.

____ ______________________

Parent/Guardian Signature Date

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: ____ / ______________________

Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1)________________________________ (2) ________________________________ to provide health information from the above-named child's medical record to and from:

________________________________ ________________________________

School or school district to which disclosure is made Address / City and State / Zip Code

________________________________ ________________________________

Contact person at school or school district Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

____

Requested information shall be limited to the following: ❑ All health information; or ❑ Disease-specific information as described:

____

DURATION:
This authorization shall become effective immediately and shall remain in effect until ____________(enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:
Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:
I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.

RE-DISCLOSURE:
I understand that the Requestor (School District) will protect this information as prescribed by the Family Equal Rights Protection Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL: ______________________ ______________________ ______________

Printed Name Signature Date

______________________ ______________________

Relationship to Patient/Student Area Code and Telephone Number

My Asthma Plan ENGLISH

Patient Name: ______________________

Medical Record #: ______________________

Provider's Name: ______________________ DOB: ______________________

Provider's Phone #: ______________________ Completed by: ______________________ Date: ____________

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		______ times per day **EVERY DAY!**	
		______ times per day **EVERY DAY!**	
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- ☐ Avoid things that make my asthma worse. (See back of form.)

YELLOW ZONE

Getting *worse.*

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- Waking at night due to asthma symptoms, or
- Can do some, but not all, usual activities.

Peak Flow (for ages 5 and up):
______ to ______(50 to 79% of personal best)

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- ☐ Take ______________________________
- ☐ Call ______________________________

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______________________________ ______________________________
Healthcare Provider Signature Date

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This Asthma Plan was developed by a committee facilitated by the Regional Asthma Management and Prevention (RAMP) Initiative, a program of the Public Health Institute. This publication was supported by Cooperative Agreement Number 1U58DP001016-01 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC. This plan is based on the recommendations from the National Heart, Lung, and Blood Institute's, "Guidelines for the Diagnosis and Management of Asthma," NIH Publication No. 07-4051 (August 2007).
The information contained herein is intended for the use and convenience of physicians and other medical personnel and may not be appropriate for use in all circumstances. Decisions to adopt any particular recommendation must be made by qualified medical personnel in light of available resources and the circumstances presented by individual patients. No entity or individual involved in the funding or development of this plan makes any warranty or guarantee, express or implied, of the quality, fitness, performance or results of use of the information or products described in the plan or the Guidelines.
For additional information, please contact
RAMP at (510) 302-3365, http://www.rampasthma.org.

Seizure Care Plan

The seizure care plan defines all members of the team, communication guidelines (how, when, and how often), and all information necessary to support a child who may experience seizures while in child care.

Name of Child: ______________________________ Date: ______________

Facility Name: ______________________________

Description of seizure condition/disorder: ______________________________

____

Describe what the child's seizures look like: (1) what part of the body is affected? (2) How long do the seizure episodes usually last?

____

____

Describe any know "triggers" (behaviors and/or symptoms) **for seizure activity**: ______________________________

____

Detail the frequency and duration of child's typical seizure activity: ______________________________

Has the child been treated in the emergency room due to their seizures? ______________ How many times? __________

Has the child stayed overnight in the hospital due to their seizures? ______________ How many times? __________

Team Member Names and Titles (parents of the child are to be included)

Care Coordinator (responsible for developing and administering the Seizure Care Plan): ______________________________

____

____

ⓘ *If training is necessary, then ALL team members will be trained.*

Planned strategies to support the child's needs and safety issues when the child has a seizure:
(e.g., diapering/toileting, outdoor play, nap/sleeping, etc) ______________________________

____

____

❑ Individualized Family Service Plan **(IFSP)** attached. ❑ Individualized Education Plan **(IEP)** attached.

PROBLEM	TREATMENT	EXPECTED RESPONSE
At risk for injury due to uncontrolled seizure activity.	If a seizure occurs, staff will remove objects from the area and place a folded towel/clothing beneath the child's head. Protective helmet is worn as prescribed.	Injuries related to seizure activity will be prevented.
At risk for aspiration of respiratory secretions or vomitus during seizure activity.	If a seizure occurs, staff will roll the child onto his/her side.	Child will not aspirate during seizure activity.
Self-esteem disturbance related to occurrence of seizure or use of protective helmet.	Provide many opportunities for success. Praise achievements and accomplishments. Provide opportunities for child to express feelings about seizures and any activity restrictions. Reassure the other children in the group that the child will be OK if a seizure occurs.	The child will successfully adapt to requirements of living with a seizure disorder. The child will demonstrate a positive attitude toward learning activities. Other children will feel safe.
Parent and child may not be aware of possible triggers.	Staff will document the occurrence of any seizure activity on attached *Seizure Activity Log*.	Parents, staff and the child will learn to identify triggers and how to avoid them.
Child may be very sleepy, but not unresponsive after a seizure occurs.	Staff will make sure that the child is responsive after a seizure, then will allow the child to sleep/rest after the seizure.	The child may safely sleep/rest, if needed, after seizure occurs.

Communication

What is the team's communication goal and how will it be achieved (e.g., notes, communication log, phone calls, meetings, etc.): __________

____

How often will team communication occur: ❑ **Daily** ❑ **Weekly** ❑ **Monthly** ❑ **Bi-monthly**

Date and time specifics: ______________________________

Other Professionals Involved **Telephone**

Health Care Provider (MD, NP, etc.): ______________________________ ______________

Occupational Therapist: ______________________________ ______________

Physical Therapist: ______________________________ ______________

Neurology Specialist: ______________________________ ______________

Other: ______________________________ ______________

Specific Medical Information

❖ Medical documentation provided & attached: ❑ Yes ❑ No

❑ **Information Exchange Form** completed by Health Care Provider on-file.

Any known allergies to food and/or medications: ______________________________

❖ Medication to be administered: ❑ Yes ❑ No

❑ **Medication Administration Form** completed by Health Care Provider and parents is on file (including: type of medications, method, amount, time schedule, potential side effects, etc.)

Special Staff Training Needs

Type (be specific): ______________________________

Training done by: ______________________ Date of Training: ______________

Additional Information (include any unusual episodes/behavior changes that might arise while in care and how the situation should be handled)

____

____

____

Support Program the Child is Involved With Outside of Child Care

Name of program: ______________________________

Address and telephone: ______________________________

Contact person: ______________________________

Emergency Procedures

❑ *Special emergency and/or medical procedure required.* Emergency instructions: ______________________________

____

❖ Call 911 if: ❑ Seizure lasts longer then ____ minutes. ❑ Child is unresponsive after seizure.
❑ Other: ______________________________

Emergency contact: ______________________ Telephone: ______________

Follow-up: Updates/Revisions

This *Seizure Care Plan* will be updated/revised whenever medications or child's health status changes, or at least every 12 months as a result of the collective input from team members.

Date for revision and team meeting: ______________

Special Health Care Plan

The special health care plan defines all members of the care team, communication guidelines (how, when, and how often), and all information on appropriately accommodating the special health concerns and needs of this child while in child care.

Name of Child: ______________________________ **Date:** ____________________

Facility Name: ______________________________

Description of condition(s): (include description of difficulties associated with each condition) ______________________________

____

____

____

Team Member Names and Titles (parents of the child are to be included)

Care Coordinator (responsible for developing and administering the Special Health Care Plan): ______________________________

____

____

____

____

____

____

ⓘ If training is necessary, then all team members will be trained.

❑ Individualized Family Service Plan **(IFSP)** attached ❑ Individualized Education Plan **(IEP)** attached

Outside Professionals Involved	**Telephone**
Health Care Provider (MD, NP, etc.): ____________	____________
Speech & Language Therapist: ____________	____________
Occupational Therapist: ____________	____________
Physical Therapist: ____________	____________
Psychologist/Mental Health Consultant: ____________	____________
Social Worker: ____________	____________
Family-Child Advocate: ____________	____________
Other: ____________	____________

Communication

How the team will communicate (notes, communication log, phone calls, meetings, etc.):

____

____

How often will team communication occur: ❑ **Daily** ❑ **Weekly** ❑ **Monthly** ❑ **Bi-monthly** ❑ **Other** ____________

Date and time specifics: ______________________________

Specific Medical Information

- ❖ Medical documentation provided and attached: ❑ Yes ❑ No
- ❑ **Information Exchange Form** completed by health care provider is in child,s file on site.
- ❖ Medication to be administered: ❑ Yes ❑ No
- ❑ **Medication Administration Form** completed by health care provider and parents are in child's file on site (including: type of medications, method, amount, time schedule, potential side effects, etc.)

Any known allergies to foods and/or medications: ______________________

Specific health-related needs: ______________________

____

____

____

____

Planned strategies to support the child's needs and any safety issues while in child care: (diapering/toileting, outdoor play, circle time, nap/sleeping, etc.) ______________________

____

____

____

____

____

Plan for absences of personnel trained and responsible for health-related procedure(s): ______________________

____

____

Other (i.e., transportation, field trips, etc.): ______________________

____

Special Staff Training Needs

Training monitored by: ______________________

1) Type (be specific): ______________________

Training done by: ______________________ Date of Training: ______________________

2) Type (be specific): ______________________

Training done by: ______________________ Date of Training: ______________________

3) Type (be specific): ______________________

Training done by: ______________________ Date of Training: ______________________

Equipment/Positioning

- ❖ Physical Therapist (PT) and/or Occupational Therapist (OT) consult provided: ❑ Yes ❑ No ❑ Not Needed

Special equipment needed/to be used: ______________________

____

Positioning requirements (attach additional documentation as necessary): ______________________

____

Equipment care/maintenance notes: ______________________

Nutrition and Feeding Needs

❏ **Nutrition and Feeding Care Plan Form** completed by team is in child's file on-site . See for detailed requirements/needs.

Behavior Changes (be specific when listing changes in behavior that arise as a result of the health-related condition/concerns)

____

____

____

Additional Information (include any unusual episodes that might arise while in care and how the situation should be handled)

____

____

____

Support Programs the Child Is Involved with Outside of Child Care

1. Name of program: ____________________________ Contact person: ______________________

   Address and telephone: ____

   Frequency of attendance: ____

2. Name of program: ____________________________ Contact person: ______________________

   Address and telephone: ____

   Frequency of attendance: ____

3. Name of program: ____________________________ Contact person: ______________________

   Address and telephone: ____

   Frequency of attendance: ____

Emergency Procedures

❏ Special emergency and/or medical procedure required (additional documentation attached)

Emergency instructions: ____

____

____

Emergency contact: ________________________________ Telephone: ________________________

Follow-up: Updates/Revisions

This Special Health Care Plan is to be updated/revised whenever child's health status changes or at least every __________ months as a result of the collective input from team members.

Due date for revision and team meeting: ______________________

Cleaning, Sanitizing and Disinfecting With Bleach

For early care and education facilities

Clean first!
Scrub with soap and warm water and rinse. Always clean surfaces to remove visible soil before sanitizing or disinfecting to remove all dirt and contamination.

Next mix bleach solution.
Mix bleach with cool water. Mix fresh solutions daily. Do not mix liquid bleach with other cleaning products, toilet bowl cleaners or ammonia, which may release hazardous gases into the air.

Then sanitize or disinfect.

- Wet entire surface until glistening.
- Leave solution on surface for two minutes.
- Dry with a paper towel or air-dry.

Store all cleaning products where children cannot reach them.

Sanitizing: Reducing germs on surfaces to safer levels

- **Sanitize after EACH use:**
  - Children's mouthed toys
  - Food service areas, dishes
- **Sanitize daily or when soiled:**
  - Dishcloths, synthetic sponges
  - Common surfaces (other than in bathrooms), floors, mats, tables, countertops and hard surfaces, door knobs, etc.

Sanitizing solution
10 drops bleach/pint water
¼ teaspoon bleach/quart water
1 teaspoon bleach/gallon water

Disinfecting: Destroying or inactivating most germs

- **Disinfect after EACH use:**
  - Diaper changing surface
- **Disinfect daily or when soiled:**
  - Bathroom areas:
    - Toilet bowls and seats and flush handles
    - Toilet training equipment
    - Sinks, faucets

Disinfecting solution
½ tablespoon bleach/pint water
1 tablespoon bleach/quart water
¼ cup bleach/gallon water

Procedimiento para cambiar pañales

1 Organícese

Lávese las manos.

Reúna los artículos que necesite:

- ✔ papel desechable no absorbente (se recomienda) o un cojín o un colchoncito
- ✔ pañal nuevor
- ✔ ropa limpia (en caso de ser necesario)
- ✔ bolsas de plástico para artículos o ropa sucia
- ✔ toallitas desechables
- ✔ guantes (se recomienda)
- ✔ crema para rozaduras, sáquela del envase y póngala en un pañuelo de papel desechable

Póngase guantes desechables.

2 Cargue al niño al área donde lo va a cambiar

Evite el contacto con la ropa sucia, con la orina o excremento (gérmenes).

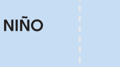
- Ponga al niño con cuidado sobre el lugar donde lo va a cambiar.

Siempre detenga al niño por lo menos con una mano.

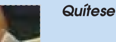
- Según sea necesario, quítele su ropa, sus zapatos y sus calcetines.
- Coloque la ropa sucia en una bolsa de plástico. Cierre la bolsa con cuidado para enviarla a la casa del niño. *No enjuague ninguno de los contenidos.*

3 Limpie al niño

- Limpie el excremento de adelante hacia atrás.
- Use una toallita fresca o una toalla de papel nueva y húmeda cada vez que limpie al niño de adelante hacia atrás.
- Ponga la toallita o toalla de papel sucia en un bote de basura que esté forrado por dentro de plástico y que tenga una tapa. Este bote se debe de abrir con un pedal de pie (sin tocar el bote con las manos).
- Si se usa papel desechable, dóblelo empezando por la parte de los pies si hay algún derrame debajo del niño.



4 Quítele el pañal sucio al niño



INMEDIATAMENTE ponga el pañal desechable en un bote de basura con tapa, forrado por dentro de plástico, y no utilice sus manos para abrir el bote.

Ponga el pañal reciclable y/o la ropa sucia en una bolsa de plástico, ciérrela con cuidado para enviársela a la casa del niño. *No enjuague nada.*

Quítese los guantes.

Tírelos inmediatamente.

5 Póngale un pañal limpio al niño

- Coloque el pañal nuevo abajo del niño.
- Use una gasa o un pañuelo de papel para ponerle la crema de rozaduras. Tire la gasa o el papelito en el bote de basura forrado de plástico, tapado y sin utilizar las manos.
- Ajuste y abroche el pañal.
- Póngale el resto de su ropa al niño.

6 Lávele las manos al niño

Lleve al niño al lavabo. Detenga al niño y lávele las manos con agua y con jabón

Si el niño tiene la capacidad de pararse solo, lávese las manos en el lavabo de adultos y después asista al niño a lavarse las manos en el lavabo para niños.

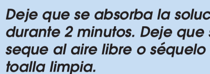
Si usted no tiene la capacidad de cargar al niño y si el niño no tiene la capacidad de parase enfrente del lavabo, use toallitas desechables comerciales para limpiar las manos del niño: límpielo en medio de los dedos, limpiele las muñecas y de los dos lados de la mano. O utilice el método de las tres toallas desechables: utilice la primera toalla húmeda y con jabón para lavarle las manos, utilice la segunda toalla para enjuagarle las manos, y utilice la tercera toalla para secarle las manos.

Regrese al Niño al Área de Supervisión.

7 Limpie, enjuague, y desinfecte el área donde se cambian los pañales

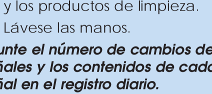
- Si se utilizó un forro de papel, tire el forro en el bote de basura forrado de plástico, tapado y sin utilizar las manos.
- Rocíe y limpie completamente con detergente **toda** el área donde se cambian los pañales.
- Enjuague el área con agua.
- Rocíe **toda** el área con solución desinfectante.

Si utilizó un cojín o un colchoncito, rocíe los dos lados del cojín y la superficie de la mesa con detergente. Enjuague el área con agua. Rocíe los dos lados del cojín con la solución desinfectante.



Deje que se absorba la solución durante 2 minutos. Deje que se seque al aire libre o séquelo con una toalla limpia.

8 Lávese las manos



- Guarde la solución desinfectante y los productos de limpieza.
- Lávese las manos.

Apunte el número de cambios de pañales y los contenidos de cada pañal en el registro diario.

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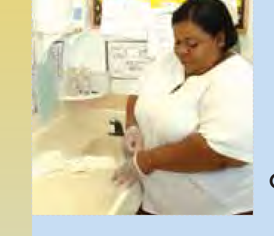
Procedimiento para cambiar pañales



1 Organícese

Lávese las manos.

Reúna los artículos que necesite:

- ✔ papel desechable no absorbente (se recomienda) o un cojín o un colchoncito
- ✔ pañal nuevor
- ✔ ropa limpia (en caso de ser necesario)
- ✔ bolsas de plástico para artículos o ropa sucia
- ✔ toallitas desechables
- ✔ guantes (se recomienda)
- ✔ crema para rozaduras, sáquela del envase y póngala en un pañuelo de papel desechable

Póngase guantes desechables.

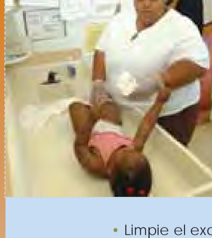
2 Cargue al niño al área donde lo va a cambiar

Evite el contacto con la ropa sucia, con la orina o excremento (gérmenes).

- Ponga al niño con cuidado sobre el lugar donde lo va a cambiar.

Siempre detenga al niño por lo menos con una mano.

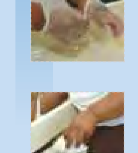
- Según sea necesario, quítele su ropa, sus zapatos y sus calcetines.
- Coloque la ropa sucia en una bolsa de plástico. Cierre la bolsa con cuidado para enviarla a la casa del niño. *No enjuague ninguno de los contenidos.*



3 Limpie al niño

- Limpie el excremento de adelante hacia atrás.
- Use una toallita fresca o una toalla de papel nueva y húmeda cada vez que limpie al niño de adelante hacia atrás.
- Ponga la toallita o toalla de papel sucia en un bote de basura que esté forrado por dentro de plástico y que tenga una tapa. Este bote se debe de abrir con un pedal de pie (sin tocar el bote con las manos).
- Si se usa papel desechable, dóblelo empezando por la parte de los pies si hay algún derrame debajo del niño.

4 Quítele el pañal sucio al niño



INMEDIATAMENTE ponga el pañal desechable en un bote de basura con tapa, forrado por dentro de plástico, y no utilice sus manos para abrir el bote.

Ponga el pañal reciclable y/o la ropa sucia en una bolsa de plástico, ciérrela con cuidado para enviársela a la casa del niño. *No enjuague nada.*

Quítese los guantes.

Tírelos inmediatamente.

5 Póngale un pañal limpio al niño

- Coloque el pañal nuevo abajo del niño.
- Use una gasa o un pañuelo de papel para ponerle la crema de rozaduras. Tire la gasa o el papelito en el bote de basura forrado de plástico, tapado y sin utilizar las manos.
- Ajuste y abroche el pañal.
- Póngale el resto de su ropa al niño.

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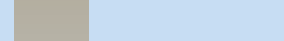
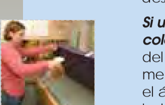
Regrese al Niño al Área de Supervisión.

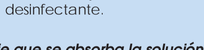


7 Limpie, enjuague, y desinfecte el área donde se cambian los pañales

- Si se utilizó un forro de papel, tire el forro en el bote de basura forrado de plástico, tapado y sin utilizar las manos.
- Rocie y limpie completamente con detergente **toda** el área donde se cambian los pañales.
- Enjuague el área con agua.
- Rocie **toda** el área con solución desinfectante.



Si utilizó un cojín o un colchoncito, rocie los dos lados del cojin y la superficie de la mesa con detergente. Enjuague el área con agua. Rocie los dos lados del cojin con la solución desinfectante.



Deje que se absorba la solución durante 2 minutos. Deje que se seque al aire libre o séquelo con una toalla limpia.

8 Lávese las manos

- Guarde la solución desinfectante y los productos de limpieza.
- Lávese las manos.

Apunte el número de cambios de pañales y los contenidos de cada pañal en el registro diario.

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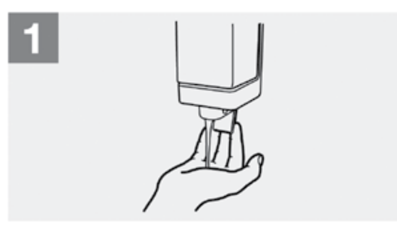
How to Handwash?

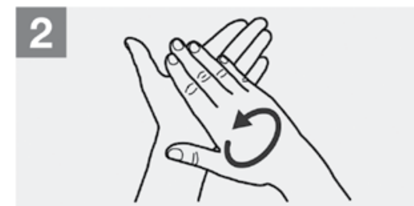
WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

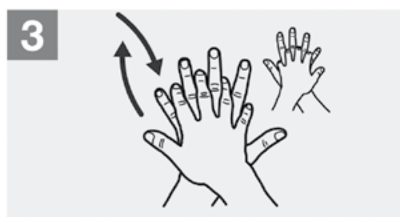
Wet hands with water;



Apply enough soap to cover all hand surfaces;



Rub hands palm to palm;

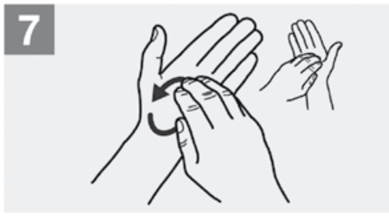


Right palm over left dorsum with interlaced fingers and vice versa;

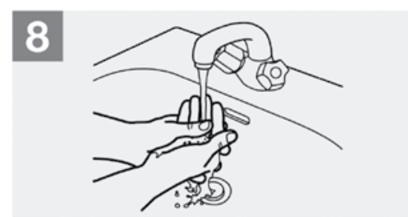
Palm to palm with fingers interlaced;

Backs of fingers to opposing palms with fingers interlocked;

Rotational rubbing of left thumb clasped in right palm and vice versa;



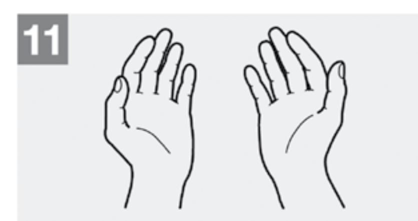
Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



Rinse hands with water;

Dry hands thoroughly with a single use towel;

Use towel to turn off faucet;



Your hands are now safe.

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WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

Infant Handwashing

When to Wash Infant's Hands

- Upon arrival
- Before and after infant receives bottle or food
- After diapering
- After contact with body fluids
- After outside play
- Before and after water play
- After handling pets
- Whenever hands are visibly dirty
- Before going home

Handwashing Steps

- Turn on warm water (90-110ºF in NC).
- Wet hands with water.
- Apply liquid soap.
- Wash hands for 10-15 seconds. Rub top and inside of hands, under nails and between fingers.
- Rinse hands with water.
- Dry hands with disposable paper towel.
- Turn off the water using paper towel.
- Throw paper towel into a lined trash container.

Very Young Infants

Very Young Infants

unable to support their heads

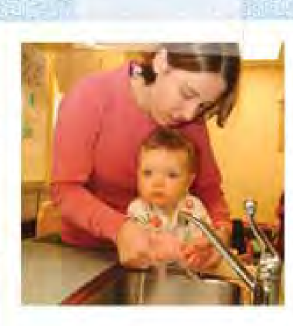
The infant is unable to hold head up or stand at sink, or the infant is too heavy for you to hold at sink.

Wash the infants hands with:

- disposable wipes

or

- the three towel method (prepared ahead):
  1. dampened and soapy for washing infant's hands
  2. dampened with water for rinsing infant's hands
  3. dry for drying infant's hands



Young Infants

Young Infants

who can support their heads but not stand at the sink

You are able to hold the infant, but the infant cannot stand at the sink.

- Carry infant to sink.
- Hold infant at the sink and wash infant's hands.

Caution! Do not push the infant's tummy into the sink.

Back Aid Place your foot on a 12" stool to lift your leg. Rest the infant on your knee at the sink.

Older Infants

Older Infants

who can stand at the sink

Infant can stand at a toddler height sink or on a stool at a sink.

- First wash your hands.
- Then assist the infant with hand washing.

"Working together for healthy and safe child care"

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The development, translation, and mailing of the Infant Handwashing Poster are supported by funding from the Child Care and Development Fund Block Grant of the Child Care Bureau, Administration on Children and Families, USDHHS, through a contract between the NC Division of Child Development, NCDHHS, and the Department of Maternal and Child Health, School of Public Health, The University of North Carolina at Chapel Hill.

Procedimiento para lavarle las manos a los bebés

Se les deben de lavar las manos a los bebés

- Al recibirlos
- Antes y después de tomarse su botella y de comer
- Después de cambiarles el pañal
- Después de haber tenido cualquier contacto con fluidos corporales
- Después de haber jugado al aire libre
- Después de haber jugado con agua
- Después de haber tocado o jugado con cualquier animal
- Siempre que sus manos se vean sucias
- Antes de regresarse a su casa

Pasos para lavarles las manos a los bebés

- Abra el agua tibia (90-110ºF en Carolina del Norte).
- Moje las manos del bebé con agua.
- Póngale jabón líquido.
- Lave las manos del bebé de 10 a 15 segundos. Frote todas las partes de las manos, limpie debajo de las uñas y en medio de los dedos.
- Enjuague las manos con agua.
- Seque las manos con una toalla de papel desechable.
- Cierre las llaves del agua utilizando una toalla de papel.
- Tire la toalla de papel en un bote de basura forrado por dentro.

Bebés muy pequeños

Para bebés muy pequeños

que no tienen la capacidad de sostener la cabezas

Si el bebé no tiene la capacidad de sostener su cabeza o de pararse en el lavabo, o si el bebé está demasiado pesado para que usted lo cargue junto al lavabo.

Lave las manos del bebé con:

- Toallitas desechables

o

- Utilice el método de las tres toallas (previamente preparadas):
  1. una toalla húmeda y enjabonada para lavarle las manos al bebé
  2. una toalla húmeda con agua para enjuagarle las manos al bebé
  3. una toalla seca para secarle las manos al bebé

Bebés pequeños

Para bebés pequeños

que puedan sostener la cabeza pero que no puedan pararse al lado del lavabo

Usted tiene la capacidad de cargar al bebé, pero el bebé no puede pararse enfrente del lavabo.

- Cargue al bebé al lavabo.
- Sostenga al bebé junto al lavabo y lávele las manos.

¡Precaución! No empuje la pancita del bebé contra el lavabo.

Ayuda para la espalda Ponga su pie sobre una banca de 12″ pulgadas. Recargue al bebé sobre su rodilla para poder alcanzar el lavabo.

Bebés más grandes

Para bebés más grandes

que puedan pararse al lado del lavabo

Para un bebé que pueda pararse enfrente de un lavabo infantil o que pueda parase en un banco junto al lavabo.

- Primero lávese las manos usted.
- Después ayude al bebé a lavarse las manos.

"Trabajando juntos para lograr un cuidado de niños saludable y seguro"

http://www.oregonccrr.com

Oregon DHS-Office of Family Health (971) 673-0232

• El desarrollo, la traducción y distribución del póster del procedimiento para lavarle las manos a los bebés reciben fondos y apoyo por parte del Fund Block Grant de Desarrollo y Cuidado para los Niños del Buró de Cuidado para los Niños, USDHHS, por medio de un contrato entre la División de Carolina del Norte del Desarrollo para los Niños, NCDHHS, y el Departamento de Salud Maternal e Infantil de la Escuela de Salud Pública de la Universidad de Carolina del Norte en Chapel Hill.

Mixing Sanitizing and Disinfecting Solutions

1 pint solution

Sanitizing

10 drops bleach/pint water

Disinfecting

½ tablespoon bleach/pint water

1 quart solution

Sanitizing

¼ teaspoon bleach/quart water

Disinfecting

1 tablespoon bleach/quart water

1 gallon solution

Sanitizing

1 teaspoon bleach/gallon water

Disinfecting

¼ cup bleach/gallon water

Oregon Kids: Healthy and Safe 3/2012

Washing Your Hands

1. Turn water on.

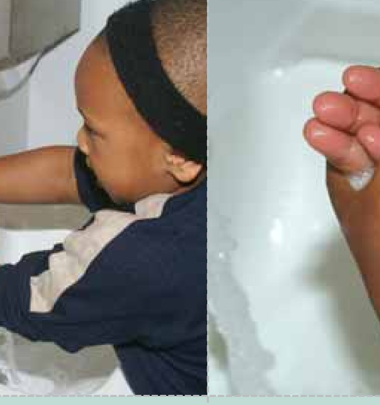
- Be sure clean, disposable paper towels are available.
- Turn on warm water.

2. Wet hands.

- Wet hands with water.

3. Apply soap.

- Apply liquid soap.



4. Wash hands.

- Wash hands well for at least 10-15 seconds. Rub top and inside of hands, under nails and between fingers.

5. Rinse hands.

- Rinse hands under running water for at least 10 seconds.

6. Dry hands.

- Dry hands with clean, disposable paper towel.

7. Turn water off.

- Turn off the water using the paper towel.

8. Throw paper towel away.

- Throw the paper towel into a lined trash container.

Teach children to wash their hands:

- Upon arrival to the center

- Before and after eating

- After using the toilet/diapering

- After coughing or contact with body fluids: runny nose, blood, vomit
- Before and after using water tables
- After outside play
- After handling pets
- Whenever hands are visibly dirty
- Before going home

Bye!

Oregon DHS-Office of Family Health
(971) 673-0232

"Working together for healthy and safe child care"
http://www.oregonccrr.com

The development, translation, and mailing of the Infant Handwashing Poster are supported by funding from the Child Care and Development Fund Block Grant of the Child Care Bureau, Administration on Children and Families, DHHS, through a contract between the NC Division of Child Development, NCDHHS, and the Department of Maternal and Child Health School of Public Health, The University of North Carolina at Chapel Hill.

Lavado de Manos

1. Abra la llave.

- Asegú rese de que h aya toallas de papel limpias.
- Abra la llave de agua caliente.

2. Mójese las manos.

- Mójese las manos con agua.

3. Aplíquese jabón.

- Aplíquese jabón líquido en las manos.

4. Lávese las manos.

- Lávese bien las manos durante 10 a 15 segundos. Frote la parte de arriba y la parte de adentro de las manos, debajo de las uñas y entre los dedos.

5. Enjuáguese las manos.

- Enjuáguese las manos bajo el agua por lo menos 10 segundos.

6. Séquese las manos.

- Séquese las manos con una toalla de papel limpia.

7. Cierre la llave de agua.

- Cierre la llave de agua usando la toalla de papel.

8. Bote la toalla de papel.

- Bote la toalla de papel en un basurero con bolsa.

Enseñe a los niños a lavarse las manos:

- Al llegar al centro
  hóla!
- Antes y después de comer
- Después de ir al baño o de que se les cambian los pañales
- Después de toser o tocar líquidos corporales, excreciones nasales, sangre o vómito
- Antes y después de usar las mesas de agua
- Después de jugar afuera
- Después de tocar animales domésticos
- Cuando sea que las manos se vean claramente sucias
- Antes de irse a casa
  adios..

Oregon DHS-Office of Family Health

(971) 673-0232

DHS Oregon Department of Human Services

Healthy Child Care Oregon

"Trabajando juntos para lograr un cuidado de niños saludable y seguro"

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Oregon Certificate of Immunization Status
Oregon Department of Human Services, Immunization Program

Oregon law requires proof of immunization be provided or a religious or medical exemption be signed prior to a child's attendance at school, preschool, child care or home day care. This information is being collected on behalf of the Oregon Department of Human Services, Immunization Program and may be released to the Department or the local Public Health Authority by the school or children's facility upon request of the Department. Vaccine history must include at least the month and year. Please list immunizations in the order they were received.

Complete for all
Up-to-date
Medical
Religious

Child's Last Name *Apellido*	First *Primer Nombre*	Middle Initial *Segundo Nombre*	Birthdate *Fecha de Nacimiento*

Mailing Address *Dirección*	City *Ciudad*	State *Estado*	Zip Code *Codigo Postal*

Parents' or Guardians' Names *Nombre de los padres o guardian*	Home Telephone Number *Número de Teléfono*

Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria/Tetanus/Pertussis (DTaP, Tdap, Td)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)
Booster Dose Tdap (not given prior to 10 years of age)					
Polio (IPV or OPV)					
Varicella (Chickenpox) [VZV or VAR] ☐ Check here if child has had chickenpox disease _____________ (mm/dd/yy)					
Measles/Mumps/Rubella (MMR)					
or Measles vaccine only					
Mumps vaccine only					
Rubella vaccine only					
Hepatitis B (Hep B)					
Hepatitis A (Hep A)					
Haemophilus Influenzae Type B (Hib) (Only children less than 5 years)					

I certify that the above information is an accurate record of this child's immunization history.

Signature* ______________________________ Date

Update Signature ______________________________ Date

Update Signature ______________________________ Date

Update Signature ______________________________ Date

*Parent, guardian, child at least 15 years of age, medical provider or county health department staff person may sign to verify vaccinations received.

For school/facility use only
School/facility Name
Student ID Number
Grade

Continued On Reverse Side

Oregon Certificate of Immunization Status, Page 2
Oregon Department of Human Services, Immunization Program

Child's Last Name *Apellido*	First *Primer Nombre*	Middle Initial *Segundo Nombre*	Birthdate *Fecha de Nacimiento*

Recommended Vaccines

Recommended Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Pneumococcal (PCV7) (Only children less than 5 years)					
Meningococcal (MCV4, MPSV4)					
Human Papilloma Virus (HPV) (Only girls age 9 years or older)					
Influenza (Flu)					
Other Vaccine Please specify:					
Other Vaccine Please specify:					

For medical exemptions:

Please submit a *letter* signed by a licensed physician stating:

- Child's name
- Birth date
- Medical condition that contraindicates vaccine
- List of vaccines contraindicated
- Approximate time until condition resolves, if applicable
- Physician's signature and date
- Physician's contact information, including phone number

For Immunity Exemptions (history of disease or positive titer)**:**
Please submit a *letter* signed by a licensed physician stating:

- Child's name and birth date
- Diagnosis or lab report
- Physician's signature and date

Religious exemption:

I have read and understand the information in the brochure that I received. I am aware of the potential risks of my child being unimmunized, including being excluded from attending school during a disease outbreak. My child is being raised as an adherent to a religion the teachings of which are opposed to immunization and I request that my child be exempted from the following required immunizations:

- Diphtheria/ Tetanus ☐
- Measles ☐
- Mumps ☐
- Rubella ☐
- Hepatitis B ☐
- Pertussis ☐
- Polio ☐
- Varicella ☐
- Hib ☐
- Hepatitis A ☐

Signature of Parent or Guardian ______ Date ______

I certify that the above information is an accurate record of this child's immunization history and exemption status.

Signature ______________________ Date

Update Signature ______________________ Date

Update Signature ______________________ Date

Update Signature ______________________ Date

53-05A (01/2008)

CHAPTER D

PREVENTING AND RESPONDING TO INJURIES AND POISONING

Injury Report Form

Any time a child is injured, you must make a record of the incident and keep it on file. Complete the form as soon as possible. Obtain the signature of a parent or legal guardian. Make sure the parent/guardian has a copy of the injury report form. Injuries that require treatment from a licensed health care professional such as a physician, EMT or nurse must be reported to the Child Care Division within seven days.

Name of injured ____

Age ________

Date of injury ___________________________

Time of injury ________

Date of this report_____________________________

Where injury occurred

____

Description of incident

____

____

Nature of injury

____

Any equipment or product involved? If yes, list ____

What first aid was given and by whom

____

____

Name of parent/guardian notified_______________________________________

Time of notification ____________ am/pm Notified by ____________________

Follow-up plan for injured

____

Injury prevention steps to be taken

____

____

Who else was present at time of injury

____

Parent/guardian signature

____ Date:__________________

Supervisor signature_____________________________________ Date:__________________

Caregiver signature______________________________________ Date:__________________

A GUIDE TO PLANT POISONING PREVENTION AND TREATMENT

Plants beautify our homes. They add color and accent to our lawns and gardens. They feed us. Yet we need to handle them properly or they can become deadly.

Many plants are not poisonous. These plants are considered “good” to have around children. They are usually not poisonous.

However, a person who swallows some other plants may have mild symptoms. These plants are considered “bad” because they can have unpleasant effects.

Many plants around us can cause serious symptoms or even death if eaten in moderate amounts. These plants are considered “very bad.”

Review the list of plants in the categories below. Many of these plants are not native to the Pacific Northwest. They may be transplants that thrive in our climate.

Please note that even nontoxic plants can be poisonous and block a child’s airway. Review “Plant poison prevention tips” in the back of this guide for more information.

Common questions about plants

Q: What if I’m not sure of the name of my plant?

A: Take parts of the plant to a master gardener working at your local nursery. Then call the Oregon Poison Center with the Latin or commonly known name of the plant for further instructions.

Q: Where can I find photos of some of these plants?

A: Go to the Cornell University plant site at *www.ansci.cornell.edu/plants*.

NONTOXIC PLANT LIST

THE "GOOD" PLANTS

The following plants are "good" or nonpoisonous. People are not likely to have symptoms from eating or handling small amounts of them. However, some people may be more sensitive or react differently to any of these plants.

Remember, any plant may cause unexpected problems. This includes choking. Always The "good" plants

Common name	Latin name	Spanish name
Abelia	Abelia x grandiflora	
African daisy	Dimorphotheca Pluvialis	
African violet	Saintpaulia Ionantha	
Air fern	Sertularia Argenta	
Aluminum plant	Pilea Cadierei	
Asparagus fern	Asparagus Setaceus	
Aster	Aster Sinensis	
Baby's breath	Gypsophila	
Baby tears	Hypoestes Phyllostachya	
Bachelor button	Centaurea Cyanus	
Bamboo	Phyllostachys Aurea	
Begonia (except sand begonia)	Pellionia Daveauana	
Birch, Sweet or Cherry	Betula Lenta	
Bleeding heart vine	Clerodendrum Thomsoniae	
Bloodleaf plant	Iresine	
Boston fern	Nephrolepis Exalta	
Bromeliad	Neoregelia Carolinae	
Butterfly tulip	Calochortus Nuttalli	
Cactus, Christmas	Schlumbergera Bridgesii	
Camellia	Camelina Sativa	
Chinese evergreen	Aglaonema Modestum	
Coleus	Solenostemon	
Columbine	Aquilegia	
Corn plant	Dracaena Fragrans	

Creeping Charlie (house plant)	Plectranthus Australis	
Dahlia	Dahlia Species	
Dandelion	Taraxacum Officinale	
Dracaena	Cordyline Australis	
Elm tree	Pleurotus Ulmarius	
Eugenia	Syzygium Cuminii	
False aralia	Dizygotheca Elegantissima	
Fittonia, red	Fittonia Verschaffettii	
Forsythia	Forsythia species	
Friendship plant	Billbergia Nutans	
Fuchsia	Fuchsia species	
Gardenia	Gardenia Jasminoides	
Gloxinia	Incarvillea	
Goldfish plant	Hypocyrta species	
Grape ivy	Cissus Rhombifolia	
Hawthorne	Crataegus monogyna, Midland Hawthorn = C.laevigata	
Hens and Chicks	Echeveria Imbricata	
Hibiscus	Hibiscus Acerifolius	
Impatiens	Impatiens Balsamina	
Japanese aralia	Fatsia Japonica	
Lipstick plant	Alcalypha or Aeschynanthus	
Maidenhair fern, Southern	Adiantum Capillus Veneis	
Magnolia bush	Magnolia Stellata	
Marigold	Tagetes [French Marigold] or Calendula [Pot Marigold]	
Mountain ash	Sorbus Americana	
Nasturtium	Tropaeolum	
Parlor palm	Chamaedrea Elegans	
Patient Lucy	Impatients Wallerna	
Peperomia	Peperomia Dahlstedtii	
Petunia	Petunia	

CHAPTER D

Phlox	Phlox Diuaricata	
Piggyback plant	Tolmiea Menziesii	
Polka dot plant	Hypoestes Phyllostachya	
Prayer plant	Maranta Leuconeura Kerchoveana	
Pregnant plant	Kalanchoe Pinnata	
Purple passion	Gynura Aurantiaca	
Rose	Rosa species	
Schefflera	Brassaria Actinophylla	
Snapdragon	Antirrhinum	
Snake plant	Sansevieria Trifasciata	
Snowball bush	Viburnum	
Spider plant	Chlorophytum Comosum	
Spider aralia	Dizygotheca Elegantissima	
Staghorn fern	Platycerium Bifurcatum	
Swedish ivy	Plectranthus Australis	
Swordfern	Nephrolepis Exalta	
Tiger lily	Lilium Tigrinum	
Umbrella tree	Magnolia Tripetala	
Velvet plant	Gynura Aurantiaca	
Venus flytrap	Dionaea muscipula	
Wandering Jew	Zebrina Pendula	
Yucca	Yucca Aliofolia Marginata	
Zebra plant	Aphelandra Squarrosa	
Zinni, creeping	Sanvitalia	

THE "BAD" PLANTS

Common name	Latin name	Spanish name
Alyssum	Alyssum	
American ivy	Parthenocissus Quinquefolia	
Apricot (pit)	Prunus Armeniaca	
Arrowhead, vine	Syngonium Podophyllum	
Avocado (leaves, stem)	Persea Americana	
Birch tree	Betula species	
Black walnut	Junglans Nigra	
Bleeding heart	Dicentra spectabilis	
Boston ivy	Parthenocissus Tricuspidata	
Cactus	Lophophora Williamsii	
Carnation	Dianthus Caryophyllus	
Carrot (greens)	Daucus Carota	
Cattail	Typha Latifolia	
Chrysanthemum	Chrysanthemum	
Daisy	Cinerareaefolium	
Dahlia	Dahlia species	
Devil's Ivy	Epipremnum Aureum	
Dogwood	Cornus Sanguinea	
Elephant's ear	Colocasia	
Ficus Benjamina	Ficus Benjamina	
Fig tree	Ficus Carica	
Geranium	often used to refer to Pelargonium	
Gladiola	Gladiola species	
Honeysuckle	Lonicera	
Inch plant	Tradescantia species	
Iris	Iris	
Ivy	Hedera helix	
Lady slipper	Cypripedium species	
Lamb's tail	Sedum Marganianum	
Narcissus	Narcissus Pseudo-Narcissus	
Oak tree	Quercus robur	

Oxalis (varieties)	Cernua Cernua	
Painted leaf	Euphorbia Pulcherrima	
Pansy	Viola Tricolor	
Peace lily	Spathiphyllum genus	
Peach (pit)	Prunus Persica	
Philodendron	Philodendron species	
Poinsettia	Euphorbia Pulcherrima	
Potato (all green parts)	Solanum Tuberosum	
Rose (thorns)	Rosa species	
Rubber plant	Ficus Elastica	
Sedum	Sedum Species	
Sensitive fern	Onoclea Sensibilis	
Snake plant	Sansevienia Trifasciata	
Sweet pea	Lathyrus	
Tomato (entire plant except the ripe fruit)	Lycopersicon Lycopersicum	
Violet	Viola odorata	
Weeping willow	Salix Babylonica	
Woodbine	Lonicera periclymenum	

VERY BAD PLANTS

Common name	Latin name	Spanish name
Amaryllis	Amaryllis species	
Anemone	Anemone Alpina	
Arbor Vitae	Thuja Occidentalis	
Bird of paradise	Poinciana Gilliesii	
Bittersweet	Celastrus Scandens	
Black locust	Robinia Pseudoacacia	
Black root	Cimicifuga	
Buckeye, Red	Aesculus Pavia	
Buttercup, Common	Ranunculus Acris	
Caladium	Caladium Bicolor	
Castor bean	Ricinus Communis	
Crown of thorns	Euphorbia	
Crown vetch	MiliiCoronilla Varia	
Cyclamen		
Daphne	Daphne Caucasica	

Delphinium	Delphinium Alpinum	
Dieffenbachia	Diffenbachia Amoena	
Elderberry, American Red	Sambucus Pubens	
Foxglove	Digitalis	
Hedge apples	Maclura Pomifera	
Holly	Ilex aquifolium	
Hyacinth	Hyacinthus Orientalis	
Hydrangea	Hydrangea Arborescens	
Jack in the pulpit	Arum maculatum	
Jerusalem cherry	SOLANUM PSEUDOCAPSICUM	
Jimson weed	DATURA STRAMONIUM	
Jonquil	NARCISSUS SPECIES	
Juniper	JUNIPERUS SABINA	
Laurel	GENUS KALMIA	
Lily of the valley	Convallaria	
Lobelia	LOBELIA BERLANDIERI	
Locoweed	DATURA STRAMONIUM	
Maidenhair tree	GINKGO BILOBA	
Mistletoe	Viscum album	
Moonseed	MENISPERMUM	
Monkshood	Aconitum napellus	
Morning Glory	Ipomea	
Mother-in-law plant	GENUS CALADIUM	
Mother-in-law tongue	GENUS DIEFFENBACHIA	
Mushrooms (some varieties)	Note: too many to list here	
Nightshade (all varieties)	SOLANUM DULCAMARA	
Oleander	NERIUM OLEANDER	
Peony	PAEONIA OFFICINALIS	
Periwinkle	Vinca	
Poison hemlock	CONIUM MACULATUM	
Poison oak	TOXICODENDRON QUERCIFOLIUM	
Pokeweed	Phytolacca	

Poppy (except California)	Papave	
Pothos	EPIPREMNUM AUREUM	
Ranunculus	RANUNCULACEAE	
Rhubarb (leaves)	Rheum Rhabarbarium	
Rosary beans	ABRUS PRECATORIUS	
Rosary peas	ABRUS PRECATORIUS	
Sand begonia	RUMEX VENOSUS	
Snow on the mountain	EUPHORBIA MARGINATA	
Solomon's seal	POLYGONATUM MULTIFLORUM	
String of beads	SENECIO ROWLEYANUS	
String of pearls	SENECIO ROWLEYANUS	
Sumac	RHUS CORIARIA	
Vinca (all varieties)	CANTHARANTHUS ROSEUS	
Water hemlock	GENUS CICUTA	
Wild parsnip	PASTINACA SATIVA	
Wisteria	WISTERIA FRUTESCENS	
Yew	Taxus baccata	

PLANT POISONING AND PREVENTION TIPS

Overview

Plants beautify our homes. They can also become deadly poisons if not handled properly.

The Oregon Poison Center most often gets questions when a person do not know what plant someone, especially a child, has eaten.

Review the following plant poisoning prevention tips to maintain a safe and secure home. Please note that even nontoxic plants can block a child's airway. Review these tips to prepare for the unthinkable.

Prevention tips

- Identify all the plants in your house and yard today. Your list of plants should include their common name and their Latin or scientific name. The Oregon Poison Center staff cannot safely identify a plant over the phone. The nearest garden store or county extension agent can help you in identifying your plants.
- Decorate your home and yard with nonpoisonous plants.
- Keep all poisonous plants out of the reach of children and pets.
- Pick and dispose of all mushrooms and toadstools in your yard. They are all 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. Though they look dead, these plants may still contain poisonous chemicals.
- Store seeds and bulbs safely out of children's reach. Help identify an unknown plant, berry or mushroom by saving the rest of the leaf, stem, and branch from a tree or berry that a child or pet has eaten.