

HEALTHY FUTURES



Improving Health Outcomes for Young Children

A program of the American Academy of Pediatrics

Curriculum for Managing Infectious Diseases in Early Education and Child Care Settings

INSTRUCTOR'S MANUAL



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American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



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The recommendations in this curriculum do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Please note: Listing of resources does not imply an endorsement by the AAP. The AAP is not responsible for the content of resources mentioned in this curriculum. Phone numbers and Web site addresses are as current as possible, but may change at any time.

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Curriculum For Managing Infectious Diseases in Early Education and Child Care Settings

INSTRUCTOR'S MANUAL

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Introduction

The Healthy Futures: Improving Health Outcomes for Young Children, Curriculum on Infectious Diseases in Early Education and Child Care has been made available by the American Academy of Pediatrics (AAP) Early Education and Child Care Initiatives. It is designed as an educational tool for child care providers with all levels of understanding about infectious diseases. With this curriculum, participants will learn how to prevent, recognize, and manage infectious diseases in early education and child care settings. The curriculum contains the following components:

Getting Started

Module 1: Understanding Infectious Diseases

Module 2: Preventing Infectious Diseases

Module 3: Recognizing and Managing Infectious Diseases

Wrap Up

The *Curriculum on Infectious Diseases* is a collaborative effort of health care and early education and child care professionals from the AAP, the State Child Care and Development Fund, Early Childhood Comprehensive Systems, Family Voices, the National Association for the Education of Young Children, the National Association of Pediatric Nurse Practitioners, the National Child Care Information and Technical Assistance Center, the National Resource Center for Health and Safety in Child Care and Early Education, the National Training Institute for Child Care Health Consultants, and the Office of Head Start.

The *Curriculum on Infectious Diseases* went through extensive review through the AAP, specifically the Board of Directors; the Committee on Early Childhood, Adoption, and Dependent Care; the Committee on Infectious Diseases; the Section on Infectious Diseases; and the Section on Early Education and Child Care.

Optimal instructors for this course include pediatricians, Child Care Health Consultants, or other licensed health care professionals with experience in child care settings.

Instructor Guidance:

- *Length of the course is 3 to 3 ½ hours. The proposed time to cover the material allows all*

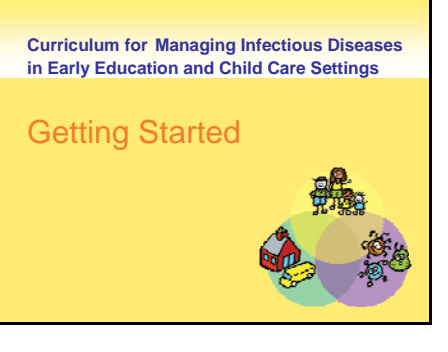
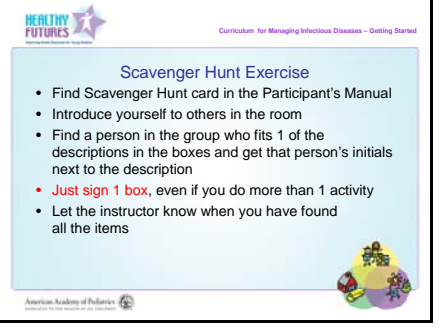
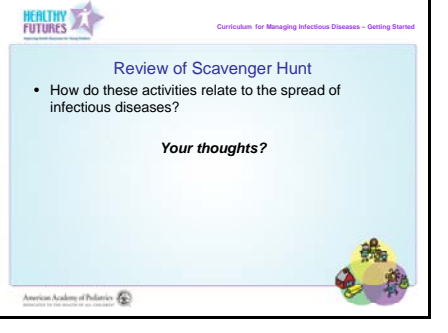
the content on the slides to be mentioned. The instructor's notes offer a variety of detail. Instructors should select from the notes the details that match the sophistication, interests, and time available to conduct the course for each group they teach. The times suggested for individual slides or activities are the minimum times required to present the material. When time and the interest of the group warrants, plan to spend additional time on the material.

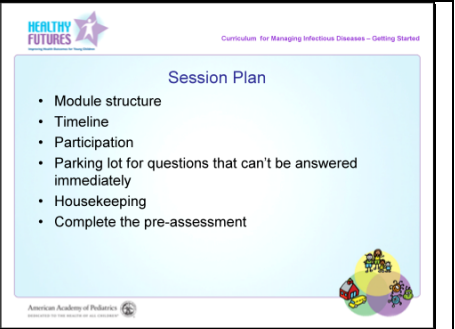
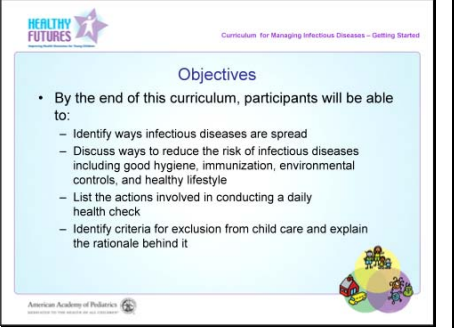

- *Instructors may add state materials, where appropriate, directly into the manuals.*
- *Notes on the slides include:*
 - **Lecture** – provides critical information, history, and background about the topic.
 - **Guided Discussion** – used to encourage group discussion and problem solving, providing participants the freedom to express their opinions and propose resolutions. This helps participants develop a deeper understanding of the material.
 - **Participant Activities** – provides participants with an opportunity to practice what they have learned.
 - **Videos** – supports material within the curriculum. Please check videos to make sure they work correctly prior to presenting the curriculum.
 - **Manual Materials** – supporting materials, provided in the Instructor's Manual and Participant's Manual, that apply to the discussion on a particular slide.
 - **Resources** – supporting materials; not provided, but may provide additional information that supports the lecture.
 - **References** – citations quoting other published materials; referred to in text by a reference mark.
- *Materials needed include flip chart/chalkboard/whiteboard; markers/chalk; overhead projector (if not available, printed copies can be used); a copy of the Participant's Manual for each learner; and a copy of the Instructor's Manual. It is recommended that instructors have a copy of Managing Infectious Diseases in Child Care and Schools when presenting this curriculum as a reference. Available at www.aap.org/bookstore.*
- *Curriculum materials can be downloaded from www.healthychildcare.org.*


Curriculum for Managing Infectious Diseases in Early Education and Child Care Settings

GETTING STARTED



#1	<p>Welcome and Introductions</p> <ul style="list-style-type: none"> Instructor should introduce her- or himself and then call on the participants to raise their hands according to their role in child care (teacher/caregiver, director, supervisor, child care health consultant, any other). Ask participants by raising hands if they previously have had some education about infectious diseases in child care. This will allow the instructor to have a better idea of the knowledge level of the group. 	 <p>Curriculum for Managing Infectious Diseases in Early Education and Child Care Settings</p> <p>Getting Started</p>
#2	<p>Participant Exercise</p> <ul style="list-style-type: none"> Give token prizes (eg, pencils, stickers, brochures, etc) to everyone who completes the scavenger hunt. Instruct participants to take the pre-assessment under Getting Started of the Participant's Manual while others finish the scavenger hunt and collect their prizes. Wait for all participants to complete the pre-assessment and hand it in before reviewing the scavenger hunt exercise in the next slide. <p>Manual Materials</p> <ul style="list-style-type: none"> Scavenger Hunt Pre-assessment <p>(1 minute)</p>	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases - Getting Started</p> <p>Scavenger Hunt Exercise</p> <ul style="list-style-type: none"> Find Scavenger Hunt card in the Participant's Manual Introduce yourself to others in the room Find a person in the group who fits 1 of the descriptions in the boxes and get that person's initials next to the description Just sign 1 box, even if you do more than 1 activity Let the instructor know when you have found all the items
#3	<p>Lecture</p> <ul style="list-style-type: none"> Review a few of the topics listed in the scavenger hunt boxes to reinforce why they are relevant to today's talk. Each item is an important factor in the spread of infectious diseases or in preventing the spread. Examples: <ul style="list-style-type: none"> Cares for infants: Infants have immature immune systems and are more vulnerable to some infections. Prepares food: Foodborne illness is a common way to spread infection. Items such as eggs, meat, and dairy products need to be handled carefully to ensure they are safe to eat. Checks vaccine records: Immunization is a mainstay of defense in the battle against infectious diseases for both children and caretakers/teachers. Cleans up after meals: Saliva can contain infectious organisms that spread disease. Eating utensils need to be cleaned well. Changes diapers: Stool carries lots of germs and using proper technique when changing diapers can prevent outbreaks of certain diseases. Performs daily health check: The daily health check is a way to evaluate children each day as they come into the program to determine how they are doing. Stays home when sick: Exclude ill people from the group when science shows that it matters to reduce the spread of bad germs. Up to date on vaccines: Child care policies should require that children and adults are up to date with vaccines, including the annual flu vaccine, and that child care staff check for up-to-date status at enrollment and hiring, as well as track vaccines that children will need during the year. Washes hands after helping with toileting: Hands should be washed after diapering and toileting when hands are likely to touch body fluids, even if gloves are worn. Gloves reduce the contact with germs, but all gloves allow some germs through. All of these topics will be discussed in this presentation. <p>(5 minutes)</p>	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases - Getting Started</p> <p>Review of Scavenger Hunt</p> <ul style="list-style-type: none"> How do these activities relate to the spread of infectious diseases? <p><i>Your thoughts?</i></p>

#4	<p>Lecture</p> <ul style="list-style-type: none"> • Module structure: There will be 3 modules: <ul style="list-style-type: none"> – Understanding Infectious Diseases – Preventing Infectious Diseases – Recognizing and Managing Infectious Diseases – We will try to break between modules. • Timeline: The proposed time to cover the material allows all the content on the slides to be mentioned. The instructor's notes offer a variety of detail. Instructors should select from the notes the details that match the sophistication, interests and time available to conduct the course for each group they teach. The times suggested for individual slides or activities are the minimum times required to present the material. When time and the interest of the group warrants, plan to spend more time on them. <ul style="list-style-type: none"> – Getting Started: 8 minutes – Module 1: 38 minutes – Module 2: 64 minutes – Module 3: 81 minutes – Wrap Up: 28 minutes • Participation: This curriculum is designed to be interactive, with lots of opportunity for discussion and activities. Everyone is expected to participate. • Parking lot: We will try to stay on time, so there will be a "parking lot" for questions that cannot be answered immediately. <ul style="list-style-type: none"> – Instructor: Make sure you have a flip chart dedicated to parking lot questions. • Housekeeping: Location of restrooms, break times, name tags, etc. • Pre-assessment: Please complete and submit the pre-assessment under Getting Started in the Participant's Manual. <p>Manual Materials</p> <ul style="list-style-type: none"> • Pre-assessment <p>(<1 minute)</p>	
#5		
#6	<ul style="list-style-type: none"> • <i>Caring for Our Children</i> (<i>CFOC</i>) is a joint publication of the American Academy of Pediatrics (AAP), the American Public Health Association, and the National Resource Center for Health and Safety in Child Care and Early Education. • <i>CFOC</i> was developed by bringing together leaders in the field of child care to review the literature and develop standards that are based on research, knowledge, and experience. Each standard is supported with references and a rationale. Many groups of people in the fields of child care, health, and public health contribute to the review of the standards. • The second edition is quoted in this curriculum, but the third edition is in progress and should be published in 2011. Substitute new wording when the third edition is available. • An online version of <i>CFOC</i> can be viewed at the National Resource Center for Health and Safety in Child Care and Early Education Web site (http://nrckids.org/CFOC/index.html) or print copies can be obtained through the AAP, the American Public Health Association, the National Association for the Education of Young Children, or from Redleaf Press. • State standards and regulations are developed by the state regulatory agency. State standards may apply to graduated recognition systems or may be used as a regulatory tool. Regulations are the minimum performance required to operate legally. They must be followed even if they are not up to date. Performance may exceed the threshold set by regulation. The process for developing standards and regulations varies from state to state. There is no requirement for states to base 	

	<p>their standards and regulations on evidence supported by research.</p> <p>Reference</p> <p>1. American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. <i>Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs</i>. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2002. Also available at http://nrckids.org</p> <p>(<1 minute)</p>
#7	<div><div></div><div><div><div><div>HEALTHY FUTURE</div><div>Curriculum for Managing Infectious Diseases – Getting Started</div></div><div><div>References</div><div><ul style="list-style-type: none">American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. <i>Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs</i>. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2002. Also available at http://nrckids.org (Slide 6)</div></div><div><div>American Academy of Pediatrics</div><div>ADVANCING THE HEALTH OF ALL CHILDREN</div></div><div></div></div></div></div>

Getting Started

References

- American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2002. Also available at <http://nrckids.org> (Slide 6)



Scavenger Hunt

- Introduce yourself to others in the room.
- Find a person in the group who fits 1 of the descriptions and get that person's initials next to the description.
- Each person should just sign 1 box, even if she does more than 1 activity.
- Let the instructor know when you have found all the items .

Cares for infants	Prepares food	Checks vaccine records
Cleans up after meals	Changes diapers	Performs daily health check
Stays home when sick	Up-to-date on vaccines	Washes hands after helping with toileting

Name

State

Date

☐ Caregiver/teacher☐ Health Professional☐ Other _____

Curriculum for Managing Infectious Diseases in Early Education and Child Care Settings Pre-assessment

Instructions: Circle the letter of the choice that best complements the statement or answers the question

MODULE 1: Understanding Infectious Diseases

1. **Viruses should be treated with antibiotics.**
 - a. True
 - b. False
2. **Children who attend child care are less likely to have antibiotic resistant ear infections and have tubes placed.**
 - a. True
 - b. False
3. **Children who attend child care are more resistant to infections after their first year of attendance.**
 - a. True
 - b. False
4. **The most important surface to clean to avoid spread of disease is our hands.**
 - a. True
 - b. False
5. **Children's immune systems:**
 - a. Get stronger as they are exposed to infectious diseases
 - b. Get weaker when they are exposed to infectious diseases
 - c. Are not affected by infectious diseases

MODULE 2: Preventing Infectious Diseases

6. **Mixing children from different groups together when staffing is short in the morning and late afternoon spreads infection from group to group.**
- a. True
 - b. False
7. **Which of the following is the best answer for how to reduce the number of germs in child care settings?**
- a. Circulate fresh outdoor air, use right-size flushing toilets, wash hands, and clean and sanitize surfaces that have been in contact with body fluids
 - b. Clean and sanitize eating and diaper/underwear changing surfaces before and after each use, wash hands with antibacterial soap, and use germ-killing aerosol sprays to remove odors
 - c. Wear disposable gloves to change diapers; serve and prepare food and clean up blood; and teach everyone to cover their mouths with their hands when they sneeze or cough
 - d. Quickly remove children who seem sick from the facility and do not allow them to return until they have a note from a health care professional that says they are well

MODULE 3: Recognizing and Managing Infectious Diseases

8. **Children should be excluded (sent home) from child care if they (Choose all the answers that apply):**
- a. Have a fever
 - b. Cannot participate in activities
 - c. Require more care than can be provided in child care
 - d. Have a condition that the health department says requires exclusion
 - e. Have any diarrhea
9. **The goal of exclusion is to:**
- a. Provide a setting where the child can recover more easily
 - b. Prevent other children from getting fever
 - c. Keep certain specific diseases from spreading through the child care site
 - d. A and C
 - e. None of the above

- 10. The daily health check is performed:**
- a. When the parent is transferring care of the child to the care of facility staff
 - b. When the child leaves the facility to go on a field trip or has a new caregiver
 - c. When the caregiver notices that a child has symptoms of illness
 - d. A and C
- 11. A note from a child's health care professional to return to child care after an illness is not necessary for children who act and feel well.**
- a. True
 - b. False
- 12. To care for an ill child, caregivers should (Choose all answers that apply):**
- a. Adapt activities to the activity level of the ill child
 - b. Provide extra attention to the ill child
 - c. Inform parents of new symptoms by phone and use the symptom record to document the child's status
 - d. Isolate the ill child in the director's office
- 13. Before the child actually starts receiving care in the program, child care staff should discuss the following with parents:**
- a. The program's policy on caring for ill children
 - b. Parent's alternative care plans for child illness
 - c. Who makes the final decision about whether an ill child can be in child care
 - d. All of the above

Curriculum for Managing Infectious Diseases in Early Education and Child Care Settings Pre-assessment and Answer Key

Instructions: If select modules are to be presented, participants should only fill out the questions related to those modules. Have participants circle the letter of the choice that best answers the question.

MODULE 1: Understanding Infectious Diseases

1. Viruses should be treated with antibiotics.
 - a. True
 - b. False**
2. Children who attend child care are less likely to have antibiotic resistant ear infections and have tubes placed.
 - a. True
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3. Children who attend child care are more resistant to infections after their first year of attendance.
 - a. True**
 - b. False
4. The most important surface to clean to avoid spread of disease is our hands.
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 - b. Clean and sanitize eating and diaper/underwear changing surfaces before and after each use, wash hands with antibacterial soap, and use germ-killing aerosol sprays to remove odors
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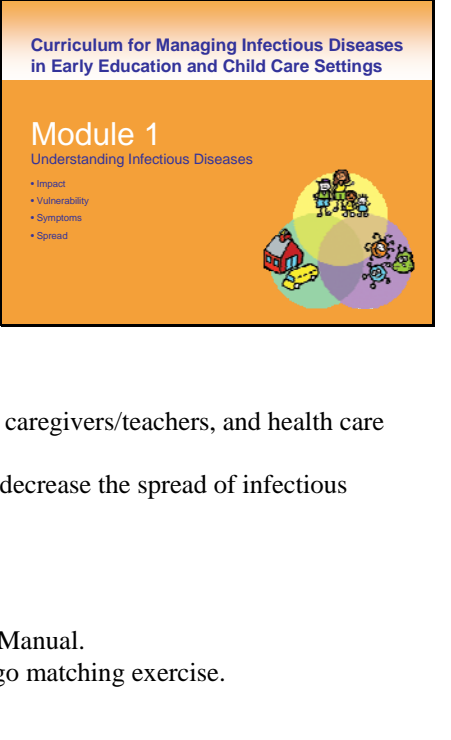
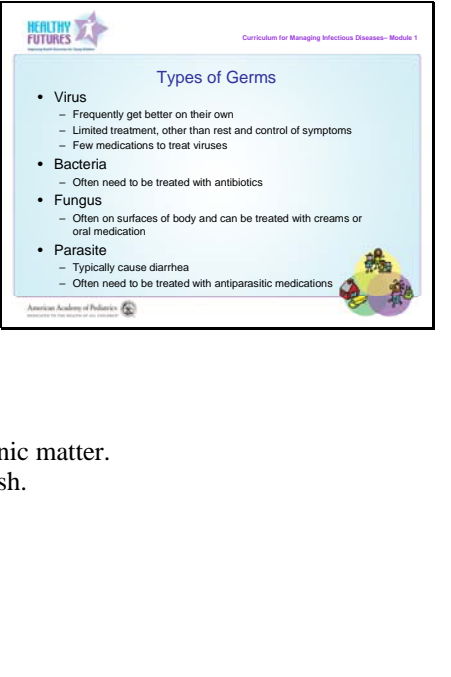
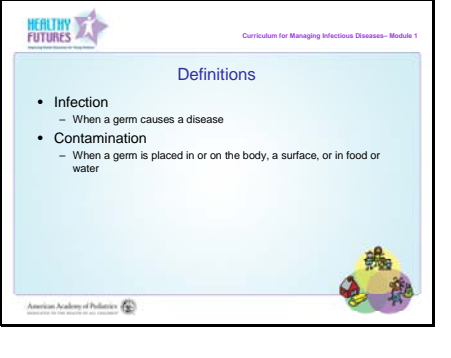
Curriculum for Managing Infectious Diseases in Early Education and Child Care Settings








MODULE 1


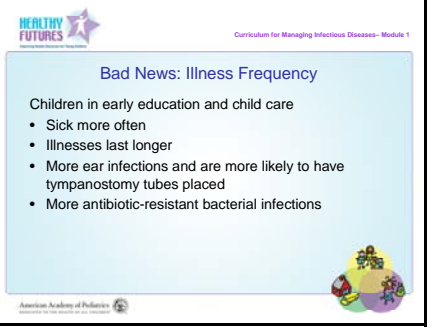
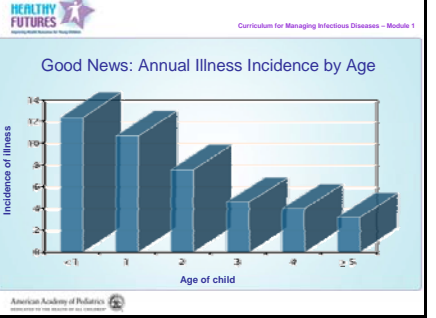

Understanding Infectious Diseases

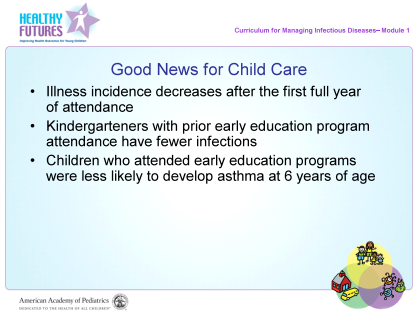

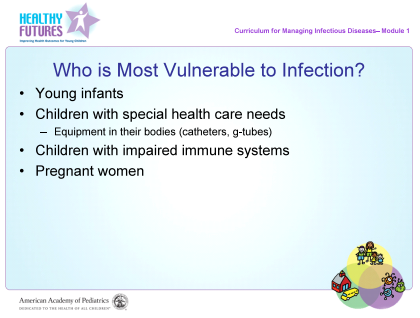
- Impact
- Vulnerability
- Symptoms
- Spread



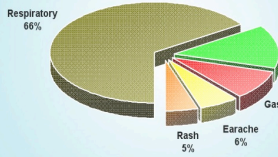
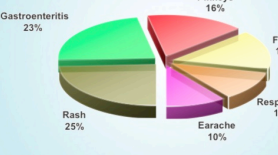


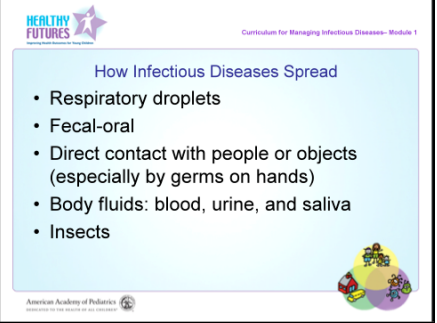
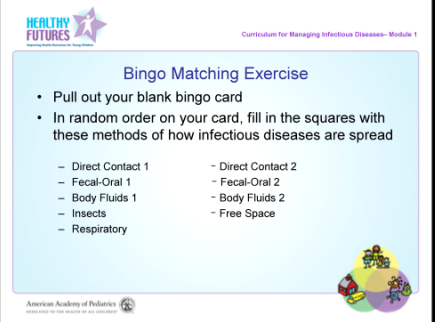


#1	<p>Objectives</p> <p>A. Knowledge Each participant will be able to:</p> <ul style="list-style-type: none"> • Identity 3 ways infectious diseases impact our society. • State reasons why some children with special health care needs are at higher risk for acquiring infectious diseases. • Name the 3 most common symptoms of infectious diseases in children in early education settings. • Identify 5 ways infectious diseases are spread. <p>B. Attitude Each participant will be able to:</p> <ul style="list-style-type: none"> • Have an understanding of the different impacts of infectious disease on parents, caregivers/teachers, and health care professionals. • Be willing to educate parents and other child care staff members on methods to decrease the spread of infectious diseases. <p>C. Behavior Each participant will:</p> <ul style="list-style-type: none"> • Answer the pre-assessment questions under Getting Started in the Participant's Manual. • Correctly identify methods by which infectious diseases spread through the bingo matching exercise. <p>(<1 minute)</p>	
#2	<p>Lecture Briefly review definitions to establish common vocabulary.</p> <ul style="list-style-type: none"> • Virus <ul style="list-style-type: none"> – Microscopic organism. – Can grow or reproduce only in living cells with limited ability to survive outside of the body. – Few medications to treat viruses (ie, influenza, herpes) – Examples are the common cold, influenza, measles, hepatitis B virus, and chicken pox. • Bacteria <ul style="list-style-type: none"> – Organism is larger than a virus. – Can survive in or out of the body. – Examples are staphylococcus, streptococcus, salmonella, and shigella. • Fungus <ul style="list-style-type: none"> – Organisms that get their nutrition from other living organisms or dead organic matter. – Examples are yeasts, molds, mildew, thrush, ringworm, and yeast diaper rash. • Parasite <ul style="list-style-type: none"> – Single or multicellular organism. – Lives on or in another living organism. – Examples are tapeworm, louse, mite, pinworm, and giardia. <p>(3 minutes)</p>	
#3	<p>Lecture</p> <ul style="list-style-type: none"> • Infection is a condition that is caused by a multiplication of an infectious agent in the body. • Contamination is the presence of infectious microorganisms in or on the body, environmental surfaces, articles of clothing, food, or water. <p>(<1 minute)</p>	

#4		 <p>Curriculum for Managing Infectious Diseases—Module 1</p> <h3>More Definitions</h3> <ul style="list-style-type: none"> Contagious <ul style="list-style-type: none"> When germs can be spread to others Infectious <ul style="list-style-type: none"> Capable of causing an infection Communicable <ul style="list-style-type: none"> Can be transmitted to others <p>Essentially all mean the same thing</p> 
#5	<p>(<1 minute)</p> <h3>Guided Discussion</h3> <ul style="list-style-type: none"> Have participants divide into 2 groups; some acting as parents and some acting as caregivers/teachers. Have them share their thoughts and think about the impact on each group. Then provide participants with the view of the health care professional. Examples: <ul style="list-style-type: none"> Parents: Missing work, possible missed revenue, who will care for the sick child, fear of exposing family/friends, guilt. Caregivers: Concern about other children being exposed, concern about themselves being exposed, extra work to care for a sick child, frustration from other parents about their child being exposed to illness, does this child need to be seen by a health care professional? Health care professionals: Does this child need to be seen, or should the child be observed at home with symptomatic care? Are there any reasons to exclude this child from care or to report this illness to the health department? <h3>Resource</h3> <ol style="list-style-type: none"> “Fact Sheet: Paid Sick Days Are Good for Children's Health,” www.nationalpartnership.org/site/DocServer/Fact_Sheet__Paid_sick_days_are_good_for_childrens_health.pdf?docID=4182 <p>(6 minutes)</p>	 <p>Curriculum for Managing Infectious Diseases—Module 1</p> <h3>Child Care at 2:00 pm</h3> <p>A 20-month-old child wakes up from a nap and is flushed. She does not want to play with other children and is irritable. Her temperature was taken and is 101°F.</p> <ul style="list-style-type: none"> How does this affect: <ul style="list-style-type: none"> Parents? <ul style="list-style-type: none"> Caregivers/teachers at the center? Health care professionals? How will the impact influence their decision making?  
#6	<h3>Lecture</h3> <ul style="list-style-type: none"> Economic: 1 Canadian study in 1999 found the costs related to 1 child were \$260.70 (Canadian) per illness. Canada has socialized medicine, so the costs in the United States 1 decade later are likely greater.¹ Contagion/Disruption: Another study showed that greater than one-third of families face over 2 weeks of sick time per year.² Health care: In one study of 34 child care centers, antibiotics were thought useful for nonspecific upper respiratory tract infections to prevent the spread of infection in 9 centers (26%), to speed up recovery in 7 centers (21%), and to prevent bacterial infection in 13 centers (38%).³ All of these are incorrect assumptions. <h3>References</h3> <ol style="list-style-type: none"> Carabin H, Gyorkos TW, Soto JC, Penrod J, Joseph L, Collet J. Estimation of direct and indirect costs because of common infections in toddlers attending day care centers. <i>Pediatrics</i>. 1999;103(3):556–564 Heymann SJ, Earle A, Egleston B. Parental availability for the care of sick children. <i>Pediatrics</i>. 1996;98(2):226–230 Skull SA, Ford-Jones EL, Kulin NA, Einarson TR, Wang EEL. Child care center staff contribute to physician visits and pressure for antibiotic prescription. <i>Arch Pediatr Adolesc Med</i>. 2000;154:180–183 <p>(3 minutes)</p>	 <p>Curriculum for Managing Infectious Diseases—Module 1</p> <h3>Impact of Infectious Diseases</h3> <ul style="list-style-type: none"> Economic <ul style="list-style-type: none"> Loss of revenue for the family Loss of productivity for the employer Contagion <ul style="list-style-type: none"> Other children in child care Families Caregivers/teachers and their families Disruption <ul style="list-style-type: none"> Alternative caregivers Other colleagues filling in for missing parent at work Health care <ul style="list-style-type: none"> Many office visits to get “sick notes” Inappropriate use of antibiotics Added responsibility of administering medication in child care 

#7		 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases – Module 1</p> <p>Impact of Infectious Diseases</p> <ul style="list-style-type: none"> All members of society are affected <p>American Academy of Pediatrics Advancing the Health of the World's Children</p>
#8	<p>Lecture</p> <ul style="list-style-type: none"> Tympanostomy tubes are small tubes that are surgically inserted into the ear drum to drain fluid to the outside. <p>References</p> <ol style="list-style-type: none"> Wald ER, Guerra N, Byers C. Frequency and severity of infections in day care: three-year follow-up. <i>J Pediatr.</i> 1991;118:509–514 Holmes, SJ, Morrow, AL, Pickering, LK. Child-care practices: effects of social change on the epidemiology of infectious diseases and antibiotic resistance. <i>Epidemiologic Review.</i> 1996;18:10–28 	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases – Module 1</p> <p>Bad News: Illness Frequency</p> <p>Children in early education and child care</p> <ul style="list-style-type: none"> Sick more often Illnesses last longer More ear infections and are more likely to have tympanostomy tubes placed More antibiotic-resistant bacterial infections <p>American Academy of Pediatrics Advancing the Health of the World's Children</p>
#9	<p>Lecture</p> <ul style="list-style-type: none"> As children age, the incidence of illness decreases from 12 per year to 4 per year by the time the child is 5 years old. <p>Reference</p> <ol style="list-style-type: none"> Cordell RL, Waterman SH, Chang A, et al. Provider-reported illness and absence due to illness among children attending child-care homes and centers in San Diego, Calif. <i>Arch Pediatric Adolescent Medicine.</i> 1999;153:275–280 	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases – Module 1</p> <p>Good News: Annual Illness Incidence by Age</p> <p>Incidence of illness</p> <p>Age of child</p> <p>American Academy of Pediatrics Advancing the Health of the World's Children</p>
#10		 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases – Module 1</p> <p>More Good News</p> <ul style="list-style-type: none"> Germs in early education programs are the same as those in community outbreaks 90% of infections are mild, self-limited, and require no treatment <p>American Academy of Pediatrics Advancing the Health of the World's Children</p>

#11	<p>Lecture</p> <ul style="list-style-type: none"> Illness incidence decreases after the first full year of attendance.^{1,2} Kindergartners with prior early education program attendance have fewer infections.^{3,4} Many factors contribute to causing asthma and this needs further study, but the association of attending early education and decrease in asthma is present.⁵ <p>References</p> <ol style="list-style-type: none"> Hurwitz ES, Gunn WJ, Pinsky PF, et al. Risk of respiratory illness associated with day-care attendance: a nationwide study. <i>Pediatrics</i>. 1991;87:62–69 Collet JP, Burtin P, Bossard N, et al. Type of day-care setting and risk of repeated infections. <i>Pediatrics</i>. 1994;94:997–999 McCutcheon H, Woodward A. Acute respiratory illness in the first year of primary school related to previous attendance at child care. <i>Australian and New Zealand Journal of Public Health</i>. 1996;20:49–53 Ball TM, Holberg CJ, Aldous MB, Martinez FD, Wright AL. Influence of attendance at day care on the common cold from birth through 13 years of age. <i>Arch Pediatric Adolescent Medicine</i>. 2002;156:121–126 Ball TM, Castro-Rodriguez JA, Griffith KA, et al. Siblings, day-care attendance, and the risk of asthma and wheezing during childhood. <i>New England Journal of Medicine</i>. 2000;343:538–543 <p>(<1 minute)</p>	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases—Module 1</p> <p>Good News for Child Care</p> <ul style="list-style-type: none"> Illness incidence decreases after the first full year of attendance Kindergartners with prior early education program attendance have fewer infections Children who attended early education programs were less likely to develop asthma at 6 years of age <p>American Academy of Pediatrics PEDIATRIC INFECTION DISEASE SOCIETY</p>
#12	<p>Reasons why children are more vulnerable to infectious diseases include:</p> <ul style="list-style-type: none"> Frequent hand-to-mouth behaviors Still learning appropriate hygiene skills (keeping fingers out of nose, covering coughs, proper hand washing, etc) Some children may not be fully immunized, such as young infants Children have close physical contact/do not practice much social distancing <p>(<1 minute)</p>	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases—Module 1</p> <p>Why Are Children More Vulnerable to Infectious Diseases?</p> <p>American Academy of Pediatrics PEDIATRIC INFECTION DISEASE SOCIETY</p>
#13	<p>Lecture</p> <ul style="list-style-type: none"> Young infants are more susceptible because their immune systems are immature and don't have a lot of defenses (antibodies) built up yet. Some immunity is received from the mother through the placenta and some can be passed through breast milk, but it is still less than adults have. Children with special health care needs, including equipment in bodies: foreign bodies like metal devices can carry or capture bacteria, even if they were sterile when the device was placed. Devices like catheters can also carry bacteria even if the catheter is sterile and good cleaning procedures are followed. Children with impaired immune systems, including HIV/AIDS, chemotherapy, genetic conditions, transplants, or high-dose steroid therapy for longer periods. Pregnant women are not necessarily more susceptible themselves, but they can pass on certain infections to the fetus if the mother is not immune to the disease. <p>(2 minutes)</p>	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases—Module 1</p> <p>Who is Most Vulnerable to Infection?</p> <ul style="list-style-type: none"> Young infants Children with special health care needs <ul style="list-style-type: none"> Equipment in their bodies (catheters, g-tubes) Children with impaired immune systems Pregnant women <p>American Academy of Pediatrics PEDIATRIC INFECTION DISEASE SOCIETY</p>


#14	<p>Guided Discussion</p> <p>Remind participants of the earlier scenario for this child: A 20-month-old child wakes up from a nap and is flushed. She does not want to play with other children and is irritable. Her temperature was taken and is 101°F.</p> <ul style="list-style-type: none">Elicit audience response about what symptoms the child might develop.Do not linger over these points. Keep the discussion moving.If audience is not responding, suggest an answer, such as a runny nose. <p>(2 minutes)</p>	<div><div>HEALTHY FUTURES Helping Health Educators Do Their Job Better</div><div>Curriculum for Managing Infectious Diseases – Module 1</div><div>Symptoms of Infectious Diseases</div><ul style="list-style-type: none">What symptoms might this child have or develop in the next few days?<div></div><div>American Academy of Pediatrics ADVANCING THE HEALTH OF ALL CHILDREN</div></div>
#15	<ul style="list-style-type: none">Refer to Enrollment/Attendance/Symptom Record in Module 1 of the Participant’s Manual. This record can help teacher/caregivers note symptoms over time for individual children and for the group to spot trends and outbreaks as early as possible. <p>Manual Material</p> <ul style="list-style-type: none">Enrollment/Attendance/Symptom Record <p>(>1 minute)</p>	<div><div>HEALTHY FUTURES Helping Health Educators Do Their Job Better</div><div>Curriculum for Managing Infectious Diseases – Module 1</div><div>Symptoms of Infectious Diseases</div><ul style="list-style-type: none">CoughRunny nose and/or congestionDifficult or noisy breathingVomiting, nausea, or stomachacheDiarrheaRashItchingDrainage or irritation of eye or other infected body partFeverAches or pains: Sore throat, earache, headache, body acheMouth soresSwollen glandsBehavior changes<div></div><div>American Academy of Pediatrics ADVANCING THE HEALTH OF ALL CHILDREN</div></div>
#16	<p>Lecture</p> <ul style="list-style-type: none">Respiratory symptoms (cough, congestion, runny nose) are the most common symptoms seen in early education settings. They comprise 66% of the total.The second most common is fever (14%).The third most common is gastrointestinal (vomiting and diarrhea) (9%). <p>Ask the audience if this matches with their experience.</p> <p>Reference</p> <ol style="list-style-type: none">Cordell RL, Waterman SH, Chang A, et al. Provider-reported illness and absence due to illness among children attending child-care homes and centers in San Diego, Calif. <i>Arch Pediatric Adolescent Medicine</i>. 1999;153:275–280 <p>(1 minute)</p>	<div><div>HEALTHY FUTURES Helping Health Educators Do Their Job Better</div><div>Curriculum for Managing Infectious Diseases – Module 1</div><div>Common Symptoms Reported in Early Education Settings</div><div></div><div>American Academy of Pediatrics ADVANCING THE HEALTH OF ALL CHILDREN</div></div>
#17	<p>Lecture</p> <ul style="list-style-type: none">Although respiratory symptoms are the most common (65%), they only cause 11% of the absences.Symptoms that are more likely to cause absence are rash, gastrointestinal (vomiting and diarrhea), and pinkeye.The difference between which symptoms are common and which ones cause absence probably has to do with exclusion policies.New vaccines like rotavirus and pneumococcal may change these statistics. <p>Reference</p> <ol style="list-style-type: none">Cordell RL, Waterman SH, Chang A, et al. Provider-reported illness and absence due to illness among children attending child-care homes and centers in San Diego, Calif. <i>Arch Pediatric Adolescent Medicine</i>. 1999;153:275–280 <p>(1 minute)</p>	<div><div>HEALTHY FUTURES Helping Health Educators Do Their Job Better</div><div>Curriculum for Managing Infectious Diseases – Module 1</div><div>Symptoms That Cause The Most Absence</div><div></div><div>American Academy of Pediatrics ADVANCING THE HEALTH OF ALL CHILDREN</div></div>

#18	<p>Lecture</p> <ul style="list-style-type: none"> • Respiratory droplets <ul style="list-style-type: none"> – Some germs from the respiratory tract can spread by breathing the air close to someone who has coughed or sneezed. – Most germs from the respiratory tract, however, are spread when a person's hands are contaminated by touching moist secretions from an infected person's nose, eye, or mouth, and then touching his or her own eyes, nose, or mouth. • Fecal-Oral <ul style="list-style-type: none"> – Germs spread from the feces to the mouth, usually via the hands. – With typical diaper changing and mouthing behaviors, hands, floors, toilet and faucet handles, diaper changing areas, toys, and countertops frequently are contaminated with fecal matter. • Direct contact <ul style="list-style-type: none"> – Touching the person or the object that has live germs on it. – Examples are: hands mix germs into modeling compound, and mucus is mouthed onto toys. – This can be easily confused with the other methods since there is always some direct contact with the germs. • Body fluids <ul style="list-style-type: none"> – Blood, urine, and saliva have germs that touch someone and enter the body through open skin, the mouth, nose, or other mucous membranes. – In most cases, intimate contact is required for transmission and does not usually occur in child care settings. • Insects <ul style="list-style-type: none"> – Can harbor germs that can be passed, especially if the insects pierce the skin. <p>(3 minutes)</p>	
#19	<p>Participant Exercise</p> <ul style="list-style-type: none"> • Blank bingo cards are in Module 1 of the Participant's Manual. • Instruct participants to fill in their cards. <p>Manual Materials</p> <ul style="list-style-type: none"> • Bingo <p>(11 minutes for bingo exercise)</p>	
#20	<p>Participant Exercise</p> <ul style="list-style-type: none"> • Show the slides depicting how infectious diseases are spread. • The participants will mark the right response on their cards. • The first participant to have "BINGO" should read out the 3 items that made the bingo and connect those with the pictures. • There might be some controversy over whether something is "direct contact" or "body fluid" or "respiratory." 	
#21	<p>Answer</p> <ul style="list-style-type: none"> • Sneeze spray: Respiratory 	

#22	<p>Answer</p> <ul style="list-style-type: none"> Changing diaper: Fecal-Oral 	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases - Module 1</p> <p>American Academy of Pediatrics</p>
#23	<p>Answer</p> <ul style="list-style-type: none"> Potty: Fecal-Oral 	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases - Module 1</p> <p>American Academy of Pediatrics</p>
#24	<p>Answer</p> <ul style="list-style-type: none"> First aid to a cut: Body Fluids 	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases - Module 1</p> <p>American Academy of Pediatrics</p>
#25	<p>Answer</p> <ul style="list-style-type: none"> Child mouthing a toy: Body Fluid/Direct Contact 	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases - Module 1</p> <p>American Academy of Pediatrics</p>
#26	<p>Answer</p> <ul style="list-style-type: none"> Child with a weeping sore: Body Fluid/Direct Contact 	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases - Module 1</p> <p>American Academy of Pediatrics</p> <p>Courtesy of Public Health Image Library (PHIL), CDC</p>

#27	<p>Answer</p> <ul style="list-style-type: none"> • Mosquito: Insect 	
#28	<p>Answer</p> <ul style="list-style-type: none"> • Sharing food: Body Fluid 	
#29	<p>Answer</p> <ul style="list-style-type: none"> • Spoiling food: Direct Contact 	
#30	<p>Answer</p> <ul style="list-style-type: none"> • Runny nose: Direct Contact 	
#31	<p>(1 minute)</p>	



#32



Curriculum for Managing Infectious Diseases- Module 1

References

- Carabin H, Gyorkos TW, Sox JC, Perreid J, Joseph L, Collet J. Estimation of direct and indirect costs because of common infections in toddlers attending day care centers. *Pediatrics*. 1999;103(3):596-604 (Side 6).
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- Ward EF, Chuang A, Byers C. Frequency and severity of infections in day care: three-year follow-up. *J Pediatr*. 1991;118:566-570 (Side 8).
- Holmes SJ, Morrow AL, Pinkering LK. Child-care practices: effects of social change on the epidemiology of infectious diseases and antibiotic resistance. *Epidemiology Reviews*. 1999; 16: 10-33 (Side 8).
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- Ball TM, Holberg CJ, Andrus MB, Martinez FD, Wright AL. Influence of attendance at day care on risk of asthma. *Chest*. 1997; 111: 104-111.
- Ball TM, Camero-Rodriguez JA, Griffith KA, et al. Siblings, day-care attendance, and the risk of asthma and wheezing during childhood. *New England Journal of Medicine*. 2000;343: 536-543 (Side 11).

Module 1: Understanding Infectious Diseases

Objectives

A. Knowledge

Each participant will be able to:

1. Identify 3 ways infectious diseases impact our society.
2. State reasons why some children with special health care needs are at higher risk for acquiring infectious diseases.
3. Name the 3 most common symptoms of infectious diseases in children in early education settings.
4. Identify 5 ways infectious diseases are spread.

B. Attitude

Each participant will be able to:

1. Have an understanding of the different impacts of infectious disease on parents, caregivers/teachers, and health care professionals.
2. Be willing to educate parents and other child care staff members on methods to decrease the spread of infectious diseases.

C. Behavior

Each participant will:

1. Answer the pre-assessment questions under Getting Started in the Participant's Manual.
2. Correctly identify methods by which infectious diseases spread through the bingo matching exercise.

Module 1: Understanding Infectious Diseases

References

- Carabin H, Gyorkos TW, Soto JC, Penrod J, Joseph L, Collet J. Estimation of direct and indirect costs because of common infections in toddlers attending day care centers. *Pediatrics*. 1999;103(3):556–564 (Slide 6)
- Heymann SJ, Earle A, Egleston B. Parental availability for the care of sick children. *Pediatrics*. 1996;98(2):226–230 (Slide 6)
- Skull SA, Ford-Jones EL, Kulin NA, Einarson TR, Wang EEL. Child care center staff contribute to physician visits and pressure for antibiotic prescription. *Arch Pediatr Adolesc Med*. 2000;154:180–183 (Slide 6)
- Wald ER, Guerra N, Byers C. Frequency and severity of infections in day care: three-year follow-up. *J Pediatr*. 1991;118:509–514 (Slide 8)
- Holmes, SJ, Morrow, AL, Pickering, LK. Child-care practices: effects of social change on the epidemiology of infectious diseases and antibiotic resistance. *Epidemiologic Review*. 1996;18:10–28 (Slide 8)
- Cordell RL, Waterman SH, Chang A, et al. Provider-reported illness and absence due to illness among children attending child-care homes and centers in San Diego, Calif. *Arch Pediatric Adolescent Medicine*. 1999;153:275–280 (Slides 9, 16, 17)
- Hurwitz ES, Gunn WJ, Pinsky PF, et al. Risk of respiratory illness associated with day-care attendance: a nationwide study. *Pediatrics*. 1991;87:62–69 (Slide 11)
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- McCutcheon H, Woodward A. Acute respiratory illness in the first year of primary school related to previous attendance at child care. *Australian and New Zealand Journal of Public Health*. 1996;20:49–53 (Slide 11)
- Ball TM, Holberg CJ, Aldous MB, Martinez FD, Wright AL. Influence of attendance at day care on the common cold from birth through 13 years of age. *Arch Pediatric Adolescent Medicine*. 2002; 156:121–126 (Slide 11)
- Ball TM, Castro-Rodriguez JA, Griffith KA, et al. Siblings, day-care attendance, and the risk of asthma and wheezing during childhood. *New England Journal of Medicine*. 2000;343: 538–543 (Slide 11)



Module 1: Understanding Infectious Diseases

Resources

1. “Fact Sheet: Paid Sick Days Are Good for Children’s Health,”

www.nationalpartnership.org/site/DocServer/Fact_Sheet__Paid_sick_days_are_good_for_childrens_health.pdf?docID=4182

Enrollment/Attendance/Symptom Record

Pennsylvania Chapter, American Academy of Pediatrics. *Model Child Care Health Policies*. 3rd ed. Washington, DC: National Association for the Education of Young Children; 1997. Also available at www.ecels-healthychildcarepa.org/content/MHP4thEd%20Total.pdf

B I N G O !

In a random order, fill in the squares below with these methods of how infectious diseases are spread:

Direct Contact 1	Direct Contact 2
Fecal-Oral 1	Fecal-Oral 2
Body Fluids 1	Body Fluids 2
Insects	Free Space
Respiratory	

View slides depicting how infectious diseases are spread.
Mark the right response on your card.
Get 3 in a row and be the first 1 to have BINGO!

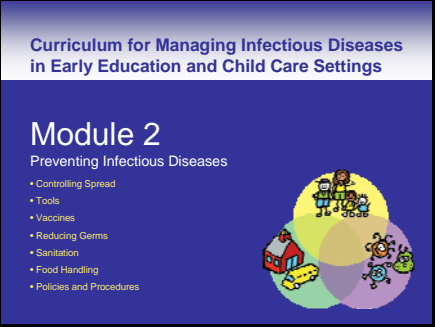
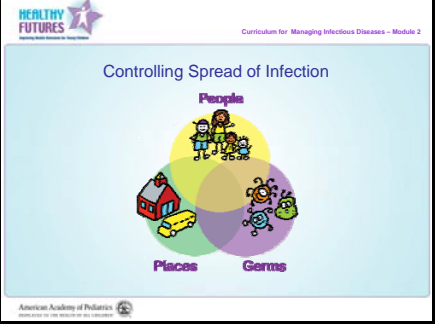
Curriculum for Managing Infectious Diseases in Early Education and Child Care Settings

MODULE 2

Preventing Infectious Diseases

- Controlling Spread
- Tools
- Vaccines
- Reducing Germs
- Sanitation
- Food Handling
- Policies and Procedures



#1	<p>Objectives</p> <p>A. Knowledge Each participant will be able to:</p> <ol style="list-style-type: none"> 1. Identify the 3 factors involved in controlling the spread of infection. 2. Explain the role of nutrition, healthy lifestyle, and immunization in preventing infectious diseases. 3. Identify 4 ways to reduce the number of germs in child care settings. 4. Explain at least 1 activity that families, caregivers/teachers, and health care professionals can do to prevent infectious diseases. <p>B. Attitude Each participant will be able to:</p> <ol style="list-style-type: none"> 1. Feel knowledgeable about good diaper changing techniques. 2. Plan to promote healthy lifestyles in children and staff by practicing good nutrition, and getting adequate exercise and rest. 3. Commit to updating and implementing policies and procedures to decrease the spread of infectious diseases, like effective hand washing and sanitizing. 4. Commit to keeping vaccine status current, plan to encourage other staff to do likewise, and explore how to improve efforts to have parents keep their children's immunizations updated. <p>C. Behavior Each participant will:</p> <ol style="list-style-type: none"> 1. Perform a self-assessment of vaccine status. 2. Demonstrate the proper technique for hand washing. 3. Participate in look-up exercise using <i>Caring for Our Children</i> standards. <p>(<1 minute)</p>	
#2	<p>Lecture</p> <ul style="list-style-type: none"> • Infection illness occurs when vulnerable people succumb to disease-causing organisms (bad germs) in the places where there are too many bad germs, which then overcome barriers to infection in vulnerable people. "Bad germs" can infect people without causing illness. Illness due to infection occurs when "bad germs" cause symptoms like a sore throat or feeling terrible. • Infection control: <ul style="list-style-type: none"> – Makes people more resistant by measures that foster health and well-being, including using vaccines for immunization. – Reduces the number of disease-causing organisms (bad germs). – Modifies the environment (places) people occupy to separate people from the bad germs that are likely to cause illness. • Illness can be reduced and managed, but not eliminated completely. • Management of illness is achieved through preventive health policies and practices. • Participants can use the information in this curriculum to educate and encourage child care staff, children, families, and employers to plan and reinforce desired preventive practices. • Written program policies should describe expectations for staff and families.¹ • Child care staff practices must be regularly monitored to ensure performance. <p>Reference</p> <ol style="list-style-type: none"> 1. <i>Caring for Our Children (CFOC)</i> 2nd ed standard 8.004. <ul style="list-style-type: none"> – American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. <i>Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs</i>. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2002. Also available at http://nrckids.org – CFOC is a joint publication of the American Academy of Pediatrics, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care and Early Education. – CFOC was developed by bringing together leaders in the field of child care to review the literature and develop standards that are based on research, knowledge, and experience. Each standard is supported with references and a rationale. Many groups of people in the fields of child care, health, and public health contribute to the review of the standards. – The second edition is quoted in this curriculum, but the third edition is in progress and should be published in 	

- 2011. Substitute new wording when the third edition is available.
- An online version of *CFOC* can be viewed at the National Resource Center for Health and Safety in Child Care and Early Education Web site (<http://nrckids.org/CFOC/index.html>) or print copies can be obtained through the AAP, American Public Health Association, National Association for the Education of Young Children, or from Redleaf Press.

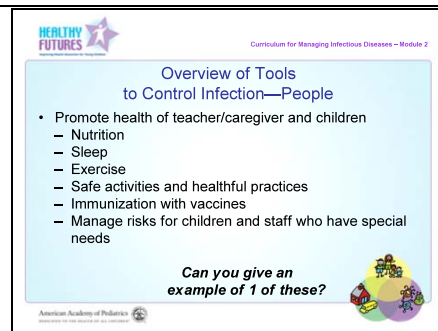
(1–2 minutes)

#3

- The next 3 slides give an overview of tools to control infection. Detailed discussion will be deferred to later in this module. Encourage participants to refer to this list to evaluate infection control in their programs—to plan a healthy program and to manage symptoms when more infectious illness seems to be occurring. The Enrollment/Attendance/Symptom Record in Module 2 of the Participant's Manual can be helpful to identify a trend for an individual or the beginning of an outbreak in a group of children.

Lecture and Limited Guided Discussion

- Health promotion practices make people (teacher/caregiver and children) stronger, with better body defenses.
- **Ask** participants to draw from their experience to give an example of 1 of the topics on the slide. Allow 2 or 3 examples to be mentioned before moving to the next.
- The following are background notes for the instructor about examples that the participant might share:
 - While attendance of infants in group care settings slightly increases the risk of upper respiratory infection and wheezing illness for infants, breastfeeding protects against these increased risks. Therefore, everyone involved with families with infants should encourage and support continued breastfeeding of infants to any extent throughout infancy if mothers and their babies are willing. While some have recommended avoiding group care for young infants, the benefits of group care for each family must be weighed and efforts made to offset risks to the extent possible.¹ In addition, early child care attendance **REDUCES** asthma risk in late preschool/kindergarten age group.^{2,3,4,5}
 - When people drink enough water, avoid sugar-containing beverages, and practice oral hygiene, their teeth are healthier and are less likely to develop caries (cavities). Caries are the result of an infection by bad germs (a specific type of bacteria) in the mouth, usually transmitted from a parent or other caregiver to the child by contact with the adult's saliva.
 - Good nutrition, enough rest, and skin care are essential for healthy skin. Healthy skin prevents germs from entering the body, while cracked skin provides openings to start infections. That is why using lotion after hand washing to keep skin from cracking is an infection-prevention measure.
 - Hand washing removes bad germs from the skin that would be transferred into the mouth, nose, eyes, or other body openings by touching surfaces that other people then handle and then transfer into their body openings. Frequent hand washing is, with immunization, a key tool to control the spread of infection. Hand washing is mentioned repeatedly in this curriculum.
 - Skill and practice is required to follow the healthful practices recommended for sanitary diaper changing while interacting with the child to use the 1:1 time as a relationship-building opportunity. Refer to Diaper Changing in Module 2 of the Participant's Manual.
 - Limit exposure to insects, mice, rats, and other vermin. Practice Integrated Pest Management to reduce the risk of exposure with the minimally toxic methods.
 - Stay indoors at dawn and dusk because these are times of day when disease-carrying insects are most active. Use screens on windows. Eliminate standing water, fruit trees, and open trash that attract biting and stinging insects from child play areas. When children get insect bites, the swelling of body tissues or scratching may lead to infection. This is a common cause of impetigo, or superficial, crusty infections of the skin.
 - When in an area where biting insects are unavoidable, get advice from a health care professional (a Child Care Health Consultant or public health professional) about the advisability of using insect repellants. If recommended by a health care professional, and with parent consent, use DEET-containing products. DEET (N,N-diethyl-3-methylbenzamide) should be applied to skin or clothing. DEET is the most effective insect repellent; DEET is safe when used properly, even in very young children. The AAP recommends using low concentrations of DEET, not more than 30%, for children over 2 months of age.⁶ Concentrations as low as 10% are just as effective as 30%, but they don't last as long (typically 2 hours). For more information, refer to Insect Repellent: Safety Considerations in Module 2 of the Participant's Manual.

**Manual Materials**

- Enrollment/Attendance/Symptom Record
- Diaper Changing
- Insect Repellent: Safety Considerations

References

1. Garcia-Marcos L, Mallol J, Solé D, Brand PLP, the EISL Study Group. International study of wheezing in infants: risk factors in affluent and non-affluent countries during the first year of life. *Pediatr Allergy Immunol.* 2010;21(5):878–888
2. Ball TM, Castro-Rodriguez JA, Griffith KA, Holberg CJ, Martinez FD, Wright AL. Siblings, day-care attendance, and the risk of asthma and wheezing during childhood. *N Engl J Med.* 2000;343(8):538–543
3. Midodzi WK, Rowe BH, Majaesic CM, Saunders LD, Senthilselvan A. Early life factors associated with incidence of physician-diagnosed asthma in preschool children: results from the Canadian Early Childhood Development cohort study. *J Asthma.* 2010;47(1):7–13
4. Nicolaou NC, Simpson A, Lowe LA, Murray CS, Woodcock A, Custovic A. Day-care attendance, position in sibship, and early childhood wheezing: a population-based birth cohort study. *J Allergy Clin Immunol.* 2008;122(3):500–506.e5
5. Celedón JC, Litonjua AA, Ryan L, Weiss ST, Gold DR. Day care attendance, respiratory tract illnesses, wheezing, asthma, and total serum IgE level in early childhood. *Arch Pediatr Adolesc Med.* 2002;156(3):241–245
6. American Academy of Pediatrics. Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds. *Red Book: 2009 Report of the Committee on Infectious Diseases.* 28th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009

Resources (Diapering)

1. *CFOC* 2nd ed standard 3.014
2. National Association for the Education of Young Children. *Keeping Healthy: Families, Teachers, and Children.* 2007. Available at www.naeyc.org/store/node/66

Resource (Pest Management)

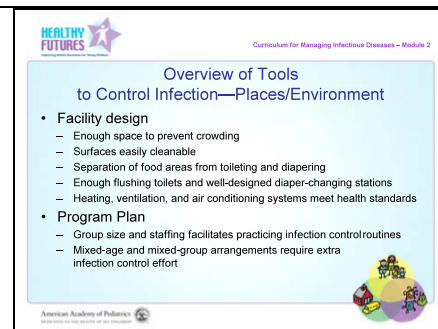
1. California Childcare Health Program: www.ucsfchildcarehealth.org (search pest management)
2. Eco-Healthy Childcare: www.oeconline.org/resources/publications/factsheetarchive/Pesticides.pdf

(2 minutes)

#4

Lecture and Limited Guided Discussion

- Using environmental tools can reduce the number of bad germs where children are in care
- **Ask** participants to draw from their experience to give an example of one of the topics on the slide. Allow examples to be discussed within the limited time assigned to this slide before moving to the next slide. The following are background notes for the instructor about examples that the participants might share:
 - In general, the designated area for children's activities shall contain a minimum of 35 square feet of usable floor space per child (or compensating for typical furnishings and equipment being present, 50 square feet measured on the inside, wall-to-wall dimensions).¹
 - Non-porous smooth surfaces should be used in high risk areas such as food preparation, toileting, and diapering areas. While soft materials are desirable on cuddle toys, for sound absorption, and texture experiences, these must all be treated as potential germ-holding materials. Cuddle toys should belong to an individual child and be regularly laundered at home. Other materials should be regularly cleaned and sanitized according to the Cleaning and Sanitizing Chart in Module 2 of the Participant's Manual.
 - Special attention should be paid to separation of food and beverage sinks, equipment, containers, and activities from anything to do with handling of body fluids (nose wiping, diapering, toileting). Diapering surfaces should not be in places that tempt parents and staff to use them for any other purpose (eg, to unpack lunch or formula bottles, lay out other materials).
 - Flushing toilets with seat adapters (if needed), not potty chairs, should be used in child care
 - Well-designed diaper changing areas facilitate best practice.² The floor should never be used for diapering because of poor staff ergonomics and risk of environmental contamination.
 - Heating, ventilation, and air conditioning should meet *CFOC*³ standards with the technical details assured by a certified heating contractor.
 - Group size and staffing ratios sufficient to follow recommended infection control practices are available in *CFOC*.⁴
 - Mixing groups together provides a larger pool of germs to be shared with everyone. Because of infant and toddler touching behaviors and their need for diapering, they are more likely to share germs with whoever is in their group. Research shows that consistent, small groupings of same-age children are less likely to spread infection. If programs choose to mix children from different groups during some parts of the day, or mix ages in a group, they will need to practice infection control more vigilantly to prevent illness from infection.⁵

**Manual Materials**

- Cleaning and Sanitizing Chart

References

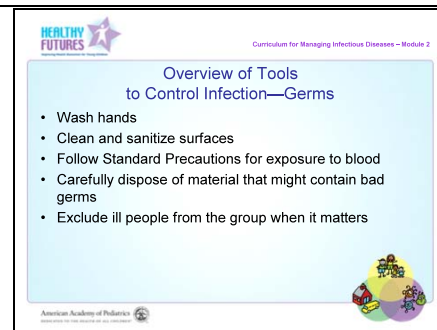
1. CFOC 2nd ed standard 5.112
2. Kotch JB, Isbell P, Weber DJ, et al. Hand-Washing and Diapering Equipment Reduces Disease Among Children in Out-of-Home Child Care Centers. *Pediatrics*. 2007;120:e29-e36
3. CFOC 2nd ed standard 5.032
4. CFOC 2nd ed standard 1.001–1.002
5. Bell DM, Gleiber DW, Mercer AA, Phifer R, Guinter RH, Cohen AJ, Epstein EU, Narayanan M. Illness associated with child day care: a study of incidence and cost. *Am J Public Health*. Apr 1989;79:479-484

(4 minutes)

#5

Lecture and Limited Guided Discussion

- Routinely following practices that reduce the number of bad germs in the environment makes it less likely that these germs will be able to make vulnerable people ill. People without symptoms of illness can have bad germs that will make others sick. This may either be because they are just starting to come down with an illness or because their bodies carry the bad germs without getting sick. Infection control practices must be routinely practiced while providing all the other aspects of the program.
- **Ask** participants to draw from their experience to give an example of 1 of the topics on the slide. Allow 3 or 4 examples to be mentioned before moving to the next slide. The following are background notes for the instructor about examples that the participants might share:
 - Hand washing is the most important way to reduce the number of disease-causing germs from entering the body. Hand washing will be discussed in more detail later in this module.
 - Reduce the numbers of bad germs on surfaces with routine cleaning on a recommended housekeeping schedule with special attention to visible soil and high risk areas.
 - See *Managing Infectious Diseases in Child Care and Schools*¹ for the details of Standard Precaution when handling blood. In child care, these procedures require gloves, special approaches to clean up, and disposal of blood-contaminated materials. The procedures are less stringent than those used in health care settings and meet the requirements for Universal Precautions. Universal Precautions is the term used by the Occupational Safety and Health Administration (OSHA).
 - Disposal of materials that might have bad germs in it requires avoiding any extra touching of these materials, as well as any touching of these materials, to other surfaces. That is why plastic lined, hands-free lidded receptacles are recommended to receive soiled diapers and wipes and individual bagging of soiled diapers is not a good idea.
 - Excluding people for specific types of infections will be discussed in Module 3. A limited exposure to a small amount of bad germs may be handled by the body and produce immunity. This explains why every exposure to bad germs does not cause illness. Some illnesses are most infectious when the infected person has no symptoms. That is why exclusion of symptomatic children does little to control the spread of infection in those situations.
 - Continuing exposure to a small number of bad germs maintains immunity that may come from having the illness in the past. That is why people in group care settings may be ill more frequently in their first year of group experience and then seem to have much less illness as long as they remain in the group setting.

**Reference**

1. Aronson SS, Shope TR. *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:15

(4 minutes)

#6

Lecture and Guided Discussion

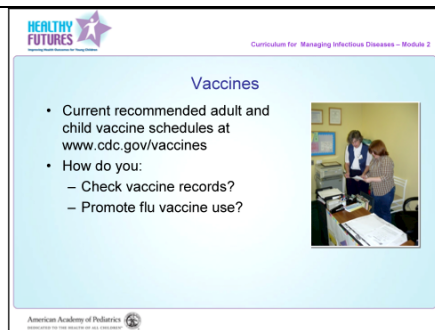
Caution: The curriculum allows 5 minutes for each of the next 2 slides. Ask the participants to use the “parking lot,” or consult their personal physicians or Child Care Health Consultants if this discussion becomes too extended for this and the next slide.

- Routine vaccine schedules: *Prior to presenting, download the current child and adult schedules from the CDC Web site (www.cdc.gov). Copy and distribute to the participants.* Emphasize that participants should go to the CDC Web site for annual updates in January to have the current recommended schedules, since these change with new vaccines and science that need to be included. All children and adults in child care settings should receive the vaccines currently and jointly recommended by the CDC, the AAP, and the Academy of Family Practice for their age and circumstances.
 - Follow these national schedules to protect children in your care even though state regulations may not specify all the vaccines as requirements. State regulations may lag behind current recommendations and may be limited by factors such as the funding available to offer low or no cost vaccines. State regulations may require less, but will not require more than national recommendations. Contact state/local public health professionals for details about locally enforced vaccine requirements.
 - Nationally recommended child vaccine recommendations are updated annually in January. States’ regulatory vaccine requirements for children in child care vary, but public and private health professional expert organizations agree on 1 nationally recommended schedule.
 - Child care policies should require that children and adults be up to date with vaccines, and child care staff check for up-to-date status at enrollment and hiring, as well as track vaccines that children will need during the year.
- **Ask** participants how they check vaccine records and coordinate with families and health care professionals.
- Influenza vaccine:
 - All children and adults in child care need the annual flu vaccine in the fall. Infection control measures that reduce the spread of influenza to children, staff, and families who use the child care program also reduce the subsequent spread to the entire community.
 - “Flu viruses change from year to year, which means 2 things. First, you can get the flu more than once during your lifetime. The immunity (natural protection that develops against a disease after a person has had that disease) that is built up from having the flu caused by 1 virus strain doesn’t always provide protection when a new strain is circulating. Second, a vaccine made against flu viruses circulating last year may not protect against the newer viruses. That is why the influenza vaccine is updated to include current viruses every year. Another reason to get flu vaccine every year is that after you get vaccinated, your immunity declines over time and may be too low to provide protection after a year.”¹
 - **Ask** participants what they do to promote annual influenza vaccine use by children and staff in their programs.

Reference

1. CDC, www.cdc.gov/flu/about/qa/flu vaccine.htm

(5 minutes)



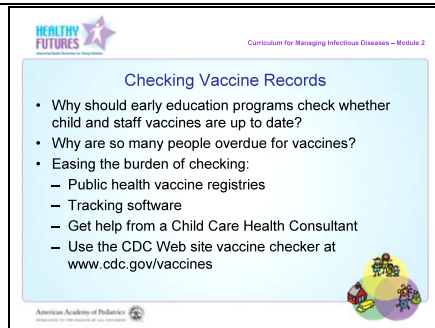
#7

Participant Exercise

- **Ask** participants to use the recommended adult vaccine schedule to perform a self-assessment of vaccine status. Comment on their knowledge of what vaccines they have received and any they find they have missed.

Limited Guided Discussion

- **Ask** questions in first 2 bullets of slide, making sure the discussion covers the following points:
 - Programs must check vaccine records to be sure that all the adults and children regularly spending time in the facility are protected from the increased risk of exposure in the group setting and to protect all the members of the group from being exposed to disease brought to the group by someone who is not protected by vaccine. The program check provides a safety net to identify and send those with gaps in their immunizations back to their health care professionals for needed vaccines.
 - Overcoming barriers to full immunization requires collaboration among all those involved: families, health care professionals, and child care program staff.
 - Barriers include missed opportunities to give vaccine when the child is ill at the time of a health care professional visit; busy parent schedules and frequent health visits required for young children; concerns about insurance coverage of cost; and concerns about vaccine safety.
 - Tracking systems used by health care professionals are improving, but are not sufficient to keep vaccines up to date. Some communities have immunization registries for children where teachers/caregivers can check to see if



- children are up to date.
- Most insurance covers vaccines for children. If coverage is not available, teachers/caregivers can refer families to health clinics for free or low cost vaccines. Many types of insurance cover vaccines for adults. When insurance does not pay, the cost for the vaccines is small compared with the lost time from work or the cost of discretionary purchases.
 - Vaccine refusal: An increasing number of people have been misled by antivaccine campaigns and are refusing vaccines that their children should have to protect them from bad germs. While all vaccines have some risk of bad effects, overall the risk of going without the routinely recommended vaccines is much higher than the risk of a bad reaction from the vaccine. "Vaccine refusal" poses a risk to infants and others who legitimately are underimmunized because of age or medical conditions that limit their ability to receive full vaccine protection. Disease spreads more easily in groups as the number of underimmunized and unimmunized individuals increases. Outbreaks of vaccine-preventable diseases and severe complications that could have been prevented have occurred. Some children and adults who have not received vaccines may have valid medical or religious reasons for this refusal, but they are at risk and increase the risk of others who are in group care with them, requiring special planning with a Child Care Health Consultant or other health care professional for how to handle these situations. Child care programs must consider their liability for accepting a child into the group whose family refuses vaccine for their child. This child poses a risk to others, as well as to her- or himself, for which a child care program, and not just the parent, has been held responsible. Child care programs should consult an attorney in their state to establish a policy for handling voluntary (non-medical) vaccine refusal.
- Easing the burden of checking:
 - Checking vaccine records by matching the schedules to the records is a complex task, even for health care professionals.
 - Child care programs can make arrangements to check child vaccine status with public health immunization registries where they exist. They may or may not hold complete information depending on whether the different places the child received vaccines or parents provided the data to the registry.
 - Vaccine records may list trade names or abbreviations for vaccines. The CDC Web site provides information about the abbreviations and meaning of the names of vaccines on vaccine records. The CDC has individual vaccine checking software on their Web site into which the dates when a particular child or an adult received specific recommended vaccines. The software identifies gaps in receipt of recommended vaccines.
 - Internet-based software is available to enable child care providers to check and track vaccine records for all the enrolled children. Some things to consider when looking at software are the ability to run reports for the individual child and the entire group; time involved in running reports and data entry; and the ability to apply complex rules for age and intervals between doses or variations, such as a child who received vaccines late or missed doses.

Resource

1. www.aap.org/immunization

(5 minutes)

#8

Refer participants to Hand Hygiene in Module 2 of the Participant's Manual.**Guided Discussion**

- **Ask** "When should children and adults wash their hands in child care settings?"
- Guide discussion referring to Hand Hygiene and Why Is Hand Hygiene Important? in Module 2 of the Participant's Manual.
- Clarify why these times are important:
 - When arriving for the day or moving from 1 group to another to keep from spreading bad germs among those in child care.
 - Before and after:
 - Eating, handling food, or feeding a child, to avoid putting into the body bad germs picked up on the hands from touching surfaces in the environment and from touching the mouth during eating.
 - Administering medicine for the same reasons as apply to food handling.
 - Playing with water or moist materials, such as play dough, that is used by more than 1 person. Water is an excellent carrier for germs to spread from 1 person to another. Before or while playing in water, children may touch their mouths, eyes, or noses.
 - After:
 - The hands of children of all ages, including infants, should be washed after each diapering or toileting activity since their hands are likely to pick up bad germs at these times that can subsequently spread by touching other surfaces.
 - Diapering and toileting when hands are likely to touch body fluids, even if gloves are worn. Gloves reduce the contact with germs, but all gloves allow some germs through.
 - Handling body fluids (mucus, blood, vomit).



- Wiping noses, mouths, or touching sores.
- Handling uncooked food, especially meat and poultry, because these are more likely than other foods to have bad germs on them.
- Handling pets and other animals (including tropical fish) or cleaning their cages or litter boxes, because of the bad germs these animals may carry without being sick themselves.
- Playing in sandboxes which hold bad germs from insect and animal contact as well as from the hands of the children who play in the sand.
- Cleaning surfaces.
- Handling garbage.
- When leaving for the day, to avoid bringing bad germs home to families from the group.
- Note that child care staff evaluation should include observed performance of hand washing at appropriate times and use of the recommended technique.
- **Ask** “What is the proper technique for hand washing? Can someone role play for us?”

Role play

- Either pretend or have props (eg, basin, liquid soap dispenser, paper towels) to perform hand washing per technique described in Hand Hygiene in Module 2 of the Participant's Manual. During the role play, sing to the tune of *Row, Row, Row your Boat* to show how to have fun and lather for **at least 10 seconds**: *Wash, wash, wash your hands. Play our handy game. Rub and scrub, and scrub and rub; germs go down the drain. Yea!*

Lecture

- When soap and running water are available, always use hand washing. Review the points under Why is Hand Hygiene Important? in Module 2 of the Participant's Manual. When soap and running water are not available, hand sanitizer is acceptable. If the program must use hand sanitizer:
 - Follow the manufacturer's instructions.
 - Keep alcohol-based hand sanitizers inaccessible to children when not in use.
 - Closely supervise children if they are using alcohol-based hand sanitizers to make sure that they are using it appropriately and safely.
- **Study quote and discuss:** “For nearly 25 years studies have demonstrated that child caregivers can be taught the proper way to diaper and wash hands, and when so taught, diarrhea in the child care center goes down. The study that my team published in 1994 was the first to randomize centers into intervention and control groups. The intervention groups received intensive training in hand washing and sanitation, resulting in significantly less severe diarrhea (5 or more stools a day), especially among younger children and in newer centers. Proper diaper changing and hand washing was associated with less diarrhea, especially among younger children and children in newer centers, but physical barriers to hand washing increased the risk of diarrhea. One thing that may have been associated with newer centers and therefore with lower illness rates was the observation that newer centers were more likely to have written infectious disease control policies.”¹
- A study from the *Pediatric Infectious Diseases Journal* shows positive results when hand washing routines are taught and monitored.²
- A study from Pediatrics shows significantly fewer child and staff illnesses: fewer antibiotic prescriptions; fewer parental absences from work; 50 percent reduction in child diarrheal illness in children over 24 months of age. So staff evaluation should include observed performance of hand washing at appropriate times and using the recommended technique.³

Manual Materials

- Hand Hygiene
- Why Is Hand Hygiene Important?

References

1. Kotch JB, Weigle KA, Weber DJ, Clifford RM, Harms TO, Loda FA, et al. Evaluation of an hygienic intervention in child day-care centers. *Pediatrics*. 1994;94 (suppl 2):991–4
2. Uhari M, Mottonen M. An open randomized controlled trial of infection prevention in child day-care centers. *Pediatr Infect Dis J*. 1999;18:672–677
3. Roberts, L, Jorm, L, Patel, M, Smith, W, Douglas, RM, McGilchrist, C. Effect of infection control measures on the frequency of diarrheal episodes in child care: a randomized, controlled trial. *Pediatrics*. 2000;105:743–746

Resources

1. *CFOC* 2nd ed standard 3.021
2. National Association for the Education of Young Children. *Keeping Healthy: Families, Teachers, and Children*. 2007. Available at www.naeyc.org/store/node/66

(5 minutes)

#9

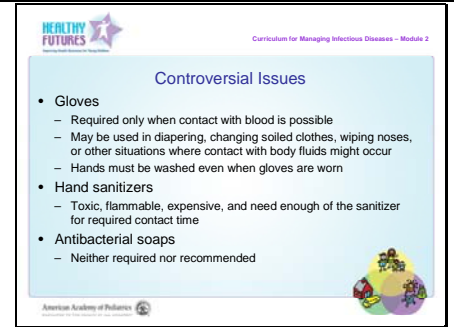
Lecture and Guided Discussion

- Review points on slide that may have already been covered in guided discussion. Invite questions and feedback from participants.
- Gloves
 - “Although gloves are not necessary for diaper changing, they may reduce contamination of the caregiver’s hands and reduce the presence of infectious disease agents under the fingernails and from the hand surfaces. Even if gloves are used, caregivers must wash their hands after each child’s diaper changing to prevent the spread of disease-causing agents. Gloves can provide a protective barrier, but they offer little protection beyond that achieved by good hand washing. To achieve maximum benefit from use of the gloves, the caregiver must remove the gloves properly after cleaning the child’s genitalia and buttocks and removing the soiled diaper. Otherwise, the contaminated gloves will spread infectious disease agents to the clean surfaces as the child is dressed with a clean diaper and clothing.”¹
 - If gloves are worn for food preparation, hand washing is still a necessity. Gloves can become contaminated as the handler puts on the gloves. “Frequent and proper hand washing before and after using clean plastic gloves reduces food contamination.”²
- Hand sanitizers
 - “The use of alcohol-based hand-rub products does not substitute for hand washing in the group care setting. Hand washing is required to remove visible soil. Alcohol-based hand rubs should be limited to instances in which no sink is available.”³
- Antibacterial soaps
 - “These may be used, but are neither required nor recommended.”⁴

References

- CFOC 2nd ed standard 3.014
- CFOC 2nd ed standard 4.051
- Aronson SS, Shope TR. *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:26
- Aronson SS, Shope TR. *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:25

(2 minutes)



#10

Review Cleaning and Sanitizing Chart in Module 2 of the Participant's Manual.

- Emphasize the need to have a surface visibly clean to be able to sanitize it. Many sanitizing solutions do not clean effectively. When visible soil is present, surfaces should be cleaned with detergent, and then rinsed with water before applying a sanitizing chemical.

Participant Exercise

- After participants have looked at the Cleaning and Sanitizing Chart, have them mark any items that need to be improved in their work setting. On flip charts hung around the room (which list the major categories from the chart), have participants put colored dots or use markers to make a check next to the items they think need to be improved in their programs.

Guided Discussion

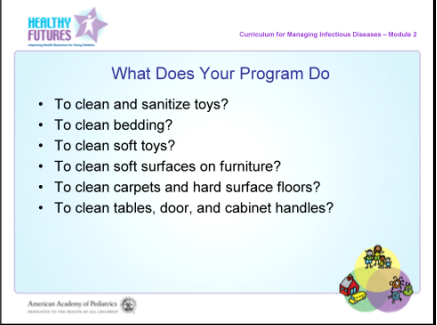

- Note and discuss items with the most dots or checks as time permits.

Manual Materials

- Cleaning and Sanitizing Chart

(9 minutes)



#11	<p>Guided Discussion</p> <ul style="list-style-type: none"> • Ask participants to volunteer or round-robin among the group, ask for a brief response to the questions on the slide. Encourage brief sharing of different approaches, such as: <ul style="list-style-type: none"> – Clean and sanitize toys <ul style="list-style-type: none"> ▪ Use a “soiled” bin to hold toys until they can be washed and sanitized. ▪ Use a dishwasher to wash and sanitize toys—perhaps using a nylon bag to contain the toys in the dishwasher and then hanging up the bag with the toys in it so they can fully dry without having to handle each 1. – Bedding <ul style="list-style-type: none"> ▪ Have a washing machine and dryer to launder bedding at the facility. ▪ Send the child’s bedding home with parents to launder and return to the program. ▪ Have extra bedding at the center for those who do not remember to return the bedding they took home. – Soft toys and any soft surfaces such as upholstered furniture <ul style="list-style-type: none"> ▪ Accept only soft toys that can be used by only 1 child before they are laundered in a washing machine. ▪ Either launder soft toys at the facility or send personal toys home to be laundered. ▪ Cover soft surfaces with removable, easily washed surfaces. – Carpets and hard-surfaced floors <ul style="list-style-type: none"> ▪ Have a commercial carpet cleaner use hospital-type carpet cleaning. Schedule cleaning when there will be at least 24 hours after the cleaning for the carpet to dry while nobody is in the facility. ▪ Purchase a heavy-duty steam carpet cleaner to clean carpets. Schedule cleaning when there will be enough time for the carpets to dry while nobody is in the facility. ▪ Hard-surfaced floors, countertops, tabletops, doors, and cabinet handles should be cleaned and sanitized daily as well as anytime they are soiled. <p>(3 minutes)</p>	
#12	<p>Guided Discussion</p> <ul style="list-style-type: none"> • Encourage participants to collaborate and piggy-back on each other’s responses, using Diaper Changing in Module 2 of the Participant’s Manual. • Ask “What are the strengths of this diaper changing area?” <ul style="list-style-type: none"> – Open storage of supplies that might be needed. – Nothing is kept on the diapering surface. – Probably what is in the spray bottle that is out of child reach is a spray dilution of bleach and water, 1 tablespoon of bleach to 1 quart of water. This 1:64 solution gives the minimum effective dilution if left for 2 minutes of contact with a visibly clean surface. Evaporation of bleach reduces the concentration, so the solution should be made fresh daily. – The diaper table surface has sides which tend to keep the child from rolling off, and no safety straps, which trap germs and do not make a child safe on the table. The caregiver must have a hand on the child at all times. • Ask “What needs to be improved?” <ul style="list-style-type: none"> – Food preparation area with microwave oven is too close to diaper changing area, tempting people to put food on the diapering surface or to put soiled diapers on the food preparation surface. – No sink within an arms reach of the diaper changing surface, which is necessary for diaper changing. Children should never be left unattended on a table during the diapering. – Unclear whether the diaper changing surface is or will be covered by disposable paper to reduce the transfer of germs to the diapering surfaces. – The sides of the diapering surface look like they might be made of wood which would be harder to clean and sanitize properly with each diaper change. A surface that is non-porous, durable, and easy to clean and sanitize is best. – No hands-free lidded, plastic-lined trash receptacle to receive the soiled diapers and wipes is visible in the photo. – The caregiver/teacher with the Child Care Health Consultant is facing away from the room as is the other caregiver/teacher in the photo. Who is supervising the children? When 1 staff member is diaper changing, the effective staff:child ratio decreases substantially, leaving the other caregivers/teachers with more children than is usually appropriate. Turning the table around so the caregiver/teacher who is doing diapering can glance at the group while diapering and talking with the child being diapered helps. • Reference and review Diaper Changing in Module 2 of the Participant’s Manual. Emphasize that clothing and shoes that might become soiled during the change should be removed and placed off the diaper surface. Before putting a clean diaper or pull-up on a child, be sure that all surfaces are free of visible soil. This may require folding up the diaper changing paper to enclose the soiled surface and provide the clean back side of the paper, or changing the paper. The 	

soiled gloves should be removed at this point also. Both the caregiver's/teacher's and the child's hands should be wiped at this point—even though hand washing would be better, it would be too hard to wash hands mid-procedure while the child's bottom is uncovered.

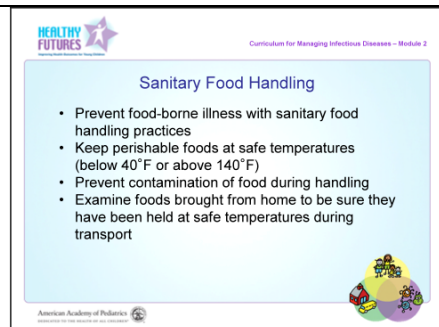
(5 minutes)

#13

Lecture

- From preparation to cleanup, sanitary food handling practices are critical to prevent food-borne illness. Wash raw foods, and cook foods thoroughly that are not safe to eat raw. Live chickens, turkeys, and raw poultry and eggs commonly carry bacteria that can cause illness. This is why poultry and eggs must be fully cooked, and any surface that touches raw poultry must be sanitized especially carefully. Soft-cooked or runny eggs are not safe to eat.
- Make sure perishable foods are held at safe temperatures, either below 40°F or above 140°F. The temperature between 40°F or above 140°F is a danger zone in which bacteria can multiply more easily than at the colder or hotter temperatures. Use a food thermometer to check both hot and cold food temperatures. Use a refrigerator thermometer to monitor the temperature of refrigerators to detect problems before food is spoiled.
- Prevent contamination of food during handling, making sure equipment and utensils are cleaned and sanitized to reduce disease-causing germs.
- Encourage safe family-style food service. Offer foods that are in a form that children can easily serve themselves without touching food for other people. Self-serving experiences need to be closely supervised.
- Examine foods brought from home and check the temperature of perishable foods when they arrive to be sure they have been and continue to be held at safe temperature zones.
- Infant formula should be ready-to-feed, factory-sealed servings, or be prepared at the facility from factory-sealed containers of powder or concentrates diluted with water.
- Wash infant feeding bottles and nipples in the dishwasher to sanitize them, or hand wash them like dishes using the wash, rinse, and sanitize steps recommended by local health authorities.

(2 minute)



#14

Guided Discussion

- Ask** “What does clean mean?”
- Encourage participant responses** and then review Sanitation, Disinfection, and Maintenance in Module 2 of the Participant's Manual. Also refer to the Cleaning and Sanitizing Chart in Module 2 of the Participant's Manual.
- Quote** “Routine housekeeping procedures can help reduce the spread of germs in child care and school environments. Routine cleaning: using detergents or abrasive cleaners and rinsing with water to remove visible soil.”¹
- Surfaces must be clean before they can be sanitized, but a visibly clean surface does not need to be cleaned before sanitizing it. A spray solution of 1:64 dilution of household bleach (1 tablespoon to 1 quart of water) made fresh daily and given 2 minutes of contact time with the surface to be sanitized is commonly used in child care. Bleach is inexpensive and non-toxic in this dilution. Some public health professionals follow guidelines for hospitals and other settings where more concentrated bleach solutions are used to wipe surfaces because the wipe is repeatedly dipped in the solution. For marketing reasons, bleach manufacturers have not sought spray solution labeling from the Environmental Protection Agency regulators. There are many commercial products to use to sanitize surfaces. Most cost more and many are toxic with instructions to keep them away from children. Follow the manufacturer's label when using products other than the bleach spray solution to sanitize surfaces.

Manual Materials


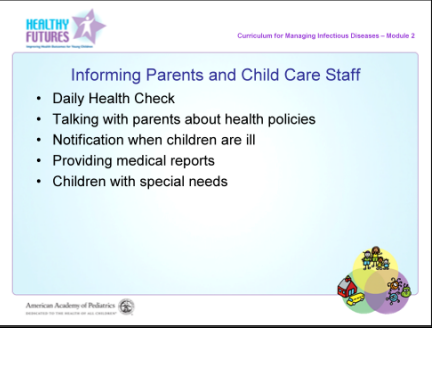
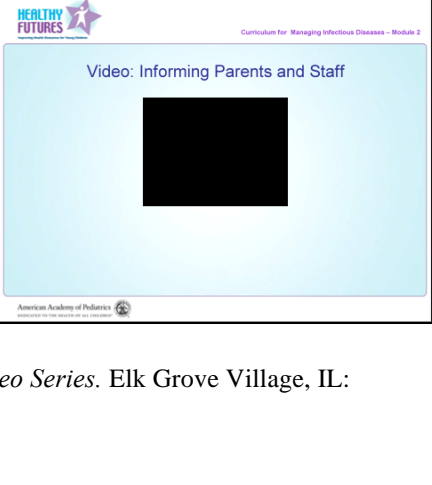
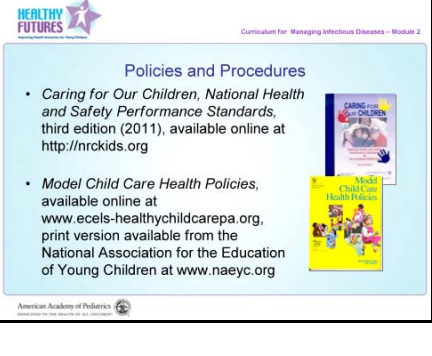
- Sanitation, Disinfection, and Maintenance

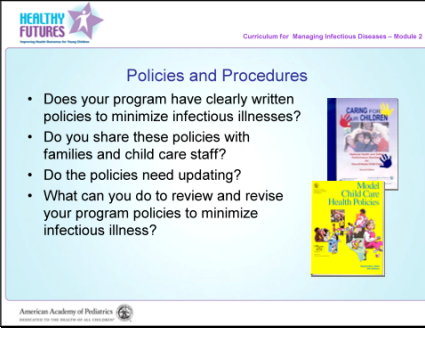
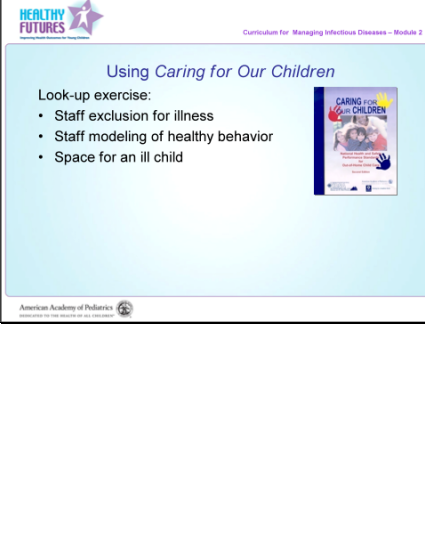
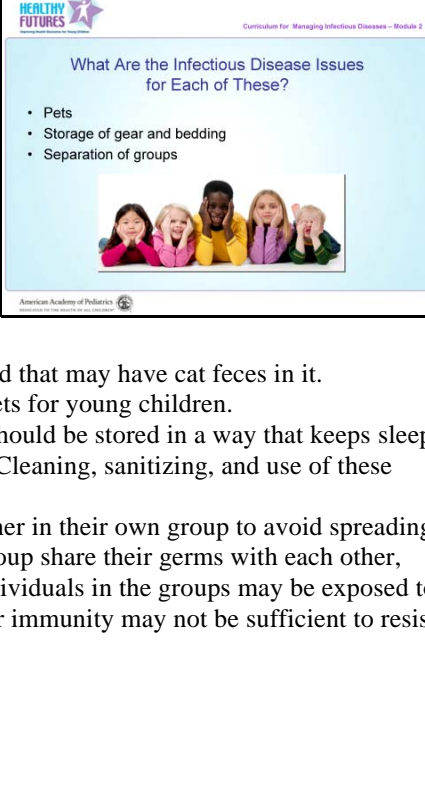
References

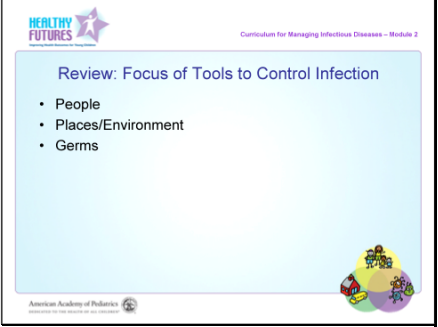
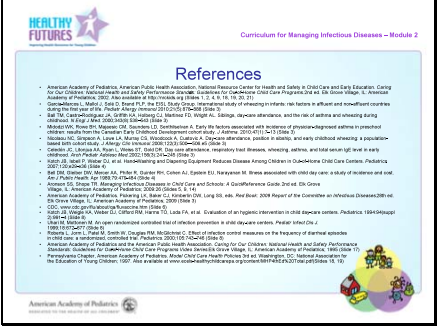
- Aronson SS, Shope TR. *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:20

(<1 minute)



#15	<p>Lecture</p> <ul style="list-style-type: none"> Review content of slide, and Sanitation, Disinfection, and Maintenance and the Cleaning and Sanitizing Chart in Module 2 of the Participant's Manual. If a product is registered with the US Environmental Protection Agency (EPA) as a sanitizer or as a disinfectant and is used according to manufacturer's instructions, it can be used in child care settings. <p>Manual Materials</p> <ul style="list-style-type: none"> Sanitation, Disinfection, and Maintenance Cleaning and Sanitizing Chart <p>(<1 minute)</p>	
#16	<p>Lecture</p> <ul style="list-style-type: none"> Explain that the video in the next slide will show how some key child care staff-parent interactions enable child care programs to be more effective in preventing infections. The video shows best practice based on national standards in <i>CFOC</i>. State regulations may differ. Check the state regulations that apply to see if they are more or less stringent than those in <i>CFOC</i>. <p>(<1 minute)</p>	
#17	<p>Video</p> <ul style="list-style-type: none"> Double-click on the black square to view video. This video segment is 4 minutes long. The video segment is taken from Part 6: <i>Caring for Our Children Video Series</i>.¹ If time is not available to show video, discuss the topics in the video. (Instructor should view video prior to training and then lead discussion with participants.) <p>Reference</p> <ol style="list-style-type: none"> American Academy of Pediatrics and the American Public Health Association. <i>Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs Video Series</i>. Elk Grove Village, IL: American Academy of Pediatrics; 1995 <p>(4 minutes)</p>	
#18	<p>Guided Discussion</p> <ul style="list-style-type: none"> Do your programs have clearly written policies that the program reviews with families and child care staff to foster effective collaboration to prevent infectious illness? Which areas are covered in written policies and procedures, and which could be improved? How can you use the publications shown on this slide to review your written policies and make needed revisions? Allow participants to offer responses to these questions. <p>(3 minutes)</p>	

#19	<p>Guided Discussion</p> <ul style="list-style-type: none"> Suggest participants will need a process to review and update their program policies. Suggest involving those affected, those with authority to implement policies, and those with health care professional expertise (ie, a Child Care Health Consultant) in reviewing facility policies. Suggest using the publications shown on the slide by dividing up the topics to be covered among those involved in the review process so everyone becomes familiar with these resources. <p>(2 minutes)</p>	
#20	<p>Look-up Exercise</p> <ul style="list-style-type: none"> Ask 1 or 2 participants to review 1 or 2 of the following exercises in the <i>CFOC</i> excerpts in Module 2 of the Participant's Manual: <ul style="list-style-type: none"> Staff Exclusion for Illness (<i>CFOC</i> 2nd ed standard 3.069) Staff Modeling of Healthy Behavior (<i>CFOC</i> 2nd ed standard 2.063) Space for Ill Child (<i>CFOC</i> 2nd ed standard 5.149) Ask the participant to read the standard and the rationale, as well as the indication of whether the standard applies to centers, or large or small family child care homes. The third edition of <i>CFOC</i> is expected in 2011. Substitute new wording when third edition is available. <p>Manual Materials</p> <ul style="list-style-type: none"> Staff Exclusion for Illness (<i>CFOC</i> 2nd ed standard 3.069) Staff Modeling of Healthy Behavior (<i>CFOC</i> 2nd ed standard 2.063) Space for Ill Child (<i>CFOC</i> 2nd ed standard 5.149) <p>(3 minutes)</p>	
#21	<p>Lecture</p> <ul style="list-style-type: none"> Having animals in child care is educational. However, some animals carry disease-causing germs even if they are not sick themselves¹. Ask "Do you know some examples?" (See list below to augment the responses of the participants.) <ul style="list-style-type: none"> Healthy reptiles and amphibians (eg, snakes, turtles, frogs, and salamanders) carry salmonella, a bacterium that causes diarrhea and serious, even life-threatening, illness. Live chickens and turkeys, and raw poultry and eggs, commonly carry this organism also. Cat claws carry a particular germ, a bacterium <i>Bartonella henselae</i>, that causes a serious disease called cat-scratch fever; cat's feces carry germ, a parasite <i>Toxoplasma</i>, that can cause serious problems for babies of pregnant women who handle cat litter or uncovered outdoor sand that may have cat feces in it. See www.cdc.gov for more detailed discussion about pet risks and safe pets for young children. Bedding and clothing that touches infected skin can transmit disease. Bedding should be stored in a way that keeps sleep surfaces used by 1 child from touching the sleep surface used by another child. Cleaning, sanitizing, and use of these articles by only 1 person are key preventive measures. Separation of groups is called "cohorting"—which means keeping people together in their own group to avoid spreading disease-causing germs from 1 group to another. Cohorting is a way to have a group share their germs with each other, developing immunity for those germs that are shared. When groups mix, the individuals in the groups may be exposed to some different disease-causing germs than they have already mastered, and their immunity may not be sufficient to resist such exposures. <p>Reference</p> <ol style="list-style-type: none"> <i>CFOC</i> 2nd ed standard 3.042–3.044 <p>(2 minutes)</p>	

<p>#22</p>	<p>Lecture Review list of tools to control infection that were discussed in this module.</p> <p>(<1 minute)</p>	
<p>#23</p>		

Module 2: Preventing Infectious Diseases

Objectives

A. Knowledge

Each participant will be able to:

1. Identify the 3 factors involved in controlling the spread of infection.
2. Explain the role of nutrition, healthy lifestyle, and immunization in preventing infectious diseases.
3. Identify 4 ways to reduce the number of germs in child care settings.
4. Explain at least 1 activity that families, caregivers/teachers, and health care professionals can do to prevent infectious diseases.

B. Attitude

Each participant will be able to:

1. Feel knowledgeable about good diaper changing techniques.
2. Plan to promote healthy lifestyles in children and staff by practicing good nutrition, and getting adequate exercise and rest.
3. Commit to updating and implementing policies and procedures to decrease the spread of infectious diseases, like effective hand washing and sanitizing.
4. Commit to keeping vaccine status current, plan to encourage other staff to do likewise, and explore how to improve efforts to have parents keep their children's immunizations updated.

C. Behavior

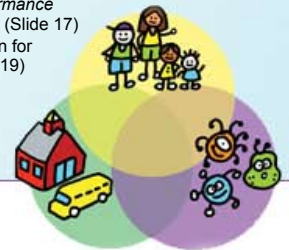
Each participant will:

1. Perform a self-assessment of vaccine status.
2. Demonstrate the proper technique for hand washing.
3. Participate in look-up exercise using *Caring for Our Children* standards.

Module 2: Preventing Infectious Diseases

References

- American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2002. Also available at <http://nrckids.org> (Slides 1, 2, 4, 9, 18, 19, 20, 21)
- Garcia-Marcos L, Mallol J, Solé D, Brand PLP, the EISL Study Group. International study of wheezing in infants: risk factors in affluent and non-affluent countries during the first year of life. *Pediatr Allergy Immunol*. 2010;21(5):878–888 (Slide 3)
- Ball TM, Castro-Rodriguez JA, Griffith KA, Holberg CJ, Martinez FD, Wright AL. Siblings, day-care attendance, and the risk of asthma and wheezing during childhood. *N Engl J Med*. 2000;343(8):538–543 (Slide 3)
- Midodzi WK, Rowe BH, Majaesic CM, Saunders LD, Senthilselvan A. Early life factors associated with incidence of physician-diagnosed asthma in preschool children: results from the Canadian Early Childhood Development cohort study. *J Asthma*. 2010;47(1):7–13 (Slide 3)
- Nicolaou NC, Simpson A, Lowe LA, Murray CS, Woodcock A, Custovic A. Day-care attendance, position in sibship, and early childhood wheezing: a population-based birth cohort study. *J Allergy Clin Immunol*. 2008;122(3):500–506.e5 (Slide 3)
- Celedón JC, Litonjua AA, Ryan L, Weiss ST, Gold DR. Day care attendance, respiratory tract illnesses, wheezing, asthma, and total serum IgE level in early childhood. *Arch Pediatr Adolesc Med*. 2002;156(3):241–245 (Slide 3)
- Kotch JB, Isbell P, Weber DJ, et al. Hand-Washing and Diapering Equipment Reduces Disease Among Children in Out-of-Home Child Care Centers. *Pediatrics*. 2007;120:e29–e36 (Slide 4)
- Bell DM, Gleiber DW, Mercer AA, Phifer R, Guinter RH, Cohen AJ, Epstein EU, Narayanan M. Illness associated with child day care: a study of incidence and cost. *Am J Public Health*. Apr 1989;79:479–484 (Slide 4)
- Aronson SS, Shope TR. *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:26 (Slides 5, 9, 14)
- American Academy of Pediatrics. Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds. *Red Book: 2009 Report of the Committee on Infectious Diseases*. 28th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009 (Slide 3)
- CDC. www.cdc.gov/flu/about/qa/flu vaccine.htm (Slide 6)
- Kotch JB, Weigle KA, Weber DJ, Clifford RM, Harms TO, Loda FA, et al. Evaluation of an hygienic intervention in child day-care centers. *Pediatrics*. 1994;94(suppl 2):991–4 (Slide 8)
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- Roberts L, Jorm L, Patel M, Smith W, Douglas RM, McGilchrist C. Effect of infection control measures on the frequency of diarrheal episodes in child care: a randomized, controlled trial. *Pediatrics*. 2000;105:743–746 (Slide 8)
- American Academy of Pediatrics and the American Public Health Association. *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs Video Series*. Elk Grove Village, IL: American Academy of Pediatrics; 1995 (Slide 17)
- Pennsylvania Chapter, American Academy of Pediatrics. *Model Child Care Health Policies*. 3rd ed. Washington, DC: National Association for the Education of Young Children; 1997. Also available at www.ecels-healthychildcarepa.org/content/MHP4thEd%20Total.pdf (Slides 18, 19)



Module 2: Preventing Infectious Diseases

Resources

1. *CFOC* 2nd ed standard 3.014
2. National Association for the Education of Young Children. *Keeping Healthy: Families, Teachers and Children*. 2007. Available at www.naeyc.org/store/node/66
3. California Childcare Health Program: www.ucsfchildcarehealth.org (search pest management)
4. Eco-Healthy Childcare:
www.oeonline.org/resources/publications/factsheetarchive/Pesticides.pdf
5. www.aap.org/immunization
6. *CFOC* 2nd ed standard 3.021

Enrollment/Attendance/Symptom Record

[illegible]

Diaper Changing

Components of a Diapering Area

Diaper-changing areas should

- Not be located in food preparation areas.
- Not be used for temporary placement of food or utensils.
- Be conveniently located, washable, with all surfaces, including walls and floors, made of a nonporous material without cracks or crevices that are difficult to clean and sanitize.
- Have tightly covered, hands-free receptacles within arm's reach to prevent environmental contamination.
- Take into account whether caregivers must provide simultaneous supervision of the other children in the group. If so, the diaper-changing table should be positioned to allow caregivers/teachers to maintain constant sight and sound supervision of children.
- Be designed to prevent contamination of surfaces during, and as a result of, the diaper-changing process.
- Provide at least one diaper-changing table per infant or toddler group to
 - ~ Allow sufficient time for changing diapers.
 - ~ Allow for cleaning and sanitizing between uses.
- Be used only by those children in one group because
 - ~ Disease spreads more easily when caregivers/teachers from different groups use the same diaper-changing surface and sinks for diapering. This means that diaper-changing tables should not be placed between or shared between classrooms because doing so promotes cross-contamination.
- Be organized to maximize the opportunity for one-on-one time between the child and the teacher/caregiver. Skilled teachers plan diaper-changing areas to give the child visual stimulation, but use objects that do not add to the burden of cleaning and sanitation after the diaper change. For example, mirrors on the wall or ceiling, mobiles, and laminated pictures on the walls or ceiling are interesting for children to look at, and they offer an opportunity for the caregiver and child to interact while diapering is done. While this interaction distracts the child during the diapering activity, more importantly, it fosters language and caring relationships. If the child is given something to hold while being diapered, that object must be considered contaminated and taken from the child to be cleaned and sanitized when the soiled diaper is removed from the child's bottom.

Changing Table Requirements

Changing tables should be

- Made of moisture-proof, nonabsorbent, smooth surfaces that do not trap soil and are easily sanitized
- Sturdy
- At a convenient height (between 28" and 32" high) for use by caregivers/teachers
- Be equipped with railings or barriers that extend at least 6" above the change surface
- Be free of restraining straps or any other objects that pose an additional challenge to cleaning and sanitizing after each diaper change

Sinks in Diaper-Changing Areas

- Sinks in diaper-changing areas should be within arm's reach of the caregivers/teachers so hand washing can be done before any other surfaces are touched and contaminated.
- At least one sink should be available for every 2 changing tables.
- Sinks and diaper-changing tables should be assigned to a specific group of children.
- Sinks should not be used for bathing or removing smeared fecal material.
- Drinking utensils and food should not be washed in these sinks.

Diaper-Changing Steps

The procedure for diaper changing is designed to reduce surface contamination that, later, will come in contact with uncontaminated surfaces such as hands, furnishings, and floors. Posting this multistep procedure may help caregivers/teachers routinely follow the correct steps to changing a child's diaper.

Staff who will be involved with food handling should avoid being involved with diaper changing if at all possible until after food handling duties are completed. All staff should follow these diapering procedures.

Step 1: Get organized.

Before bringing child to diaper area, gather the needed supplies.

- Nonabsorbent paper liner, large enough to cover changing surface from the child's shoulders to beyond the child's feet (so that the table surface is protected and

➤ *continued*



Diaper Changing, continued

the paper liner can be folded back under the child after removing the soiled diaper and cleaning the child's bottom, if the surface under the child's bottom becomes soiled during cleanup)

- Fresh diaper
- Clean clothes (if needed)
- Wipes for cleaning child's bottom and wiping the caregiver's/teacher's and child's hands between taking off the soiled diaper and putting on the clean diaper
- Plastic bag for soiled clothes
- Disposable gloves (If used, put on before touching soiled clothing or diapers and remove before touching clean diapers and surfaces.)
- Thick application of any diaper cream (when appropriate) removed from the container to a piece of disposable material (eg, a small piece of the table liner paper)

Step 2: Carry the child to changing table, avoiding contact with soiled clothing.

- Always keep a hand on the child.
- If the child's feet cannot be kept out of the diaper or from contact with soiled skin during the changing process, remove the child's shoes and socks so the child does not contaminate them with stool or urine.
- Put any soiled clothes in a plastic bag and securely tie the bag to send the soiled clothes home.

Step 3: Clean the child's diaper area.

- Place the child on the diaper-changing surface and unfasten the diaper, but leave the soiled diaper under the child.
- If safety pins are used, close each pin immediately once it is removed and keep pins out of the child's reach (never hold pins in your mouth).
- Lift the child's legs as needed to use disposable wipes to clean the skin on the child's genitalia and buttocks.
- Remove stool and urine from front to back, and use a fresh wipe each time.
- Put the soiled wipes in the soiled diaper or directly into a plastic-lined, covered, foot-operated receptacle.

Step 4: Remove the soiled diaper without contaminating any surface not already in contact with stool or urine.

- Fold the soiled surface inward.
- Put soiled disposable diapers in a plastic-lined, covered, hands-free receptacle. If reusable cloth diapers are used, put the soiled cloth diaper (without emptying or rinsing) in a plastic bag or into a plastic-lined, covered, foot-operated receptacle to give to parents or the laundry service.
- If gloves were used, remove them and put them into a plastic-lined, covered, hands-free receptacle.
- Whether or not gloves were used, use a disposable wipe to clean the surfaces of the caregiver's/teacher's hands, and another wipe to clean the child's hands, and put the wipes into the plastic-lined, hands-free, covered can.
- Check for spills under the child. If there are any, use the paper that extends under the child's feet to fold the disposable paper over so that a fresh, unsoiled paper surface is now under the child's buttocks.

Step 5: Put on a clean diaper and dress the child.

- Slide a fresh diaper under the child.
- Use tissue to apply any necessary diaper creams, discarding the tissue in a plastic-lined, covered, foot-operated receptacle.
- Observe, note, and plan to report any skin problems such as redness, skin cracks, or bleeding.
- Fasten the diaper (if pins are used, place your hand between the child and diaper when inserting the pin) and put on the child's clothing and shoes, being careful to stand the child only on a clean surface so that the child's shoes do not carry contamination from the diaper-changing table around the room.

This is the end of the soiled portion of the diaper change. Gloves should be off and all soiled articles should be in the hands-free can.

►continued



Diaper Changing, continued

Step 6: Wash the child's hands and return the child to a supervised area.

- Use soap and water (no less than 60°F [15.6°C] and no more than 120°F [48.9°C]) to wash the child's hands.
- If a child is too heavy to hold or cannot stand at the sink, use the following method to wash hands:
 - ~ Wipe the child's hands with a damp paper towel moistened with a drop of liquid soap.
 - ~ Wipe the child's hands with a paper towel wet with clean water.
 - ~ Dry the child's hands with a paper towel.

Step 7: Clean and sanitize the diaper-changing surface.

- Dispose of the paper liner used on the diaper-changing surface in a plastic-lined, covered, hands-free receptacle.
- Clean any visible soil from the changing surface with detergent and water; rinse with water.
- Spray a sanitizing bleach solution onto the entire changing surface (see "Sanitation, Disinfection, and Maintenance" on page 20).
- Leave the bleach sanitizer on the surface for at least 2 minutes. (The surface can be wiped dry or left to air-dry.)

Step 8: Wash your hands and record the diaper change in the child's daily log.

- Wash hands using soap and water, using a paper towel to turn off water faucet.
- In the daily log, record what was in the diaper and any problems (eg, diarrhea, unusual color or odor, blood in the stool, any skin irritation).

The procedure for diaper changing is designed to

- Reduce surface contact that leads to contamination of uncontaminated surfaces.
- Ensure the child's safety by assembling supplies before bringing child to the changing area.
- Reduce possible contamination and spreading of disease by taking supplies directly from their containers and leaving containers in their assigned areas.

Remember,

- Food preparation should not be permitted in the diapering area.
- Gloves are not necessary, but may reduce contamination of hands and infectious agents under the fingernails.
- After diapering, clean visible soil from surfaces followed by application of a sanitizing solution. If a spray solution of bleach (1 tablespoon bleach to 1 quart of water) is used, apply the spray until the surface is wet enough to glisten, and then leave the solution on for 2 minutes before wiping or allow the surface to air dry (see "Sanitation, Disinfection, and Maintenance" on page 20). If there is no visible soil, there is no need to clean with detergent first. The 2-minute waiting time for the bleach solution to work can be used conveniently to wash the caregiver's hands, record the diaper change, and gather supplies for the next child's diaper change. By the time these tasks are completed, if another child must use the diaper-changing table, and 2 minutes have elapsed with the table still wet from the bleach solution, the table can be wiped dry with a paper towel.



Insect Repellent: Safety Considerations

- Do not allow young children to apply insect repellent to themselves; have an adult do it for them.
- Apply it to your own hands and then rub your hands on the child.
- Avoid children's eyes and mouth and use it sparingly around their ears. Do not apply over cuts, wounds, or irritated or sunburned skin.
- Do not apply repellent to children's hands; children may tend to put their hands in their mouths.
- Use just enough to cover exposed skin.
- Do not apply repellent to skin under clothing.
- Do not use sprays in enclosed areas or near food.
- Reapply if washed off by sweating or by getting wet.
- Wash the treated skin with soap and water when the children return inside.
- If repellent is applied to clothing, wash treated clothing before wearing again.
- Keep repellents out of reach of children.
- If a child develops a rash or other reaction from any insect repellent, discontinue use, wash the repellent off with soap and water and contact the poison control center (800-222-1222) or a physician, followed by the child's parent.

References:

Centers for Disease Control and Prevention. What You Need to Know About Mosquito Repellent. 2007. Available at: www.cdc.gov/ncidod/dvbid/westnile/mosquitorepellent.htm

American Academy of Pediatrics. Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds. *Red Book: 2009 Report of the Committee on Infectious Diseases*. 28th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009

Cleaning and Sanitizing Chart			
Area	Clean	Sanitize	Frequency
Classroom/Child Care/Food Areas			
Countertops/tabletops, floors, doorknobs, and cabinet handles	X	X	Daily and when soiled
Food preparation/service surfaces	X	X	Before/after contact with food activity; between preparation of raw and cooked foods
Carpets and large area rugs	X		Vacuum daily when children are not present. Clean with a carpet-cleaning method approved by the local health authority. Clean carpets only when children will not be present until carpet is dry. Clean carpets at least monthly in infant areas, at least every 3 months in other areas, and when soiled.
Small rugs	X		Shake outdoors or vacuum daily. Launder weekly.
Utensils, surfaces/toys that go in the mouth or have been in contact with saliva or other body fluids	X	X	After each child's use, or use disposable, one-time utensils or toys.
Toys that are not contaminated with body fluids. Dress-up clothes. Sheets/pillowcases, individual cloth towels (if used), combs/hairbrushes, washcloths, and machine-washable cloth toys. (None of these items should be shared among children without washing first because of the potential for spread of germs by close contact of these items with the skin and hair of the body.)	X		Weekly and when visibly soiled. Many of these articles may be washed in a dishwasher or clothes washer. Small toys, such as plastic blocks, can be put in a net bag for washing.
Blankets, sleeping bags, cubbies	X		Monthly and when soiled
Cribs and crib mattresses	X		Weekly, before use by different child, and whenever soiled or wet
Phone receivers	X	X	Weekly
Toilet and Diapering Areas			
Hand-washing sinks, faucets, surrounding counters, soap dispensers, doorknobs	X	X	Daily and when soiled
Toilet seats, toilet handles, doorknobs or cubicle handles, floors	X	X	Daily or immediately if visibly soiled
Toilet bowls	X	X	Daily
Changing tables, potty chairs (Use of potty chairs in child care is discouraged because of high risk of contamination.)	X	X	After each child's use
General Facility			
Mops and cleaning rags	X	X	Before and after a day of use, wash mops/rags in detergent and water, rinse in water, immerse in sanitizing solution, and wring as dry as possible. After cleaning and sanitizing, hang mops and rags to dry.
Waste and diaper containers	X		Daily
Any surface contaminated with body fluids (eg, saliva, mucus, vomit, urine, stool, blood)	X	X	Immediately, using standard precautions as specified in <i>Caring for Our Children</i> , Standard 3.026
Updated from National Association for the Education of Young Children. <i>Keeping Healthy</i> . 1999, as found in American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care. <i>Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs</i> . 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2002:106. Available at: http://nrc.uchsc.edu/CFOC/index.html . Accessed March 19, 2008.			

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Hand Hygiene

When to Wash Hands

To prevent the spread of infection, signs should be posted at each sink indicating when and how staff, volunteers, and children should wash their hands.

Hand washing should occur

- When arriving for the day or when moving from one group of children to another
- Before and after
 - ~ Eating, handling food, or feeding a child; especially important for children who eat with their hands to decrease the amount of saliva (which may contain organisms) on their hands
 - ~ Administering a medication
 - ~ Playing with water that is used by more than one person
- After
 - ~ Diapering and toileting
 - ~ Handling body fluids (eg, mucus, blood, vomit)
 - ~ Wiping noses, mouths, and sores
 - ~ Handling uncooked food (especially raw meat and poultry)
 - ~ Handling pets and other animals (including tropical fish) or cleaning their cages or litter boxes
 - ~ Playing in sandboxes (to prevent the ingestion of parasites that could be present in contaminated sand and soil)
 - ~ Cleaning
 - ~ Handling garbage
- When leaving for the day

How to Wash Hands

Children and staff should wash hands using the following method:

- Make sure a clean, disposable paper (or single-use) towel is available.
- Turn on water (no less than 60°F [15.6°C] and no more than 120°F [48.9°C]).
- Moisten hands with water and apply liquid soap to hands.
- Rub hands together vigorously until soapy lather appears, and continue for at least 10 seconds; rub areas between fingers, around nail beds, under fingernails and jewelry, and on back of hands.
- Rinse hands under running water until free of soap and dirt. Leave water running while drying hands.

- Dry hands with a clean, disposable paper towel or single-use cloth towel.
- If taps do not turn off automatically, turn taps off with a disposable paper towel or single-use cloth towel.
 - ~ Shared towels can transmit infectious diseases.
- To dispose of towels
 - ~ Throw disposable towel in lined trash container.
 - ~ Place single-use cloth towel in laundry hamper.
 - ~ Hang individually labeled cloth towels to dry.
- If desired, use hand lotion from a liquid lotion dispenser to prevent chapping.

Use a source of clean, running water. Running water will initially rinse off some soil, provide moisture for a good lather, and rinse the skin thoroughly to leave the skin clean.

Children and staff should use liquid soap because

- Although adequately drained bar soap has not been shown to transmit bacteria, bar soaps sitting in water have been shown to be heavily contaminated with *Pseudomonas* and other bacteria.
- Many children do not have the dexterity to handle a bar of soap, and many adults do not take the time to rinse the soil off before putting down the bar of soap.

Additional information

- Premoistened cleansing towelettes
 - ~ Do not effectively clean hands and may spread pathogens from one hand to another.
 - ~ May be used when running water is not available (eg, during an outing).
 - ~ May be used while in the middle of diapering. After removing the soiled diaper and before putting on a clean diaper, the caregiver's/teacher's hands (and often the child's hands, too) may come in contact with feces or urine by touching the soiled skin in the diaper area. Stepping away from the diaper table to wash hands at a sink at this point is not practical. Using a wipe to reduce the level of soil on the caregiver's/teacher's and child's hands at this point is a reasonable compromise.
- Antibacterial soaps may be used, but are neither required nor recommended.

➤continued



Hand Hygiene, continued

Assisting Children With Hand Washing

Encouraging and teaching children good hand-washing practices must be done in a safe manner. Washing infants' hands helps reduce the spread of infection. Washing under running water is best. Staff should wash their own hands after assisting children with hand washing.

Caregivers/teachers should provide assistance

- At a sink for infants who can be safely cradled in one arm
- For children who can stand, but not wash their hands by themselves

For the child who is unable to stand and too heavy to hold at the sink to wash hands under running water, the following method should be used:

- Wipe the child's hands with a damp paper towel moistened with a drop of liquid soap, and discard towel.
- Wipe the child's hands with a clean, wet paper towel until hands are free of soap, and discard towel.
- Dry the child's hands with a clean paper towel.

Using Alcohol-based Hand Rubs

The use of alcohol-based hand-rub products (eg, liquid, gel, or foam hand sanitizers) does not substitute for hand washing in the group care setting. Hand washing is required to remove visible soil. Alcohol-based hand rubs should be limited to instances in which no sink is available. These products require an alcohol content of 60% or greater to be effective at killing germs. They are highly toxic if ingested by children, and they are flammable.

Caregivers/teachers should do the following:

- Limit the use of alcohol-based hand rubs to areas of the facility that are inaccessible to children (eg, in a kitchen that is off-limits to children or the maintenance equipment area).
- Discourage alcohol-based hand rubs for hand hygiene in child-use areas. If they are used in these areas because of lack of sinks, ensure that no child can have independent use of the container or dispenser.
- Be sure that hand hygiene using alcohol-based hand rubs conforms to the manufacturer's instructions. The procedure for using alcohol-based rubs should include the following:
 - ~ Apply the required volume of the product to the palm of one hand and rub together; cover all surfaces of the hands and fingers until the hands are dry. The required volume should keep the hand surfaces wet for at least 15 seconds or longer if indicated by the manufacturer.
 - ~ Check the dispenser systems for hand-hygiene rubs on a regular schedule to be sure they deliver the required volume of the product and do not become clogged or malfunction in some other way.
 - ~ Store supplies of alcohol-based hand rubs in cabinets or areas approved for flammable materials.
 - ~ Monitor hand hygiene with unannounced and regular direct observation. When hand rubs are used, check how much of the product is being used to be sure the appropriate amount gets used as a way to verify that the staff who are authorized to use this method of hand hygiene are continuing to use the material properly.



Bedding, Personal Clothing, and Cribs

Sleep equipment should be used only by one child and cleaned and sanitized before use by another child. Equipment used by one child should be stored separately from that used by others.

- Cribs and crib mattresses should have a nonporous, easy-to-wipe surface.
- Bedding (eg, sheets, pillows, blankets, sleeping bags) should be washable.
- Lice infestation, scabies, and ringworm are among the most common contagious diseases in child care and school settings. Although no evidence exists to show that lice are transmitted except by head-to-head contact, some skin diseases have been shown to spread if bedding materials, jackets with hoods, and hats used by various children are stored so that they touch each other.

Potty Chairs and Toilets

- Potty chair use is not recommended and should be discouraged. Toilets adapted for use by children are preferable.
- If potty chairs are used, they should be
 - ~ Made with a surface that is easily cleaned and sanitized
 - ~ Used only in a bathroom area
 - ~ Used over a surface that will not be damaged by moisture
 - ~ Out of reach of toilets or other potty chairs
 - ~ Emptied into a toilet, then cleaned in a sink that is used only for cleaning and sanitizing potty chairs
- Toilets should be kept visibly clean and separate from the children's activity area.

Staff Training

Provide training for staff who are responsible for cleaning, including the following:

- How to handle, mix, and store cleaning solutions. (See "Sanitation, Disinfection, and Maintenance" on page 20.)
- Proper use of protective barriers (eg, gloves).
- Proper handling and disposal of contaminated materials, such as soiled diapers or bandages that are contaminated with blood or body fluids.
- Information required by the US Occupational Safety and Health Administration about the use of any chemical agents. Even if custodial services are provided under a contract with an outside service organization, be sure that an assigned staff member supervises routine cleaning of the facility according to the facility's schedule. Be sure that the staff have read the Material Safety Data Sheet for any products they use.

Hand Hygiene

Because many infected people carry communicable diseases without having symptoms and are contagious before they experience symptoms, caregivers/teachers need to protect themselves and the children they serve by carrying out hygienic procedures on a routine basis.

Why Is Hand Hygiene Important?

Hand hygiene is the most effective means of reducing germs and infections in group care settings. Studies have shown that unwashed or improperly washed hands are primary carriers of infections. Lack of hand washing and poor hand-washing techniques have contributed to many outbreaks of diarrhea among children and staff in group care settings. Conversely, adherence to good hand-washing techniques has consistently demonstrated a reduction in disease transmission in child care and school settings. While working with children, caregivers/teachers should not wear elaborate jewelry or long or artificial nails, because these interfere with effective hand washing. Using hand lotion after hand washing to prevent chapping and cracking of skin also is important.

Although alcohol-based hand rubs have come into common use in hospitals and other health care settings, hand washing is still the preferred method of hand hygiene in educational settings. Alcohol-based hand rubs should only be used when there is no visible soil, and when soap and water washing is not practical. Proper use of alcohol-based hand rubs requires that the product contain at least 60% alcohol and that the amount of product applied to the skin be sufficient to keep the hands wet with the solution for the length of time specified on the manufacturer's label, generally 15 seconds. This is not less time than it takes to wash hands with soap and water. While the alcohol-based hand rubs are convenient carry-along products, they are expensive, toxic, and flammable. If they are used, precautions to handle these risks are required. Instructions for the use of these products are included in "Hand Hygiene" on page 25.

Hand washing is best; use hand rubs only when there is no visible soil, and soap and water washing is not practical.

Diaper Changing

See "Diaper Changing" on page 27 for sanitary procedures.



(eg, an entryway) that might tempt someone to use the diapering surface as a temporary place to put down articles unrelated to diapering.

- ~ Locate stored diaper-changing supplies off but near the diaper-changing surface, so the supplies for a single diaper change can be gathered and brought to the table without contaminating the bulk supplies during the diaper change. However, the bulk supplies should be stored so that there are no barriers, such as cabinet doors that would have to be handled to get to the supplies if an extra diaper is unexpectedly needed during the diaper change.
- ~ Post the diaper-changing procedures in graphics that are large enough and clear enough to remind staff and families who use the diaper-changing area to follow the steps of the procedure correctly.
- ~ All surfaces must be nonporous, without cracks or crevices, so that they can be effectively cleaned and sanitized between uses. That means that straps and restraints should not be a part of the table design since they cannot be cleaned and sanitized effectively after each change.
- ~ Be sure the plastic-lined, lidded, hands-free container for disposable diapering items is big enough and in good working order so that nobody uses hands to open it or push trash into it.

Routine environmental sanitation. (See the “Cleaning and Sanitizing Chart” on page 21 to establish and monitor the frequency and method of maintenance for all surfaces and “General Guidelines for Surfaces and Equipment” on page 22.)

Health Consultant

All programs in which children routinely spend time should have a health consultant to

Assist in the development and implementation of written policies for prevention and control of communicable diseases.

Perform site visits and observe program operations to spot and help correct hazards and risky practices and provide health education to children, child care providers, and families. Facilities with infants should seek services from a health consultant at least monthly, all centers at least quarterly, and all family child care homes at least annually. See Chapter 8, “Role of the Health Consultant in Child Care and Schools,” on page 161 for more information.

Written Policies

All child care facilities and schools should have written policies dealing with infectious disease control as part of the program’s health policies that describe the following:

- Environmental hygiene (cleaning and sanitizing)
- Inclusion and exclusion for children and staff illnesses
- Families’ responsibility to share information about illnesses and needs for special care of their children
- The need to notify local health authorities of certain communicable diseases involving children or staff
- Accurate record keeping and tracking for immunizations and other routine preventive health care services
- The need to identify the child’s source of routine, comprehensive health care, known as the medical home

Sanitation, Disinfection, and Maintenance

Routine Cleaning, Sanitizing, and Disinfecting of Contaminated Surfaces

Routine housekeeping procedures can help reduce the spread of germs in child care and school environments. Following are definitions of these terms and techniques for their use:

- **Routine cleaning:** using detergents or abrasive cleaners and rinsing with water to remove surface soil.
- **Sanitizing:** removing filth or soil and small amounts of certain germs. For a surface to be considered sanitary, the surface must be cleaned first, and then an additional sanitizer solution must be applied to reduce the number of germs to such a level that disease transmission by that surface is unlikely. This procedure is less rigorous than disinfecting and is applicable to a wide variety of routine housekeeping procedures.
 - ~ Many different types of sanitizing solutions are available.
 - ~ Follow the instructions on the manufacturer’s label for correct use.
 - ~ Products that are registered with the US Environmental Protection Agency (EPA) as *detergent-disinfectant* or *hospital-grade* germicides may be used for sanitizing. Although there are products that are specifically listed as effective against different types of infectious agents, except in an outbreak situation, any of these products is suitable for use in child care and schools. In an outbreak, the instructions of the local health department should be followed.
 - ~ Avoid products that are labeled as toxic for children.
 - ~ Be cautious about using industrial products advertised as “having germicidal action” or “killing germs.” They may not have the same effectiveness as bleach and water or EPA-approved hospital-grade germicides.



US Environmental Protection Agency Definitions

Sanitization—Reduce, but not necessarily eliminate, microorganisms from the inanimate environment to levels considered safe as determined by public health codes or regulations.

Disinfection—Used on hard, inanimate surfaces and objects to destroy or irreversibly inactivate infectious fungi and bacteria, but not necessarily their spores.

Sterilize—Used to destroy or eliminate all forms of microbial life including fungi, viruses, and all forms of bacteria and their spores.

Source: http://www.epa.gov/oppad001/ad_info.htm. Accessed July 21, 2008.

- ~ Consult with your local health department or regulatory licensing authority for any product other than household bleach.
- ❖ Surface sanitizing method.
 - Household bleach is inexpensive, relatively safe, and easy to use, and can be mixed as follows:
 - For all tasks that do not involve blood, mix $\frac{1}{4}$ cup of household bleach to 1 gallon of tap water (or 1 tablespoon of household bleach to 1 quart of water) for a 1:64 dilution. Because chlorine evaporates from bleach and is weakened by sunlight and heat, this minimal dilution may become too diluted to be effective if not made fresh daily from the stock bottle of household bleach. Freshly purchased stock supplies should be used within a few months so they, too, do not become too weak to be effective when diluted.
 - To sanitize with the freshly made 1:64 dilution of bleach, spray the diluted solution on the surface until glossy. Leave the bleach solution on the surface for at least 2 minutes before wiping it off with a clean paper towel, or allow it to air-dry.
 - If blood is involved, change the strength of the bleach and water solution to 1:10 and conduct the same cleaning and sanitizing procedure, carefully bagging all articles in contact with potentially contaminated surfaces.
 - Dipping methods for sanitizing dishes and toys that have been washed and rinsed also are useful.
 - Follow the manufacturer's instructions on the containers for products other than bleach.
 - Household bleach
 - Mix 1.5 teaspoons of household bleach per gallon of water (100 parts per million chlorine) that is not less than 75°F (23.9°C).
 - Immerse the object to be sanitized for at least 2 minutes.
 - Allow the object to air-dry.
 - Hot water immersion

- Completely immerse in hot water at 170°F (76.7°C) for not less than 30 seconds.
- Air-dry.

- **Disinfecting:** eliminating virtually all germs from surfaces through the use of chemicals registered with the US EPA as *disinfectants* or physical agents (eg, heat).

Prevention of Disease Transmission

Baseline routine frequency of cleaning and sanitation can be found in the “Cleaning and Sanitizing Chart” on page 21. Frequency of cleaning and sanitation should be increased when

- There are outbreaks of illness.
- There is known contamination.
- There is visible soil, blood, or other body fluids.
- There are recommendations by the health department to control certain infectious diseases.

Fecal bacteria in the environment have been shown to increase during outbreaks of diarrheal illnesses. Health officials may recommend a more frequent cleaning schedule in certain areas, depending on the nature of the problem.

General Guidelines for Surfaces and Equipment

- Carpets, porous fabrics, other surfaces that trap soil, and potentially contaminated materials, such as potted plants, should not be used in toilet rooms, diaper-changing areas, and food preparation areas.
- Walls, ceilings, floors, furnishings, equipment, and other surfaces should be maintained in good repair and kept clean.
- Because children will touch any reachable surface (including floors), all surfaces may be contaminated and can spread infectious disease agents. Generally, sanitizing agents are not very effective at removing visible soil, and do not work well to sanitize if visible soil is present. Therefore, all surfaces must be properly cleaned and then sanitized.
- Respiratory tract secretions (nasal discharge, drool, eye secretions) may contaminate surfaces. They may contain viruses that remain infectious for varying periods of time, making it possible to acquire an infection by touching these surfaces. Children usually have respiratory tract secretions on their hands and may have viruses in their respiratory tract before and after they seem sick. That is why any surface that might have been in contact with a child's hands must be cleaned and sanitized so often.
- All surfaces, furnishings, and equipment that are not in good repair or have been contaminated by body fluids should not be used until repaired, cleaned, and, if needed, sanitized effectively. Have a way to take out of service any

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surfaces or furnishings that cannot be cleaned or repaired right away. For example, you can use a plastic bin labeled, “dirty—to be washed”, for soiled toys, and yellow plastic tape or yarn to rope off areas that must be temporarily put out of use.

- Adhere to appropriate hand and personal hygiene for children and staff. (See “Hand Hygiene” on page 25.)
- Clean all toys—make it a priority to use toys that can be washed in a dishwasher or washing machine.
- Clean/sanitize tables and countertops, including those used for play, food handling, and eating.
- Clean/disinfect spills of blood or body fluids.
- Sanitize floors and handles of doors and cabinets—all surfaces that children touch.
- Use caution when shampooing rugs used by children who are crawling. Cleaning with potentially hazardous chemicals should be scheduled to minimize exposure to children.
- To prevent animal and insect access, cover sandboxes when they are not in use.
- Ensure that pets are appropriately enclosed and their enclosures are kept clean of waste.
- Ensure that staff wash hands before and after contact with any animal, and after handling animal waste, cages, or bedding (including fish tanks).
- Provide separate and sanitary sleep equipment for each child.
- One way to measure compliance with the standard for cleanliness is to wipe a surface with a clean mop or rag and then insert the mop or rag in cold rinse water. If the surface is clean, no residue will appear in the rinse water.

Cleaning Equipment

- Only utility gloves/equipment designated for cleaning and sanitizing toilets should be used. After each use, wash utility gloves with soapy water and then let them air-dry.
 - ~ Disposable gloves commonly are made of latex or vinyl. If individuals sensitive to latex are present in the facility, only vinyl disposable gloves should be used.
- Disposable towels are preferred for cleaning, and should be placed in a plastic-lined container until removed to outside garbage.
- After each day of use, place cloth rags in a closed, foot-operated receptacle until laundered.
- Reusable rags should be cleaned and sanitized before and after each day of use.
- Sponges are not recommended because they retain organic material that promotes bacterial growth.
- Mops should be assumed to be contaminated because they are used to remove contamination from floors and other soiled surfaces. Be sure they are cleaned and sanitized before and after a day of use.

~ Bleach solution that is used for sanitizing the child care and school environment (see “Routine Cleaning, Sanitizing, and Disinfecting of Contaminated Surfaces” on page 20) can be used for sanitizing mops and rags. Detachable mop heads and reusable rags may be cleaned in a washing machine without other types of articles in the same load, and dried in a mechanical dryer or hung to dry.

Waste Receptacles

Waste receptacles in toilet rooms should be kept clean, lined with plastic bags, in good repair, and emptied daily. Those that receive materials that are contaminated with body fluids should be of the hands-free type, such as a foot-operated receptacle. All other waste receptacles should be kept clean and emptied daily. This practice prevents the spread of disease.

Toys

- All toys can spread disease. Toys become contaminated when children touch them or put them into their mouths. If other children play with or mouth the toy, those children can get the germs on their hands and mucous membranes.
- Toys that cannot be washed and, if needed, sanitized should not be used.
- Mouthed toys or toys contaminated by body secretions or excretions should be removed from the play area until they are washed with water and detergent, rinsed, sanitized, and air-dried.
- Machine-washable cloth toys should be used only by one child until these toys are laundered.
- Indoor toys should not be shared between groups of infants or toddlers unless they are washed/sanitized before being moved from one group to another.
- Small, hard-surfaced toys can be cleaned in a dish pan labeled “soiled toys,” containing soapy water to remove soil, or a dry container can be used to bring the soiled toys to a toy cleaning area later in the day. A dishwasher that can sanitize dishes can be used to clean and sanitize hard-surfaced toys.
- Have more than one set of toys on hand so that one set can be used while the other is cleaned.

Mouthed Objects

Thermometers, teething toys, and similar objects should be cleaned, and reusable parts should be sanitized between uses. Pacifiers should be cleaned, and not shared. Pacifiers should never be placed in a caregiver’s mouth.



Bedding, Personal Clothing, and Cribs

Sleep equipment should be used only by one child and cleaned and sanitized before use by another child. Equipment used by one child should be stored separately from that used by others.

- Cribs and crib mattresses should have a nonporous, easy-to-wipe surface.
- Bedding (eg, sheets, pillows, blankets, sleeping bags) should be washable.
- Lice infestation, scabies, and ringworm are among the most common contagious diseases in child care and school settings. Although no evidence exists to show that lice are transmitted except by head-to-head contact, some skin diseases have been shown to spread if bedding materials, jackets with hoods, and hats used by various children are stored so that they touch each other.

Potty Chairs and Toilets

- Potty chair use is not recommended and should be discouraged. Toilets adapted for use by children are preferable.
- If potty chairs are used, they should be
 - ~ Made with a surface that is easily cleaned and sanitized
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 - ~ Used over a surface that will not be damaged by moisture
 - ~ Out of reach of toilets or other potty chairs
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- Toilets should be kept visibly clean and separate from the children's activity area.

Staff Training

Provide training for staff who are responsible for cleaning, including the following:

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- Proper use of protective barriers (eg, gloves).
- Proper handling and disposal of contaminated materials, such as soiled diapers or bandages that are contaminated with blood or body fluids.
- Information required by the US Occupational Safety and Health Administration about the use of any chemical agents. Even if custodial services are provided under a contract with an outside service organization, be sure that an assigned staff member supervises routine cleaning of the facility according to the facility's schedule. Be sure that the staff have read the Material Safety Data Sheet for any products they use.

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Hand washing is best; use hand rubs only when there is no visible soil, and soap and water washing is not practical.

Diaper Changing

See "Diaper Changing" on page 27 for sanitary procedures.



Caring for Our Children:

National Health and Safety Performance Standards



authority to contribute to transmission of the illness at the facility. These conditions that do not require exclusion include:

- a) Presence of bacteria or viruses in urine or feces in the absence of illness symptoms, like diarrhea. Exceptions include children infected with highly contagious organisms capable of causing serious illness such as *E. coli* 0157:H7, *Shigella*, or *Salmonella typhi*. Children with *E. coli* 0157:H7 or *Shigella* shall be excluded from child care until two stool cultures are negative and they are cleared to return by local health department officials. Children with *Salmonella typhi* shall be excluded from child care until three stool cultures are negative and they are cleared to return by local health department officials;
- b) Nonpurulent conjunctivitis, defined as pink conjunctiva with a clear, watery eye discharge and without fever, eye pain, or eyelid redness;
- c) Rash without fever and without behavior changes;
- d) CMV infection, as described in STANDARD 6.021 and STANDARD 6.022;
- e) Hepatitis B virus carrier state, provided that children who carry HBV chronically have no behavioral or medical risk factors, such as unusually aggressive behavior (biting, frequent scratching), generalized dermatitis, or bleeding problems;
- f) HIV infection, provided that the health, neurologic development, behavior, and immune status of an HIV-infected child are appropriate as determined on a case-by-case basis by qualified health professionals, including the child's health care provider, who are able to evaluate whether the child will receive optimal care in the specific facility being considered and whether that child poses a potential threat to others;
- g) Parvovirus B19 infection in a person with a normal immune system.

RATIONALE: Excluding children with many mild infectious diseases is likely to have only a minor impact on the incidence of infection among other children in the group and the staff (32). Thus, when formulating exclusion policies, it is reasonable to focus on the needs and behavior of the ill child and the ability of staff in the out-of-home child care setting to meet those needs without compromising the care of other children in the group (32).

COMMENTS: The lay term pink eye is used interchangeably to describe purulent and nonpurulent conjunctivitis. The infectious characteristics of purulent and nonpurulent conjunctivitis, however, are quite different. For more information on the difference between purulent and nonpurulent conjunctivitis, see STANDARD 3.068, on conjunctivitis.

For additional information on child inclusion, exclusion, and dismissal, see STANDARD 6.003 on exclusion during antibiotic treatment of *Haemophilus influenzae* type b (Hib); STANDARD 6.008, on exclusion during antibiotic treatment of meningococcal infection; STANDARD 6.011, on exclusion during antibiotic treatment of pertussis; STANDARD 6.034 on excluding children with an immune system that does not function properly to prevent infection.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 3.069 STAFF EXCLUSION FOR ILLNESS

Please note that if a staff member has no contact with the children, or with anything with which the children come into contact, this standard does not apply to that staff member.

A facility shall not deny admission to or send home a staff member or substitute with illness unless one or more of the following conditions exists (65). The staff member shall be excluded as follows:

- a) Chickenpox, until all lesions have dried and crusted, which usually occurs by 6 days;
- b) Shingles, only if the lesions cannot be covered by clothing or a dressing until the lesions have crusted;
- c) Rash with fever or joint pain, until diagnosed not to be measles or rubella;
- d) Measles, until 4 days after onset of the rash (if the staff member or substitute is immunocompetent);
- e) Rubella, until 6 days after onset of rash;
- f) Diarrheal illness, three or more episodes of diarrhea during the previous 24 hours or





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- blood in stools, until diarrhea resolves; if *E.coli* 0157:H7 or *Shigella* is isolated, until diarrhea resolves and two stool cultures are negative;
- g) Vomiting illness, two or more episodes of vomiting during the previous 24 hours, until vomiting resolves or is determined to result from noncommunicable conditions such as pregnancy or a digestive disorder;
 - h) Hepatitis A virus, until 1 week after onset or as directed by the health department when immunoglobulin has been given to appropriate children and staff in the facility;
 - i) Pertussis, until after 5 days of appropriate antibiotic therapy (which is to be given for a total of 14 days) and until disease preventive measures, including preventive antibiotics and vaccines for children and staff who have been in contact with children infected with pertussis, have been implemented;
 - j) Skin infection (such as impetigo), until 24 hours after treatment has been initiated;
 - k) Tuberculosis, until noninfectious and cleared by a health department official;
 - l) Strep throat or other streptococcal infection, until 24 hours after initial antibiotic treatment and end of fever;
 - m) Head lice, from the end of the day of discovery until after the first treatment;
 - n) Scabies, until after treatment has been completed;
 - o) Purulent conjunctivitis, defined as pink or red conjunctiva with white or yellow eye discharge, often with matted eyelids after sleep, and including eye pain or redness of the eyelids or skin surrounding the eye, until 24 hours after treatment has been initiated;
 - p) *Haemophilus influenzae* type b (Hib), prophylaxis, until antibiotic treatment has been initiated;
 - q) Meningococcal infection, until all staff members, for whom antibiotic prophylaxis has been recommended, have been treated. See STANDARD 6.006 through STANDARD 6.008;
 - r) Respiratory illness, if the illness limits the staff member's ability to provide an acceptable level of child care and compromises the health and safety of the children.

Child care providers who have herpes cold sores shall not be excluded from the child care facility, but shall:

- 1) Cover and not touch their lesions;

- 2) Carefully observe handwashing policies;
- 3) Refrain from kissing or nuzzling infants or children, especially children with dermatitis.

RATIONALE: Adults are as capable of spreading infectious disease as children are. See also the Rationale for Child Inclusion/Exclusion/Dismissal, STANDARD 3.065.

COMMENTS: Other management procedures should be followed as stated in Child Inclusion/Exclusion/Dismissal, STANDARD 3.065. For additional information on infectious disease, see STANDARD 6.001 through STANDARD 6.039.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

CARING FOR ILL CHILDREN

STANDARD 3.070 SPACE REQUIREMENTS FOR CARE OF ILL CHILDREN

Environmental space utilized for the care of children who are ill with infectious diseases and cannot receive care in their usual child care group shall meet all requirements for well children and include the following additional requirements:

- a) If the program for ill children is in the same facility as the well-child program, well children shall not use or share furniture, fixtures, equipment, or supplies designated for use with ill children unless it has been cleaned and sanitized before use by well children;
- b) Indoor space that the facility uses for ill children, including hallways, bathrooms, and kitchens, shall be separate from indoor space used with well children; this reduces the likelihood of mixing supplies, toys, and equipment. The facility may use a single kitchen for ill and well children if the kitchen is staffed by a cook who has no child care responsibilities other than food preparation and who does not handle soiled dishes and utensils until after food preparation and food service are completed for any meal;



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STANDARD 2.061 HEALTH EDUCATION TOPICS

Health education for children and staff shall include physical, oral, mental/emotional, nutritional, and social health and shall be integrated daily in the program of activities, to include such topics as:

- a) Body awareness;
- b) Families (including cultural heritage);
- c) Personal/social skills;
- d) Expression of feelings;
- e) Self-esteem;
- f) Nutrition;
- g) Personal hygiene;
- h) Safety (such as home, vehicular care seats and belts, playground, bicycle, fire, and firearms);
- i) Conflict management and violence prevention;
- j) First aid;
- k) Physical health;
- l) Handwashing;
- m) Awareness of special needs;
- n) Importance of rest and sleep;
- o) Fitness;
- p) Oral health;
- q) Health risks of secondhand smoke;
- r) Taking medications;
- s) Dialing 911 for emergencies.

RATIONALE: For young children, health and education are inseparable. Children learn about health and safety by experiencing risk taking and risk control, fostered by adults who are involved with them. Whenever opportunities for learning arise; facilities should integrate education to promote healthy behaviors. Health education should be seen not as a structured curriculum, but as a daily component of the planned program that is part of child development. Certified health education specialists are a good resource for this instruction. The American Association for Health Education (AAHE), the National Commission for Health Education Credentialing, Inc. (NCCHEC), and the State and Territorial Injury Prevention Directors' Association (STIPDA) provide information on this specialty. Contact information for the AAHE, NCCHEC, and STIPDA is located in Appendix BB.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 2.062 GENDER AND SEXUALITY

The facility shall prepare caregivers to appropriately discuss with the children anatomical facts related to gender identity and sexuality differences.

RATIONALE: Open discussions among adults concerning childhood sexuality increase their comfort with the subject. The adults' comfort may reduce children's anxiety about sexuality.

COMMENTS: Developing a common approach to matters involving young children, sexuality and gender identity is not always easy because the views of facility administrators, caregivers, parents, and community leaders do not always coincide (53).

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 2.063 STAFF MODELING OF HEALTHY BEHAVIOR

The facility shall require all staff members to model healthy behaviors and attitudes in their contact with children in the facility, including eating nutritious foods, complying with no tobacco use policies, and handwashing protocols.

RATIONALE: Modeling is an effective way of confirming that a behavior is one to be imitated.

COMMENTS: Modeling healthy behavior and attitudes can be specified in the plan as compliance with no tobacco use policies, handwashing protocols, and so forth.

See Policy on Smoking, Tobacco Use, Prohibited Substances, and Firearms, STANDARD 8.038 and STANDARD 8.039. See also Hygiene, STANDARD 3.012 through STANDARD 3.019, on handwashing protocols.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home



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of futons and ensure that bedding is not shared, thereby reducing transmission of infectious diseases and keeping children out of traffic areas.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.148 BUNK BEDS

Children younger than 6 years of age shall not use the upper levels of double-deck beds (or “bunk beds”). Bunk beds must conform to the U.S. Consumer Product Safety Commission (CPSC) Facts Document #071, Bunk Beds and the American Society for Testing and Materials (ASTM) F1427-96 Standard Consumer Safety Specification for Bunk Beds.

RATIONALE: Falls and entrapment between mattress and guardrails, bed structure and wall, or between slats from bunk beds are a well-documented cause of injury in young children.

COMMENTS: Consult the CPSC, the manufacturer's label, or the consumer safety information provided by the American Furniture Manufacturer's Association (AFMA) for advice. Contact information for the CPSC, the ASTM, and the AFMA is located in Appendix BB.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

AREAS FOR SPECIAL THERAPIES AND INJURED OR ILL CHILDREN

STANDARD 5.149 SPACE FOR ILL CHILD

Each facility shall have a separate room or designated area within a room for the temporary or ongoing care of a child who needs to be separated from the group because of injury or illness. This room or area shall be located so the child may be supervised. Toilet and lavatory

facilities shall be readily accessible. If the child under care is suspected of having a communicable disease, all equipment the child uses shall be cleaned and sanitized after use. This room or area may be used for other purposes when it is not needed for the separation and care of a child or if the uses do not conflict.

RATIONALE: Children who are injured or ill may need to be separated from other children to provide for rest and to minimize the spread of potential infectious disease. Toilet and lavatory facilities must be readily available to permit frequent handwashing and provide rapid access in the event of vomiting or diarrhea to avoid contaminating the environment. Handwashing sinks should be stationed in each room not only to provide the opportunity to maintain cleanliness but also to permit the caregiver to maintain continuous supervision of the other children in care.

COMMENTS: Separate rooms need not be used for mild illness since children may consider isolation as a form of punishment. For additional information on caring for injured or ill children, see STANDARD 3.072 through STANDARD 3.080; and STANDARD 8.011 and STANDARD 8.012. See STANDARD 3.066, for situations that require separation or isolation.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.150 SPACE FOR THERAPY SERVICES

In addition to accessible classrooms, in facilities where some but fewer than 15 children need occupational or physical therapy and some but fewer than 20 children need individual speech therapy, centers shall provide a quiet, private, accessible area within the child care facility for therapy. No other activities shall take place in this area at the time therapy is being provided.

Family child care homes and facilities integrating children who need therapy services shall receive these services in a space that is separate and private during the time the child is receiving therapy.



Curriculum for Managing Infectious Diseases in Early Education and Child Care Settings

MODULE 3

Recognizing and Managing Infectious Diseases

- Daily Health Check
- Exclusion
- Symptoms versus disease



#1

Objectives**A. Knowledge**

Each participant will be able to:

1. Identify the 3 primary reasons for exclusion, and know where to find and how to use the list of specific conditions that require exclusion.
2. Identify 2 reasons why exclusion does not reduce the spread of most common germs.
3. Explain at least 1 goal of exclusion.
4. Explain why consistent application of exclusion criteria creates clear expectations of families and child care staff, and a healthier environment.
5. Explain how to effectively manage an outbreak of an infectious disease and which people should be involved.

B. Attitude

Each participant will be able to:

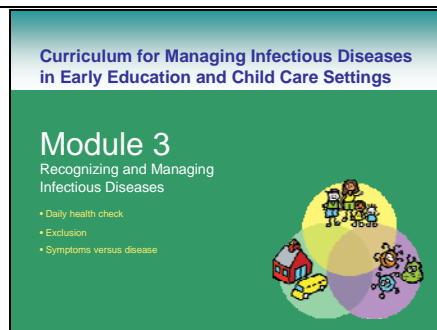
1. Commit to implementing daily health checks in the child care facility.
2. Feel comfortable using a resource, such as *Managing Infectious Diseases in Child Care and Schools*, to determine proper management of infectious disease strategies.

C. Behavior

Each participant will:

1. Demonstrate proficiency using *Managing Infectious Diseases in Child Care and Schools* and *Caring for Our Children (CFOC)* to research a disease based on symptoms.
2. Demonstrate proficiency using *Managing Infectious Diseases in Child Care and Schools* and *CFOC* to research a disease based on a diagnosis.

(<1 minute)



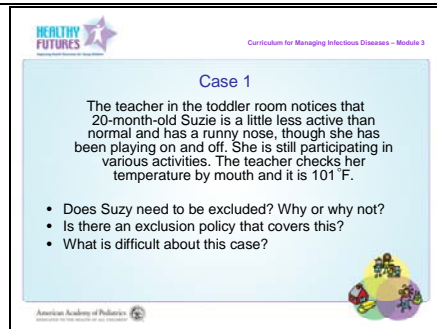
#2

Guided Discussion

- The **goal** is to engage with the participants and raise interest in the subject. The intent is NOT to answer these questions at this point.
- **Ask** for participants' opinions.
- **Establish** a safe learning environment. Assure participants there is no wrong response. Assure participants that we will answer these questions by the end of the session.
- **Write** issues that need to be answered or clarified on a flip chart using the "parking lot" concept.
- Topics that may come up, but do not need to be taught at this time:
 - Exclusion is not necessary for runny nose. Exclusion may be necessary for reduced activity or increased required care, but ... her activity level is near normal. She is participating in activities and is not requiring extra care. Exclusion may be necessary for fever if it is associated with behavior change. The fever cutoff is above 101°F orally. This case is intentionally vague to generate conversation.
 - The caregiver/teacher would have to pick and choose various aspects of several exclusion criteria. Discuss where exclusion criteria come from (*CFOC*,¹ *Managing Infectious Diseases in Child Care and Schools*,² state standards, each program's written policies).
 - Some parents/guardians might have a strong opinion that children like this should be excluded, unless it is their own child! Parents worry that this child will spread infection to their own child. Caregivers/teachers worry about the child and whether she is comfortable and that her needs are met. They also may be concerned about what the parents might think if they did not exclude Suzie. And they may have concerns about the health of the child care staff. Health care professionals generally are not concerned with something like this because they understand that acquiring viral illnesses is part of maturing the immune system in a healthy way. Caregivers/teachers might get some pushback from health care professionals if exclusion results in required doctor visits or notes to return to care. These mandated visits/notes are generally not helpful unless the parent requests the visit. Research shows that viruses and other germs are spread by children who are not ill – either before they become sick or for days or weeks afterward. Therefore, targeting exclusion only on children with symptoms, such as runny nose, is unlikely to reduce the spread of disease.

References

1. American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2002. Also available at <http://nrckids.org>



- *CFOC* is a joint publication of the American Academy of Pediatrics, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care and Early Education.
 - *CFOC* was developed by bringing together leaders in the field of child care to review the literature and develop standards that are based on research, knowledge, and experience. Each standard is supported with references and a rationale. Many groups of people in the fields of child care, health, and public health contribute to the review of the standards.
 - The second edition is quoted in this curriculum, but the third edition is in progress and should be published in 2011. Substitute new wording when the third edition is available.
 - An online version of *CFOC* can be viewed at the National Resource Center for Health and Safety in Child Care and Early Education Web site (<http://nrckids.org/CFOC/index.html>) or print copies can be obtained through the AAP, the American Public Health Association, the National Association for the Education of Young Children, or from Redleaf Press.
 - State standards and regulations are developed by the state regulatory agency. The process by which state standards are developed varies from state to state, but there is no requirement for it to be evidence-based or supported by research. Most states allow for a period of public comment when changes are being made in standards and regulations.
2. Aronson SS, Shope TR. *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009

(7 minutes)

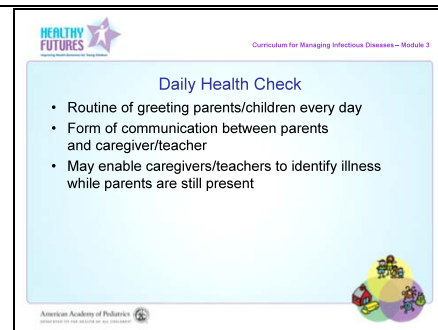
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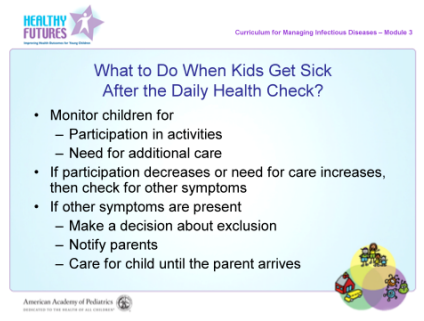

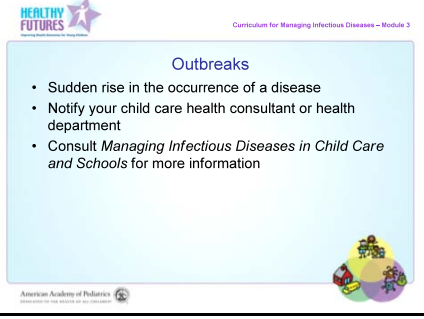
Guided Discussion

Ask the following questions to the participants. Answers are listed for the instructor. Help guide the participants toward the answers without revealing them outright. This will encourage interactive discussion.

- In order to recognize and manage infections in child care we have to be able to detect them. One of the most important methods we use is the daily health check. Let's review the daily health check again. Think about the video on the daily health check in Module 2.
 - **Question:** When is the daily health check performed?
Answer: Each day when children are dropped off at the center.
 - **Question:** Why do we do it? What are we trying to accomplish?
Answer: To detect conditions which might need exclusion because
 - 1) the child is/will be unable to participate adequately in activities, 2) the child may need more care than staff can provide and still safely attend to the other children, or 3) the child has 1 of the specific excludable conditions – we will discuss these in detail later.*Early identification of ill children before parents leave*
 - Makes management simple
 - Is better for the child
 - May reduce the chance of exposure to other children*Some children are dropped off so early they have been asleep during the car ride and the parent has not yet adequately assessed the status of the child.*
 - **Question:** Who does the daily health check?
Answer: The daily health check is done by a designated person qualified to assess the health status of young children. This may vary by the type of program from the teacher/caregiver, director, or designated/trained front desk staff.
 - **Question:** How is the daily health check done?
Answer: Engage the parent and child (if age appropriate) in conversation. Look at the child and observe his/her behavior. If you suspect illness or unusual behavior, touch the child to assess for warmth that may indicate fever. You do not need to check every child for fever, only those exhibiting symptoms of illness.

(5 minutes)



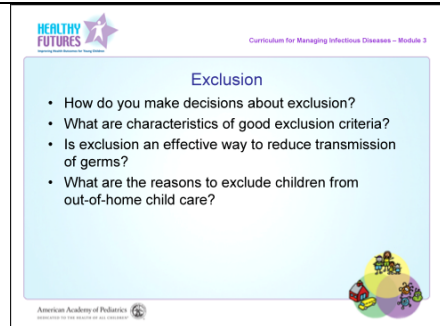
#4	<p>Lecture</p> <ul style="list-style-type: none"> Sometimes, children become ill after the parents or guardians have dropped them off. Look for children who are: <ul style="list-style-type: none"> Less active Clingy or cranky Not participating in activities If participation decreases, look for other symptoms of illness. If symptoms of illness develop, the caregiver/teacher will need to: <ul style="list-style-type: none"> Determine whether the child needs to be excluded Notify the parent or guardian <p>(<1 minute)</p>	
#5	<p>Video</p> <ul style="list-style-type: none"> Double-click on the black square to view video. This video addresses this situation and what to do with an ill child until the parent or guardian arrives. This video segment is 3:18 minutes long. The video segment is taken from Part 6: <i>Caring for Our Children Video Series</i>.¹ If time is not available to show video, discuss the topics in the video. (Instructor should view video prior to training and then lead discussion with participants.) <p>Reference</p> <ol style="list-style-type: none"> American Academy of Pediatrics and the American Public Health Association. <i>Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs Video Series</i>. Elk Grove Village, IL: American Academy of Pediatrics; 1995 <p>(4 minutes)</p>	
#6	<p>Lecture</p> <ul style="list-style-type: none"> Consider an outbreak when you see an increase in children with the same symptoms. Some outbreaks are expected each year (seasonal influenza, hand-foot-and-mouth, bronchiolitis). However, if you note unexpected numbers of children with the same symptoms, or a small number of children with unusually severe symptoms, you should report the issue to the Child Care Health Consultant, if you have one, or the health department. Extensive discussion about outbreaks, epidemics and pandemics are beyond the scope of this course. However, you may consult <i>Managing Infectious Diseases in Child Care and Schools</i>¹ for more information. The AAP has a Web site with information on preparation for pandemic influenza.² <p>Resource</p> <ol style="list-style-type: none"> Aronson SS, Shope TR. <i>Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide</i>. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:169–170 www.aap.org/disasters/pandemic-flu-cc.cfm <p>(<1 minute)</p>	

#7

Guided discussion

- How do you make decisions about exclusion?
- Steer participants to these answers after asking the questions below.
- Answers can be written on flip chart.
- **Ask** “What are 2 characteristics of good exclusion criteria?”
 1. Should be written.
 2. Should be discussed with parents or guardians at the time of enrollment of their child so they are not surprised by them.
 - The 2 steps above ensure:
 - Parents understand decisions better.
 - Parents know that their own child is being treated in a safe and healthy way that is equal to others.
 - Exclusion criteria are confusing because:
 - They vary by state and each program may write its own as long as the program's rules comply with state criteria.
 - Parents, health care professionals, and caregivers/teachers often are not aware of, or do not understand, the exclusion criteria.
- The AAP has published exclusion criteria that can be found in 2 references: *CFOC*, and *Managing Infectious Diseases in Child Care and Schools*. The AAP exclusion criteria incorporate expert advice and medical evidence from research to determine the best course of action for the most common infections or symptoms. Some states have adopted these recommendations; however, if your state has not, usually the recommendations contained in the AAP references are more detailed, and are not in conflict with the state criteria. **If there is a conflict between the AAP exclusion criteria and those of your state, you need to follow the state rules until they are updated.**
- **Ask** “Is exclusion an effective way to reduce transmission of germs?”
 - Exclusion is NOT an effective way to reduce the spread of most common germs.
 - Germs spread before kids get sick and can continue to spread after a child recovers, sometimes for weeks.
 - Some kids spread germs without ever becoming sick themselves.
 - Targeting the ones who appear ill has little or no effect on reducing the transmission of most of the common illnesses.
 - There are a small number of conditions that are reportable to the health department and that do require exclusion. We will discuss these later.
- **Ask** “What are reasons to exclude children from out-of-home child care?”
 - Allow participants to discuss this for 1 minute.
 - The list is obviously large ... BUT ... it is helpful to break this down into 3 main categories we will cover in the next slide.

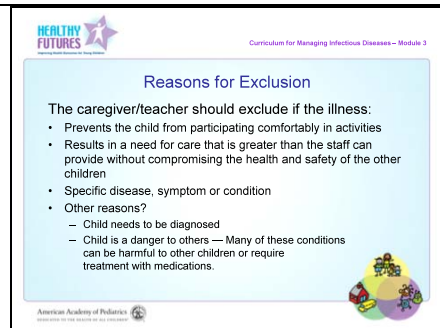
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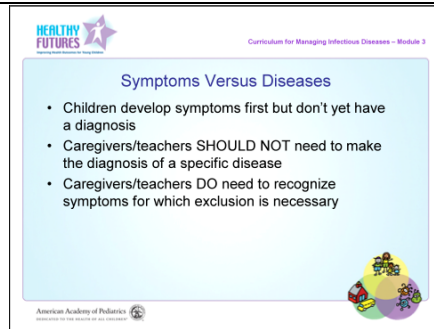
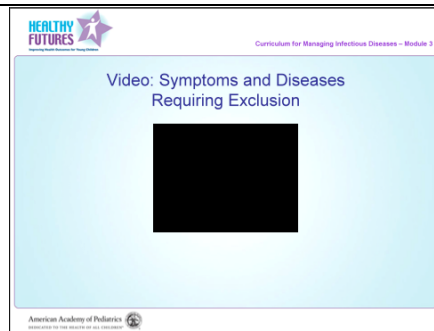
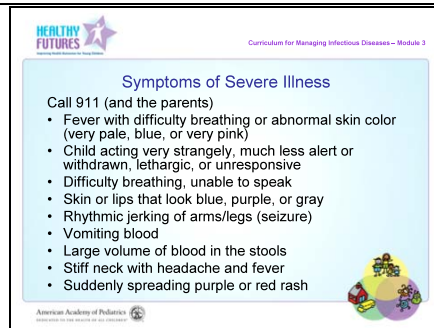


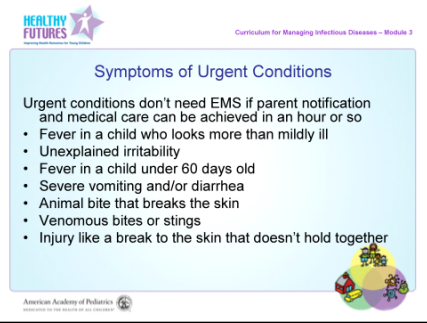
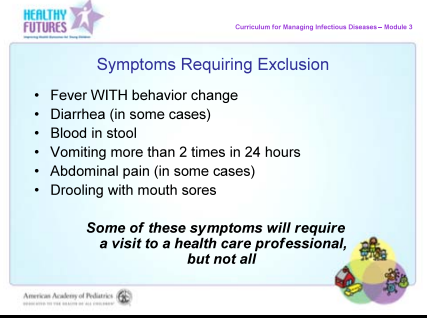
#8

Lecture

- The 3 primary reasons for exclusion:
 1. Prevents the child from participating comfortably in activities.
 2. Results in a need for care that is greater than the staff can provide without compromising the health and safety of the other children.
 3. The child has a specific disease, condition, or symptom requiring exclusion.
- These first 2 primary reasons for exclusion:
 1. Are at the discretion of the caregiver/teacher.
 2. Do not require a diagnosis from a health care professional.
- **When children meet these first 2 criteria, caregivers/teachers have the ability to decide when children need to be excluded.**
- In addition to the 2 primary reasons for exclusion above, there are specific diseases, symptoms and conditions that require exclusion, and treatment in some cases, prior to return to care. Here are some of those diseases:
 - Lice, scabies, tuberculosis, impetigo, strep throat, chickenpox, pertussis, mumps, hepatitis A, measles, rubella, shingles, and herpes simplex.
 - This is a list of diseases that require diagnosis. These are specific diseases that require a diagnosis from a health care professional. Discussion of these diseases is covered in *Managing Infectious Diseases in Child Care and Schools*.¹
 - All the diseases on this list, except lice, are usually diagnosed because the child has been ill and was seen by a doctor or other health care professional. (Lice may be identified by seeing the live insects or insect eggs (nits) within 1/4 inch of the scalp. See *Managing Infectious Diseases in Child Care and Schools*² for details about lice.
- Teachers/caregivers see the kids at the BEGINNING of the illness when they have SYMPTOMS.
- We will discuss specific diseases later.



	<p>Reference</p> <ol style="list-style-type: none"> 1. Aronson SS, Shope TR. <i>Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide</i>. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:41–42 2. Aronson SS, Shope TR. <i>Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide</i>. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:95–96 <p>(2 minutes)</p>	
#9	<p>Lecture</p> <ul style="list-style-type: none"> • Caregivers/teachers often worry about making a diagnosis. • For example: <ul style="list-style-type: none"> – Many children are excluded due to a rash but no behavioral changes. Though some might consider a rash a symptom, if the child's activity level has not been negatively affected, the rash does not represent anything harmful to the child or others. – The reason is because the caregiver/teacher is afraid the child is contagious or harmful to others and a diagnosis is necessary. – If the child does not have symptoms of illness, there is not a reason to exclude. <p>(<1 minute)</p>	
#10	<p>Video</p> <ul style="list-style-type: none"> • Double click on the black square to view video. • This video reviews symptoms and diseases that require exclusion. Although the focus is on reasons to exclude children, most of the guidelines for exclusion for infectious illness apply equally to exclusion of staff who are ill. We do not address management of staff illness in any detail, but want to remind participants that there should be similar policies and procedures in place for them. • We will have a chance for more detailed discussion about which symptoms and diseases need exclusion. Again, I want to reassure you that caregivers/teachers are not required to make diagnoses, only recognize symptoms that require exclusion. • This video segment is 1:38 minutes long. • The video segment is taken from Part 6: <i>Caring for Our Children</i> Video Series.¹ • If time is not available to show video, discuss the topics in the video. (Instructor should view video prior to training and then lead discussion with participants.) <p>Reference</p> <ol style="list-style-type: none"> 1. American Academy of Pediatrics and the American Public Health Association. <i>Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs Video Series</i>. Elk Grove Village, IL: American Academy of Pediatrics; 1995 <p>(2 minutes)</p>	
#11	<p>Lecture</p> <ul style="list-style-type: none"> • If a child has these severe symptoms, it doesn't matter what the diagnosis is. Call an ambulance. <p>(<1 minute)</p>	

#12	<p>Lecture</p> <ul style="list-style-type: none"> • These conditions don't need an ambulance as long as a parent can pick the child up within an hour. • Though we covered a lot of severe and urgent conditions, I think that all of us would recognize these conditions as needing urgent evaluation by a health care professional. • In areas where it is known that a venomous bite can pose severe risk, a venomous bite should require a 911 call. <p>(<1 minute)</p>	
#13	<p>Lecture</p> <ul style="list-style-type: none"> • These conditions are less severe <ul style="list-style-type: none"> – But do require exclusion despite the lack of a diagnosis. – Most of these conditions don't require a health visit; look up the symptom in <i>Managing Infectious Diseases in Child Care and Schools</i>¹ or contact a health care professional. – The symptom and conditions listed on this slide require exclusion in addition to the first 2 primary reasons for exclusion (prevents the child from participating comfortably in activities; results in a need for care that is greater than the staff can provide without compromising the health and safety of the other children) AND those diseases already covered in the Reasons for Exclusion slide. <ul style="list-style-type: none"> ▪ Fever with symptoms like sore throat, rash, vomiting, diarrhea, or cough. Fever can be caused by harmless conditions like exercise. A caregiver/teacher should not take temperature unless the child shows signs of illness! <ul style="list-style-type: none"> – “Fever is an elevation of the normal body temperature. Fever can be a sign of illnesses not caused by infections, such as rheumatoid arthritis or cancer; fever can be a reaction to a variety of medicines.”² – “Oral temperatures above 101°F (38.3°C), rectal temperatures above 102°F (38.9°C), or axillary (armpit) temperatures above 100°F (37.8°C) usually are considered to be above normal in children. Children's temperatures may be elevated for a variety of reason, most of which do not indicate serious illness.”² – “Infants younger than 4 months with fever should be evaluated by a medical professional. Any infant younger than 2 months with fever should get medical attention immediately. The fever is not harmful; however, the illness causing it may be serious in this age group.”² ▪ Blood in the stool not related to passage of hard stools — passage of hard stools is called constipation. ▪ Blood not due to hard stools. ▪ While vomiting more than twice in 24 hours requires exclusion, children who spit up from diagnosed conditions such as gastrointestinal reflux do not need to be excluded. Management of children who have a diagnosed condition that explains their symptoms should have a special care plan that teachers/caregivers who are responsible for them follow. ▪ Abdominal pain lasting less than 2 hours or intermittent but associated with fever or other behavior change. ▪ Drooling with mouth sores. <p>Acknowledge that the list is long and participants can refer to symptom chart in <i>Managing Infectious Diseases in Child Care and Schools</i>. These symptoms cover the vast majority of conditions that could be concerning for child care settings. <i>Managing Infectious Diseases in Child Care and Schools</i> also addresses when children with these symptoms can return to care.</p> <p>References</p> <ol style="list-style-type: none"> 1. Aronson SS, Shope TR. <i>Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide</i>. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:47 2. Aronson SS, Shope TR. <i>Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide</i>. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:73 <p>(1 minute)</p>	

#14

Participant Exercise

- Divide up into 3 groups for interactive case-based scenarios of new symptoms.
- Assign 1 symptom-based case to each group. The cases are in Module 3 of the Participant's Manual.
- Instruct the participants to follow the questions on the case.
- Show the following slides for the cases.
 - Symptom-based Case 1 (Diarrhea): No slides
 - Symptom-based Case 2 (Pinkeye): Slide 14
 - Symptom-based Case 3 (Hand-Foot-and-Mouth): Slides 15–17
- Use *Managing Infectious Diseases* and *CFOC* as resources.
 - Have 2 copies of *Managing Infectious Diseases in Child Care and Schools* and *CFOC* for each group.
 - Groups should discover that *Managing Infectious Diseases in Child Care and Schools* is an easier-to-use resource for this purpose.
 - Groups will also discover some subtle differences between the 2 references as the policies have evolved. The most recent reference is always the most current policy.
- Each group will have 10 minutes to discuss their own case and 5 minutes (total time 15 minutes) to share findings about their case to the whole group afterwards.
- **Note:**
 - The intent is to become familiar with the use of the available tools not to memorize the management of every symptom. Even health care professionals need to look up these references to determine the proper management strategies.
 - In all 3 of these cases, neither of the first 2 primary reasons for exclusion are met (nor do any of the symptoms of these cases meet specific criteria for exclusion):
 - Prevents the child from participating comfortably in activities.
 - Results in a need for care that is greater than the staff can provide without compromising the health and safety of the other children.
 - *Managing Infectious Diseases in Child Care and Schools* has specific instructions about which conditions require health department reporting under the quick reference sheet for each condition and the table, Infectious Diseases Designated as Notifiable at the National Level — United States 2008.¹

**Symptom-based Case 1 (Diarrhea) Discussion Points**

- Diapered children with diarrhea can stay in care as long as
 - Stool is contained in the diaper.
 - Less than 2 stools over normal daily amount.
 - No blood or mucus is in the stool.
 - No other exclusion criteria are met.
- This is a change from prior versions of *Managing Infectious Diseases in Child Care and Schools* and *CFOC*, where any child in diapers with diarrhea required exclusion.
- Hand hygiene, cleaning, and sanitizing are very important.
- Rotavirus vaccine may reduce the amount of diarrhea in child care settings.



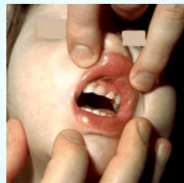
Manual Materials

- Symptom-based Case 1
- Symptom-based Case 2
- Symptom-based Case 3

Reference

1. Aronson SS, Shope TR. *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:41

(25 minutes for Symptom-based Case Activity)

#15	<p>Symptom-based Case 2 (Pinkeye) Discussion Points</p> <ul style="list-style-type: none"> For this exercise, refer participants to the Pinkeye (Conjunctivitis) Quick Reference Sheet in Module 2 of the Participant's Manual. Pinkeye is the common name for conjunctivitis. Exclusion is not necessary for red eyes with either pus watery discharge, unless other exclusion criteria are met (child not participating, requiring too much care) Antibiotics are not necessary. A medical visit is not necessary. These are changes from prior versions of <i>Managing Infectious Diseases in Child Care and Schools</i> and <i>CFOC</i>, and represent a recognition that this is a harmless condition that self-resolves adequately without antibiotics. Symptoms of conjunctivitis are generally mild. Though this condition can be passed from 1 child to another, so can the common cold, which we do not treat and do not exclude for. Caregivers/teachers may use the Parent/Guardian Alert Letter in Module 3 of the Participant's Manual to notify other parents, especially if 2 or more episodes occur at the same time. In situations where there are 2 or more children with conjunctivitis, notify the health consultant or health department if there is no health consultant, because this may represent 1 uncommon form of conjunctivitis (adenovirus) that may cause epidemics of watery, red eyes. There is no treatment for this form of conjunctivitis. Note: This policy will cause controversy and is very different from how we have practiced for years. However, the recommendation was evaluated very carefully by experts in general pediatrics, ophthalmology, and infectious diseases. <p>Manual Materials</p> <ul style="list-style-type: none"> Parent/Guardian Alert Letter Pinkeye (Conjunctivitis) Quick Reference Sheet 	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases - Module 3 American Academy of Pediatrics</p>
#16	<p>Symptom-based Case 3 (Hand-Foot-and-Mouth Disease) Discussion Points</p> <ul style="list-style-type: none"> For this exercise, refer participants to the Hand-Foot-and-Mouth Quick Reference Sheet in Module 2 of the Participant's Manual. Hand-foot-and-mouth disease is the common name for coxsackievirus. No behavioral exclusion criteria are met in this case. However, children with hand-foot-and-mouth disease might need to be excluded if the child is unable to participate or requires too much care. This is a generally harmless condition. It is impossible to stop the spread of this virus (and many others), because the virus particles are shed 3 to 6 days before illness and for weeks after symptoms have resolved. Caregivers/teachers may want to refer to the Quick Reference Sheet on hand-foot-and-mouth disease from <i>Managing Infectious Diseases in Child Care and Schools</i> in Module 3 of the Participant's Manual on this condition, because it does cause concern for parents. No health visit is necessary. No notification of the health department is necessary. <p>Manual Materials</p> <ul style="list-style-type: none"> Hand-Foot-and-Mouth Quick Reference Sheet 	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases - Module 3 American Academy of Pediatrics</p>
#17		 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases - Module 3 American Academy of Pediatrics</p>

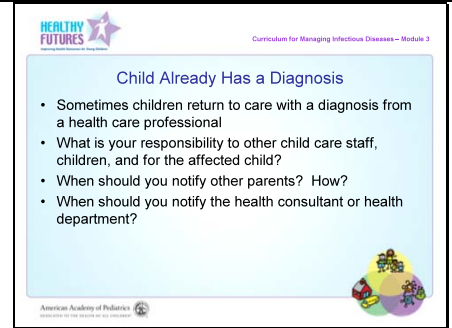
#18



#19

Participant Exercise


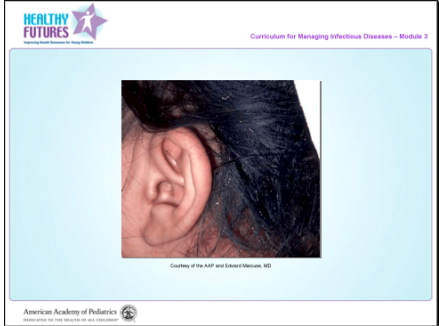

- Divide up into 3 groups for interactive case-based scenarios of new diagnoses.
- Assign 1 diagnosis-based case to each group. The cases are in Module 3 of the Participant's Manual.
- Instruct the participants to follow the questions on the case.
- This is the same type of exercise as the symptom-based cases except the emphasis is that there now is a diagnosis, which will enable caregivers/teachers to look up specific information about the disease and provide this information to parents, guardians, and potentially the health consultant or health department.
- Show the following slides for the cases.
 - Diagnosis-based Case 1 (Shigella): No slides
 - Diagnosis-based Case 2 (Lice): Slides 19–20
 - Diagnosis-based Case 3 (MRSA skin infection): Slide 21
- Use *Managing Infectious Diseases in Child Care and Schools* and *CFOC* as resources.
 - Have 2 copies of *Managing Infectious Diseases in Child Care and Schools* and *CFOC* for each group.
 - Groups should discover that *Managing Infectious Diseases in Child Care and Schools* is an easier-to-use resource for this purpose.
 - Groups will also discover some subtle differences between the 2 references as the policies have evolved. The most recent reference is always the most current policy.
 - Each group will have 10 minutes to discuss their own case and 5 minutes (total time 15 minutes) to share findings about their case to the whole group afterwards.
- **Note:**
 - The intent is to become familiar with the use of the available tools not to memorize the management of every symptom. Even health care professionals need to look up these references to determine the proper management strategies.
 - In all 3 of these cases, neither of the first 2 primary reasons for exclusion are met (nor do any of the symptoms of these cases meet specific criteria for exclusion):
 - Prevents the child from participating comfortably in activities.
 - Results in a need for care that is greater than the staff can provide without compromising the health and safety of the other children
 - *Managing Infectious Diseases in Child Care and Schools* has specific instructions about which conditions require health department reporting under the quick reference sheet for each condition and the table, Infectious Diseases Designated as Notifiable at the National Level — United States 2008.¹

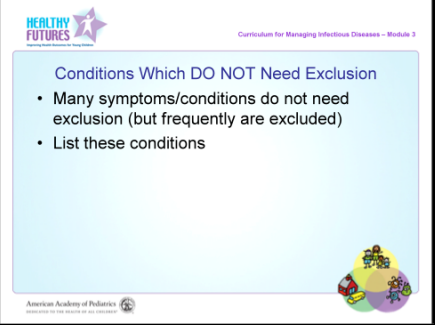
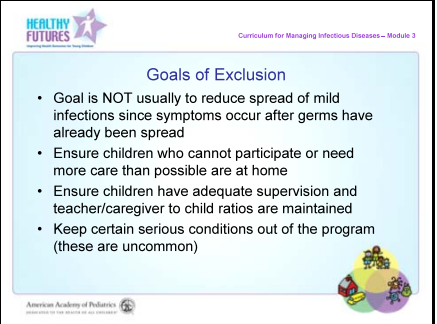
**Diagnosis-based Case 1 (Shigella) Discussion Points**

- Shigella outbreaks can spread rapidly.
- Exclusion is very necessary for bloody diarrhea and requires a doctor visit.
- Exclusion is required until:
 - Child is treated.
 - Two negative stool cultures 24 hours apart.
 - Stool is contained in diaper and fewer than 2 stools above normal or no toileting accidents for older children
- Health department reporting is necessary.
- Remember to assess the caregivers/teachers and be sure no person with diarrhea is doing food handling.

Manual Materials

- Diagnosis-based Case 1
- Diagnosis-based Case 2
- Diagnosis-based Case 3

	<p>Reference</p> <ol style="list-style-type: none"> 1. Aronson SS, Shope TR. <i>Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide</i>. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:41 <p>(25 minutes for Diagnosis-based Case Activity)</p>	
#20	<ul style="list-style-type: none"> • Child with nits in hair. <p>Diagnosis-based Case 2 (Lice) Discussion Points</p> <ul style="list-style-type: none"> • For this exercise, refer participants to the Lice (Pediculosis Capitis) Quick Reference Sheet in Module 2 of the Participant's Manual. • Exclusion is required at the end of the day, not emergently. • The affected individual should have treatment for lice. After treatment has started, allow return to the program should be allowed. For example, a child who is treated in the evening can return to the program the next morning. • The presence of nits that are more than 1/4 inch from the scalp is not a reason to exclude for lice since these do not hatch live lice. • To the extent possible, limit direct head-to-head contact to reduce the risk of person-to-person spread of lice. • Lice infestations cause a lot of concern for parents and teachers/caregivers. We acknowledge that the AAP policies and suggested practice may be in conflict with the beliefs of parents and teacher/caregivers. The AAP policies on lice are an attempt to balance the relatively harmless health affects of lice with the sometimes extreme exclusion practices, such as immediate exclusion and no return until nits are gone (no nit policies) or required exclusions after treatment has been started. These exclusion practices have not been shown to reduce the spread of lice and can result in decreased education and quality care for children and lost parental income. Some of this concern can be addressed by copying and distributing the <i>Managing Infectious Diseases in Child Care and Schools</i> handout on lice. <p>Manual Materials</p> <ul style="list-style-type: none"> • Lice (Pediculosis Capitis) Quick Reference Sheet <p>Resources</p> <ol style="list-style-type: none"> 1. AAP Healthy Children Web site for Families: www.healthychildren.org/English/News/pages/AAP-Offers-Updated-Guidance-on-Treating-Head-Lice.aspx 2. Frankowski BL, Bocchini JA, Council on School Health and Committee on Infectious Disease. Head Lice. <i>Pediatrics</i>. 2010(126):392-403 	
#21	<ul style="list-style-type: none"> • Child with nits on hair behind ears and at nape of neck. 	
#22	<p>Diagnosis-based Case 3 (MRSA) Discussion Points</p> <ul style="list-style-type: none"> • Exclusion not necessary as long as: <ul style="list-style-type: none"> – Lesion can be covered completely with no external drainage. – No other exclusion criteria met, such as prevents the child from participating comfortably in activities or results in a need for care that is greater than the staff can provide without compromising the health and safety of the other children. – Boils, abscesses, or cellulitis should be cultured to assist in treatment decisions (therefore, this child should see a health care professional). – Other children who are not having symptoms do not need to be cultured. 	

#23	<p>Guided Discussion</p> <ul style="list-style-type: none"> On a flipchart, list infections/conditions/symptoms which do NOT need exclusion (but frequently are excluded). <ul style="list-style-type: none"> Common cold (runny nose, congestion) Eye discharge (watery, yellow, green, white) with or without red eyes (unless 2 or more children have red eyes with discharge [pinkeye], until health department advises) Fever without behavior change or signs of illness (unless child is under 5 months) Rash without fever or behavioral changes Ringworm (exclusion for treatment can be delayed until the end of the day) Thrush Lice (exclusion for treatment can be delayed until the end of the day) Fifth disease (parvovirus) follows the rash exclusion criteria <ul style="list-style-type: none"> Exposure of women who lack immunity to fifth disease and CMV during pregnancy poses some risk to their fetuses. Susceptible pregnant caregivers/teachers and pregnant mothers of children in child care and school settings should carefully wash their hands to reduce their risk of this infection and infection from other viruses that could harm a fetus. These women should consult with their health care professionals about their immune status and risk of infection.¹ MRSA without an infection or illness that would otherwise require an exclusion Cytomegalovirus (CMV) infection Chronic Hepatitis B HIV (case by case, and is based on protecting the HIV-infected child, not on potential harm to others) <p>Reference</p> <ol style="list-style-type: none"> Aronson SS, Shope TR. <i>Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide</i>. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:75–76 <p>(2 minutes)</p>	
#24	<p>Lecture</p> <ul style="list-style-type: none"> The goal is NOT usually to reduce spread of mild infections since symptoms occur after germs have already spread. Instead, the goal should be to focus on the child's activity level to ensure proper teacher/caregiver to child ratios and the most comfortable environment possible for the child. There are a number of conditions that are serious. The list is long, but these occur uncommonly. We vaccinate for many of these conditions. Refer to <i>Managing Infectious Diseases in Child Care and Schools</i>.¹ <p>Reference</p> <ol style="list-style-type: none"> Aronson SS, Shope TR. <i>Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide</i>. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:41–42 <p>(<1 minute)</p>	

#25

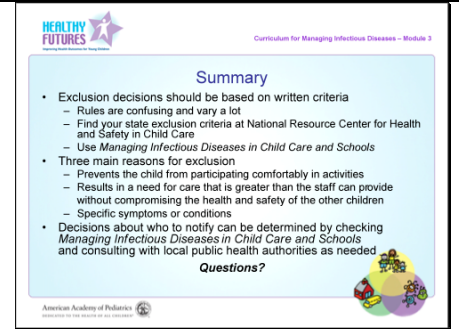
Lecture

- Exclusion decisions are emotional, controversial, and confusing.
- Exclusion criteria need to be written down and reviewed ahead of time.
- Published guides, such as *Managing Infectious Diseases in Child Care and Schools*, come from a reliable source and help to defuse controversy and fear by imparting knowledge.
- Only 3 primary reasons for exclusion:
 - Prevents the child from participating comfortably in activities.
 - Results in a need for care that is greater than the staff can provide without compromising the health and safety of the other children.
 - Specific diseases, symptoms and conditions listed in *Managing Infectious Diseases in Child Care and Schools*.
- There are other specific diseases, symptoms and conditions that can be looked up in *Managing Infectious Diseases in Child Care and Schools*.
- If you are not certain who to notify, look it up in *Managing Infectious Diseases in Child Care and Schools*.

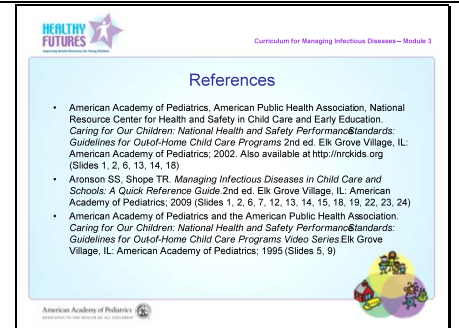
Resource

1. National Resource Center for Health and Safety in Child Care, <http://nrckids.org/>

(1 minute)



#26



Module 3: Recognizing and Managing Infectious Diseases

Objectives

A. Knowledge

Each participant will be able to:

1. Identify the 3 primary reasons for exclusion, and know where to find and how to use the list of specific conditions that require exclusion.
2. Identify 2 reasons why exclusion does not reduce the spread of most common germs.
3. Explain at least 1 goal of exclusion.
4. Explain why consistent application of exclusion criteria creates clear expectations of families and child care staff, and a healthier environment.
5. Explain how to effectively manage an outbreak of an infectious disease and which people should be involved.

B. Attitude

Each participant will be able to:

1. Commit to implementing daily health checks in the child care facility.
2. Feel comfortable using a resource, such as *Managing Infectious Diseases in Child Care and Schools*, to determine proper management of infectious disease strategies.

C. Behavior

Each participant will:

1. Demonstrate proficiency using *Managing Infectious Diseases in Child Care and Schools* and *Caring for Our Children (CFOC)* to research a disease based on symptoms.
2. Demonstrate proficiency using *Managing Infectious Diseases in Child Care and Schools* and *CFOC* to research a disease based on a diagnosis.

Module 3: Recognizing and Managing Infectious Diseases

References

- American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2002. Also available at <http://nrckids.org> (Slides 1, 2, 6, 13, 14, 18)
- Aronson SS, Shope TR. *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009 (Slides 1, 2, 6, 7, 12, 13, 14, 15, 18, 19, 22, 23, 24)
- American Academy of Pediatrics and the American Public Health Association. *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs Video Series*. Elk Grove Village, IL: American Academy of Pediatrics; 1995 (Slides 5, 9)



Module 3: Recognizing and Managing Infectious Diseases

Resources

1. Aronson SS, Shope TR. *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:169–170 (Slide 6)
2. www.aap.org/disasters/pandemic-flu-cc.cfm (Slide 6)
3. AAP Healthy Children Web site for Families:
www.healthychildren.org/English/News/pages/AAP-Offers-Updated-Guidance-on-Treating-Head-Lice.aspx (Slide 19)
4. Frankowski BL, Bocchini JA, Council on School Health and Committee on Infectious Disease. Head Lice. *Pediatrics*. 2010(126):392-403 (Slide 19)
5. National Resource Center for Health and Safety in Child Care, <http://nrckids.org/> (Slide 24)

Symptom-based Case 1

A 10-month-old girl had some loose stools yesterday. She came to child care today. By lunch time, she has had 3 stools that are larger in volume than usual and watery green with no blood or mucus. The stools are contained in her diaper. She is acting normal and does not feel warm (no fever if you check). Normally, she has 2 stools from morning drop-off until her late afternoon pick-up from the child care program.

Take 5 minutes to discuss and write down your answers. You should try to look up the American Academy of Pediatrics' policies in *Caring for Our Children* or *Managing Infectious Disease in Child Care and Schools*.

Questions to consider:

Should she be excluded?

What are your responsibilities to the affected child, the other children, and the child care staff?

When should you notify other parents or guardians?

When should you require a health visit?

When should you notify the health consultant or health department?

What do you think about the AAP policy on diarrhea?

Symptom-based Case 2

A 10-month old boy develops green/yellow eye discharge and the whites of his eyes appear red. He is otherwise acting normally other than a runny nose. He is playful, interactive, and eating and drinking well. See slide.

What are your responsibilities to the affected child, the other children, and the child care staff?

Questions to consider:

Should he be excluded?

What are your responsibilities to the affected child, the other children, and the child care staff?

When should you notify other parents or guardians?

When should you require a health visit?

When should you notify the health consultant or health department?

What do you think about the AAP policy on pink eye/conjunctivitis?

Symptom-based Case 3

A 24-month-old boy develops a rash consisting of small red bumps and white fluid-filled blisters on hands. He also complains of some mouth pain and you note some red areas with white tops inside his lips. He is otherwise acting normally other than a runny nose. He is playful, interactive, and eating and drinking well. See slides.

Take 5 minutes to discuss and write down your answers. You should try to look up the American Academy of Pediatrics' policies in *Caring for Our Children* or *Managing Infectious Disease in Child Care and Schools*.

Questions to consider:

Should he be excluded?

What are your responsibilities to the affected child, the other children, and the child care staff?

When should you notify other parents or guardians?

When should you require a health visit?

When should you notify the health consultant or health department?

What do you think about the AAP policy on rash? Is this a specific type of rash? Does the exact diagnosis make a difference in how you manage this child?

Parent/Guardian Alert Letter

Notice of Exposure to Communicable Disease

Name of Facility/School _____

Address of Facility/School _____

Telephone Number of Facility/School _____

Dear Parent or Legal Guardian:

A child in our facility/school has or is suspected of having _____.

Without violating the confidentiality of this child, the facts you need to know about your child's exposure in this situation are:

We want to inform you about this condition and the related exclusion and return-to-care practices at our facility/school. Please read the attached information sheet closely and call us with any questions.

Facility/School Staff Person's Name at _____
Telephone Number

Aronson SS, Shope TR. *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009
Available at www.aap.org/bookstore

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*. Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for such changes.

Pinkeye (Conjunctivitis)

What is conjunctivitis?

Inflammation (ie, redness, swelling) of the thin tissue covering the white part of the eye and the inside of the eyelids

What are the signs or symptoms?

There are several kinds of conjunctivitis, including

- Bacterial
 - ~ Red or pink, itchy, painful eye(s).
 - ~ More than a tiny amount of green or yellow discharge.
 - ~ Infected eyes may be crusted shut in the morning.
 - ~ May affect one or both eyes.
- Viral
 - ~ Pink, swollen, watering eye(s) sensitive to light.
 - ~ May affect only one eye.
- Allergic
 - ~ Itching, redness, and excessive tearing, usually of both eyes.
- Chemical
 - ~ Red, watery eyes, especially after swimming in chlorinated water.
- Immune mediated, such as that related to a systemic disease like Kawasaki disease.

What are the incubation and contagious periods?

Depending on the type of conjunctivitis, the incubation period varies.

- Bacterial
 - ~ The incubation period is unknown because the bacteria that cause it are commonly present in most individuals and do not usually cause infection.
 - ~ The contagious period ends when the course of medication is started.
- Viral
 - ~ Sometimes occurs early in the course of a viral respiratory tract disease that has other signs or symptoms.
 - ~ One type of viral conjunctivitis, adenovirus, may be contagious up to 14 days after the appearance of signs or symptoms. Children with adenovirus infection are often ill with fever, sore throat, and other respiratory tract symptoms. This virus may uncommonly cause outbreaks in child care and school settings. Antibiotics for this condition do not help the patient or reduce spread.
 - ~ The contagious period continues while the signs or symptoms are present.



MARK PETER HUGHES

Child with pinkeye

- Allergic
 - ~ Occurs in response to contact with the agent that causes the allergic reaction. The reaction may be immediate or delayed for many hours or days after the contact.
 - ~ No contagious period.
- Chemical
 - ~ Usually appears shortly after contact with the irritating substance.
 - ~ No contagious period.

How is it spread?

Hands become contaminated by direct contact with discharge from an infected eye, or by touching other surfaces that have been contaminated by respiratory tract secretions and gets into the child's eyes.

How do you control it?

- Consult a health professional for diagnosis and possible treatment. The role of antibiotics in treatment and preventing spread is unclear. Most children with pinkeye get better after 5 or 6 days without antibiotics.
- Careful hand hygiene before and after touching the eyes, nose, and mouth.
- Careful sanitation of objects that are commonly touched by hands or faces, such as tables, doorknobs, telephones, cots, cuddle blankets, and toys.

What are the roles of the caregiver/teacher and the family?

- Report the infection to staff designated by the child care program or school for decision making and action related to care of ill children. That person, in turn, alerts possibly exposed family members and staff to watch for symptoms.
- Notify child's parent/guardian to consult with the child's health professional about diagnosis and treatment by telephone or office visit. Documentation from the child's health professional is not required.

➤continued

Aronson SS, Shope TR. *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009. Available at www.aap.org/bookstore

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Pinkeye (Conjunctivitis), continued

- Seek advice from the health department or the program's health consultant about how to prevent further spread if 2 or more children in one room have red eyes with watery discharge.
- Review hand-hygiene techniques and sanitation routines.
- Complete course of medication, if prescribed, for bacterial conjunctivitis.

Exclude from group setting?

No, unless

- The child is unable to participate and staff determine that they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group.
- The child meets other exclusion criteria, such as fever with behavior change (see "Conditions Requiring Temporary Exclusion" on page 41).
- There is a recommendation of the health department or the child's health professional.

Readmit to group setting?

- When exclusion criteria are resolved, the child is able to participate, and staff determine that they can care for the child without compromising their ability to care for the health and safety of the other children in the group.
- Antibiotics are not required to return to care.

Comments

- It is helpful to think of pinkeye like the common cold. Both conditions may be passed on to other children but resolve without treatment. We do not exclude for the common cold. Pinkeye generally results in less symptoms of illness than the common cold. The best method for preventing spread is good hand hygiene.
- One form of viral conjunctivitis, caused by adenovirus, can cause epidemics. If 2 or more children in a group care setting develop conjunctivitis in the same period, seek the advice of the program's health consultant.

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Hand-Foot-and-Mouth Disease

What is hand-foot-and-mouth disease?

A common set of symptoms associated with viral infections that are most frequently seen in the summer and fall. Despite its scary name, this illness generally is mild. Most commonly caused by coxsackievirus A16 and enterovirus 71.

What are the signs or symptoms?

- Tiny blisters in the mouth and on the fingers, palms of hands, buttocks, and soles of feet that last a little longer than a week (one, few, or all of these may be present).
- May see common cold signs or symptoms with fever, sore throat, runny nose, and cough. The most troublesome finding is blisters in the mouth, which make it difficult for the child to eat or drink. Other signs or symptoms, such as vomiting and diarrhea, can occur, but are less frequently troublesome.
- Hand-foot-and-mouth disease caused by enterovirus 71 can cause neurologic symptoms.

What are the incubation and contagious periods?

- Incubation period: 3 to 6 days.
- Contagious period: Virus may be shed for several weeks after the infection starts; respiratory shedding of the virus is usually limited to a week or less.

How is it spread?

- Respiratory route (ie, coughing, sneezing)
- Direct contact
- Fecal-oral route

How do you control it?

- Teach children and caregivers/teachers to cover their mouths and noses when sneezing or coughing with a disposable facial tissue if possible, or with a shoulder if no facial tissue is available in time (“give your cough or sneeze a cold shoulder”). Teach everyone to wash hands right after using facial tissues or having contact with mucus.
- Dispose of facial tissues that contain nasal secretions after each use.
- Use good hand-washing technique at all the times listed in “When to Wash Hands” on page 25, especially after diaper changing.



AAP, COURTESY OF EDGAR O. LEDBETTER, MD

Child with blisters inside lips



AAP, COURTESY OF JERRI ANN JENISTA, MD

Child with blisters on hands and feet

What are the roles of the caregiver/teacher and the family?

- Report the infection to staff designated by the child care program or school for decision making and action related to care of ill children. That person, in turn, alerts possibly exposed family members and staff to watch for symptoms.
- Encourage the family to seek medical advice if the child is very uncomfortable with signs of illness from the infection, such as an inability to drink or eat, or if the child seems very ill.

Exclude from group setting?

No, unless

- The child is unable to participate and staff determine that they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group. Excessive drooling from mouth sores might be a problem that staff will find difficult to manage for some children with this disease.
- The child meets other exclusion criteria, such as fever with behavior change (see “Conditions Requiring Temporary Exclusion” on page 41).

➤continued

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Hand-Foot-and-Mouth Disease, continued

- Note: Exclusion will not reduce disease transmission because some children may shed the virus without becoming recognizably ill, and other children who became ill may shed the virus for weeks in the stool.

Readmit to group setting?

When exclusion criteria are resolved, the child is able to participate, and staff determine that they can care for the child without compromising their ability to care for the health and safety of the other children in the group

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Diagnosis-based Case 1

You are the director of a center-based program. The third child in the past 2 weeks was just excluded from the toddler room for bloody diarrhea. The first 2 were diagnosed with shigella. They were treated and allowed back in the program after being cleared by their doctor. You just learned that 1 of your child care staff members who prepares the lunch each day has been coming to work despite having stomach cramps and diarrhea. You feel you have a major problem on your hands.

Take 5 minutes to discuss and write down your answers. You should try to look up the American Academy of Pediatrics' policies in *Caring for Our Children* or *Managing Infectious Disease in Child Care and Schools*.

Questions to consider:

What are your responsibilities to the affected child, the other children, and the child care staff?

When should you notify other parents or guardians?

When should you require a health visit?

When should you notify the health consultant or health department?

What do you think about the AAP policy on shigella?

Why is this policy stricter than other policies?

Diagnosis-based Case 2

You notice that 3-year-old Billy has been scratching his head quite a bit the last few days. You take a closer look and, in horror, note a small insect running from the lower neck into the deeper hair. Though your instinct is to run, you do look closer, and note lots of white casings at the bases of the hair follicles behind both ears and...1 more live critter. You take a deep breath and...

Take 5 minutes to discuss and write down your answers. You should try to look up the American Academy of Pediatrics' policies in *Caring for Our Children* or *Managing Infectious Disease in Child Care and Schools*.

Questions to consider:

What are your responsibilities to the affected child, the other children, and the child care staff?

When should you notify other parents or guardians?

When should you require a health visit?

When should you notify the health consultant or health department?

What do you think about the AAP policy on lice?

Diagnosis-based Case 3

Sally, age 4 years, was bitten by a mosquito about a week ago. Despite your best efforts she continued to scratch at it. Today, the area of the bug bite looks worse. It is bigger, a little red, and is oozing some fluid. It doesn't seem to hurt. Sally seems to be feeling well, participating in activities, and is not warm to touch or temperature. You remember that her mom told you that another family member had a MRSA skin infection last month.

Take 5 minutes to discuss and write down your answers. You should try to look up the American Academy of Pediatrics' policies in *Caring for Our Children* or *Managing Infectious Disease in Child Care and Schools*.

Questions to consider:

What are your responsibilities to the affected child, the other children, and the child care staff?

When should you notify other parents or guardians?

When should you require a health visit?

When should you notify the health consultant or health department?

What do you think about the AAP policy on boils, abscesses, and MRSA infections?

Lice (Pediculosis Capitis)

What are head lice?

- Small, tan-colored insects (less than 1/8" long) that
 - ~ Live on blood they draw from the scalp.
 - ~ Live for days to weeks depending on temperature and humidity.
 - ~ Crawl. (They do not hop or fly.)
 - ~ Deposit tiny, gray/white eggs, known as *nits*, on a hair shaft 3 to 4 mm from the scalp because the eggs need the warmth from the scalp for hatching.
 - ~ Cannot live for more than 48 hours away from the scalp as adult insects, and as eggs, cannot hatch at temperatures lower than those found close to the scalp.
- Having an infestation with lice may cause irritation and scratching, which can lead to secondary skin infection.
- Families and caregivers/teachers often get very upset about lice; however, head lice do not carry disease. Head lice infestations occur in all socio-economic groups and do not represent poor hygiene.
- Often, normal activities are disrupted because people become so upset about these insect pests.

What are the signs or symptoms?

- Itching of skin where lice feed on the scalp or neck or complaints about itchiness by older children.
- Nits may be glued to hair, most easily seen behind ears and at or near the nape of the neck.
- Scratching, especially behind and around ears and at the nape of the neck.
- Open sores and crusting from secondary bacterial infection that may be associated with swollen lymph nodes (commonly called *swollen glands*).

What are the incubation and contagious periods?

- Incubation period: 10 to 14 days from laying to hatching of eggs.
 - ~ Lice can reproduce 2 to 3 weeks after hatching.
- Contagious period: Until lice are killed with a chemical treatment.

How are they spread?

- Direct contact with infested hair.
- Only lice, not nits, spread the infestation. (Nits must be near a warm scalp to hatch.)



EDGAR K. MARCUSE, MD

Child with nits on hair behind ears and at nape of neck

How do you control them?

- By using medications (pediculocides) that kill lice and nits. Resistance of lice and nits to these chemicals has been reported, but the extent of resistance to the chemicals varies. Some chemicals may require 2 treatments. Since the chemicals are toxic, they should be used according to the approved instructions only. If a particular chemical fails to work, repeated use of that chemical is unlikely to be successful, and an alternative chemical that has been shown to be effective should be tried.
- None of the suggested remedies using common household products (eg, salad oils, mayonnaise, petroleum jelly) or chemicals intended for other purposes have been shown to be effective. Some that have been tried (eg, kerosene) are very dangerous.
- Mechanical removal of the lice and nits by combing them out with a special fine-tooth comb is tedious and very time-consuming.
- Have families examine the heads of household and close contacts.
- Infested articles that can be laundered should be cleaned at 130°F (54.4°C) and dried on the hot setting. Dry-cleaning clothing and bedding, or separating them from contact with people also is effective.

➤ *continued*

Lice (Pediculosis Capitis), continued

- Toys, personal articles, bedding, other fabrics, and upholstered furniture that cannot be laundered with hot water and a dryer or dry-cleaned can be kept away from people (eg, in a plastic bag) for more than 2 days if there is concern about lice having crawled from an infested child onto these articles.
- Because head lice can only live for 1 to 2 days away from the scalp, chemical treatment of the environment is not necessary. Vacuum floors, carpets, mattresses, and furniture (a safe alternative to spraying).
- Help prevent lice infestation by encouraging children not to engage in activity that causes head-to-head contact.

What are the roles of the caregiver/teacher and the family?

- Report the infestation to staff designated by the child care program or school for decision making and action related to care of ill children. That person, in turn, alerts possibly exposed family members and staff to watch for symptoms.
- Have parents/guardians consult with a health professional for a treatment plan.
- Check children observed scratching their heads for lice; check all contacts.
- Educate caregivers/teachers and families on how to recognize lice and nits.

Exclude from group setting?

Yes, at the end of the program or school day.

- Children with lice should be referred for treatment at the end of the day.
- Until the end of the program or school day, avoid any activity that involves the child in head-to-head contact with other children or sharing of any headgear.

Readmit to group setting?

After the child has received the treatment recommended by the child's health professional

Comments

- Removal of nits from the hair near the scalp that might contain live eggs is very difficult. Those farther than ¼" from the scalp are empty egg casings. Nit removal may help reduce diagnostic confusion about reinfestation of children who have been successfully treated. However, no-nit policies that require children to be nit free are not recommended because they have not been shown to be effective in controlling outbreaks, may keep the child out of the program needlessly, and unduly burden the child's parents/guardians who must implement this measure.
- Education of families and caregivers/teachers about the relatively benign consequences of head lice infestations should be attempted to reduce the level of disruption for the infested child and all the others involved in the program. It may be necessary to arrange for a health professional to provide this education to overcome the widespread beliefs about this problem.
- The itching results from an allergic reaction to the saliva of the lice; itching often persists for weeks after the infestation has resolved.

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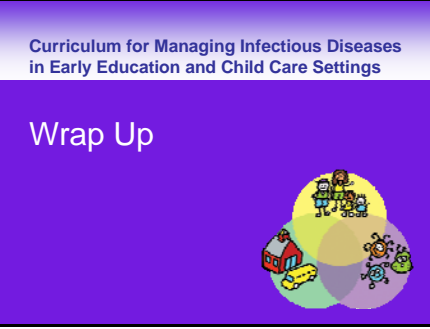




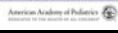





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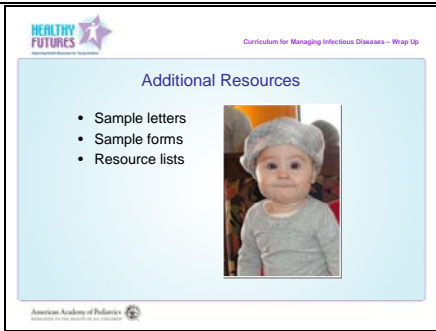
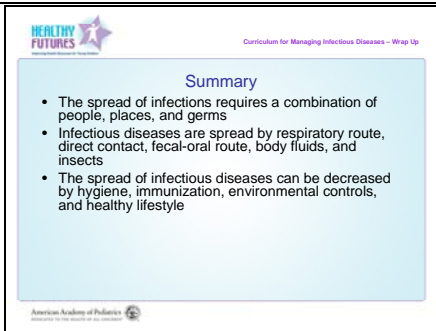




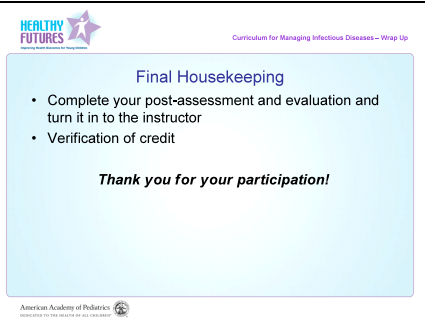
Curriculum for Managing Infectious Diseases in Early Education and Child Care Settings

WRAP UP



#1		 <p>Curriculum for Managing Infectious Diseases in Early Education and Child Care Settings</p> <p>Wrap Up</p> 
#2	<p>Participant Exercise</p> <ul style="list-style-type: none"> The following slide lists some of the policies that could be related to infectious diseases. Have the groups compare their lists to the slides. <p>(6 minutes)</p>	 <p>Curriculum for Managing Infectious Diseases – Wrap Up</p> <p>Think-Pair-Share</p> <ul style="list-style-type: none"> Find a partner Discuss what policies on infectious diseases should be present where you work Think about the items that those policies should include List them to share with the whole group You have 5 minutes 
#3	<p>(5 minutes for Policies slides)</p>	 <p>Curriculum for Managing Infectious Diseases – Wrap Up</p> <p>Policies</p> <ul style="list-style-type: none"> Exclusion (and when a child can return) Staff health Immunization Food preparation Hand washing Hygiene practices (cleaning toys, storing personal materials) Diaper changing 
#4		 <p>Curriculum for Managing Infectious Diseases – Wrap Up</p> <p>Policies</p> <ul style="list-style-type: none"> Standard precautions Daily health checks Care of an acutely ill child Parental notification Medication administration Outbreaks including pandemics Confidentiality 
#5	<p>Guided Discussion</p> <ul style="list-style-type: none"> Solicit ideas from the group of 1 thing that they learned or will do differently after your workshop. It is important to transform ideas into action and this is 1 mechanism to do it. Usually there is at least 1 person in a group who will be willing to stand up. Rewarding volunteers with a token prize (eg, pencils, stickers, brochures, etc) might help. <p>(5 minutes)</p>	 <p>Curriculum for Managing Infectious Diseases – Wrap Up</p> <p>What 1 thing will you do differently after this session?</p> <p>Volunteers?</p>  

<p>#6</p>	<p>These materials are under Additional Resources in the Participant's Manual:</p> <ul style="list-style-type: none"> • Parent/Guardian Alert Letter • Information About This Disease • Symptoms or Suspected Illness—Sample A and Sample B • Parent/Health Professional Release of Information • Medication Administration Packet • Universal Child Health Record • Return to Group Care Form <p>Resources</p> <ol style="list-style-type: none"> 1. American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. <i>Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs</i>. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2002. Also available at http://nrckids.org 2. American Academy of Pediatrics. Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds. <i>Red Book: 2009 Report of the Committee on Infectious Diseases</i>. 28th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009 3. Aronson SS, Shope TR. <i>Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide</i>. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:15 Healthychildcare.org 4. American Academy of Pediatrics (AAP) Web sites <ul style="list-style-type: none"> – www.healthychildcare.org: The Healthy Child Care America Web site is designed to provide health and safety information for early education and child care professionals. – www.healthychildren.org: The Healthy Children is the go-to destination for children's health information. – www.aap.org/immunization/: The Immunization Web site provides information and resources to parents and pediatricians. 5. Web sites <ul style="list-style-type: none"> – California Child Care Health Program: www.ucsfchildcarehealth.org: This Web site provides a wealth of resources for both professionals and families. – Centers for Disease Control and Prevention: www.cdc.gov/vaccines/recs/schedules/default.htm: This Web site provides immunization schedules for children, adolescents, and adults. – Early Childhood Education Linkage System (ECELS): www.ecels-healthychildcarepa.org: This Web site provides a wealth of resources for early education and child care providers as well as health professionals. – National Resource Center for Health and Safety in Child Care and Early Education (NRC): http://nrckids.org/STATES/states.htm: This Web site provides state child care licensing regulations. – Healthy Kids, Healthy Care (developed by the National Resource Center for Health and Safety in Child Care and Early Education): http://www.healthykids.us/: This Web site provides expert information and resources for parents of children who attend child care programs. <p>(<1 minute)</p>	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases - Wrap Up</p> <p>Additional Resources</p> <ul style="list-style-type: none"> • Sample letters • Sample forms • Resource lists <p>American Academy of Pediatrics</p>
<p>#7</p>	<p>(<1 minute)</p>	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases - Wrap Up</p> <p>Summary</p> <ul style="list-style-type: none"> • The spread of infections requires a combination of people, places, and germs • Infectious diseases are spread by respiratory route, direct contact, fecal-oral route, body fluids, and insects • The spread of infectious diseases can be decreased by hygiene, immunization, environmental controls, and healthy lifestyle <p>American Academy of Pediatrics</p>
<p>#8</p>	<p>(<1 minute)</p>	 <p>HEALTHY FUTURES Curriculum for Managing Infectious Diseases - Wrap Up</p> <p>Summary</p> <ul style="list-style-type: none"> • The daily health check is an important tool in identifying and controlling infectious disease • Exclusion from child care <ul style="list-style-type: none"> – Unable to participate – Require too much care – Specific symptoms or conditions <p>American Academy of Pediatrics</p>

<p>#9</p>	<p>Guided Discussion</p> <ul style="list-style-type: none"> • This is the time to answer any questions that remain unanswered. • Read from the parking lot flipchart on which unanswered questions were listed. • If these questions haven't been answered in the presentation, address them now. • If there are questions that you cannot answer, offer to research them and get back to the participants. • For help, www.healthychildcare.org may be able to provide technical assistance with unanswered questions. <p>(10 minutes for Parking Lot and Final Housekeeping slides)</p>	 <p>The slide is titled "Parking Lot" and features a photograph of a parking lot with yellow diagonal lines. The slide includes logos for "HEALTHY FUTURES" and the "American Academy of Pediatrics" at the top and bottom.</p>
<p>#10</p>	<p>• Instruct participants to take the post-assessment under Wrap Up in the Participant's Manual.</p> <p>Manual Materials</p> <ul style="list-style-type: none"> • Post-assessment 	 <p>The slide is titled "Final Housekeeping" and contains two bullet points: "Complete your post-assessment and evaluation and turn it in to the instructor" and "Verification of credit". It also includes the text "Thank you for your participation!". The slide includes logos for "HEALTHY FUTURES" and the "American Academy of Pediatrics" at the top and bottom.</p>

Wrap Up

Resources

1. American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2002. Also available at <http://nrckids.org>
2. American Academy of Pediatrics. Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds. *Red Book: 2009 Report of the Committee on Infectious Diseases*. 28th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009
3. Aronson SS, Shope TR. *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:15 Healthychildcare.org
4. **American Academy of Pediatrics (AAP) Web sites**
 - www.healthychildcare.org: The Healthy Child Care America Web site is designed to provide health and safety information for early education and child care professionals.
 - www.healthychildren.org: The Healthy Children is the go-to destination for children's health information.
 - www.aap.org/immunization/: The Immunization Web site provides information and resources to parents and pediatricians.
5. **Web sites**
 - California Child Care Health Program: www.ucsfchildcarehealth.org: This Web site provides a wealth of resources for both professionals and families.
 - Centers for Disease Control and Prevention: www.cdc.gov/vaccines/recs/schedules/default.htm: This Web site provides immunization schedules for children, adolescents, and adults.
 - Early Childhood Education Linkage System (ECELS): www.ecels-healthychildcarepa.org: This Web site provides a wealth of resources for early education and child care providers as well as health professionals.
 - National Resource Center for Health and Safety in Child Care and Early Education (NRC): <http://nrckids.org/STATES/states.htm>: This Web site provides state child care licensing regulations.
 - Healthy Kids, Healthy Care (developed by the National Resource Center for Health and Safety in Child Care and Early Education): <http://www.healthykids.us/>: This Web site provides expert information and resources for parents of children who attend child care programs.

Name

State

Date

☐ Caregiver/teacher

☐ Health Professional

☐ Other _____

Curriculum for Managing Infectious Diseases in Early Education and Child Care Settings Post-assessment

Instructions: Circle the letter of the choice that best complements the statement or answers the question.

MODULE 1: Understanding Infectious Diseases

1. **Children who attend child care are more resistant to infections after their first year of attendance.**
 - a. True
 - b. False
2. **Children's immune systems:**
 - a. Get stronger as they are exposed to infectious diseases
 - b. Get weaker when they are exposed to infectious diseases
 - c. Are not affected by infectious diseases
3. **Viruses should be treated with antibiotics.**
 - a. True
 - b. False
4. **The most important surface to clean to avoid spread of disease is our hands.**
 - a. True
 - b. False
5. **Children who attend child care are less likely to have antibiotic resistant ear infections and have tubes placed.**
 - a. True
 - b. False

MODULE 2: Preventing Infectious Diseases

6. Which of the following is the best answer for how to reduce the number of germs in child care settings?
- a. Circulate fresh outdoor air, use right-size flushing toilets, wash hands, and clean and sanitize surfaces that have been in contact with body fluids
 - b. Clean and sanitize eating and diaper/underwear changing surfaces before and after each use, wash hands with antibacterial soap, and use germ-killing aerosol sprays to remove odors
 - c. Wear disposable gloves to change diapers; serve and prepare food and clean up blood; and teach everyone to cover their mouths with their hands when they sneeze or cough
 - d. Quickly remove children who seem sick from the facility and do not allow them to return until they have a note from a health care professional that says they are well
7. Mixing children from different groups together when staffing is short in the morning and late afternoon spreads infection from group to group.
- a. True
 - b. False

MODULE 3: Recognizing and Managing Infectious Diseases

8. A note from a child's health care professional to return to child care after an illness is not necessary for children who act and feel well.
- a. True
 - b. False
9. The daily health check is performed:
- a. When the parent is transferring care of the child to the care of facility staff
 - b. When the child leaves the facility to go on a field trip or has a new caregiver
 - c. When the caregiver notices that a child has symptoms of illness
 - d. A and C
10. Before the child actually starts receiving care in the program, child care staff should discuss the following with parents:
- a. The program's policy on caring for ill children
 - b. Parent's alternative care plans for child illness
 - c. Who makes the final decision about whether an ill child can be in child care
 - d. All of the above

11. Children should be excluded (sent home) from child care if they (Choose all the answers that apply):

- a. Have a fever
- b. Cannot participate in activities
- c. Require more care than can be provided in child care
- d. Have a condition that the health department says requires exclusion
- e. Have any diarrhea

12. To care for an ill child, caregivers should (Choose all answers that apply):

- a. Adapt activities to the activity level of the ill child
- b. Provide extra attention to the ill child
- c. Inform parents of new symptoms by phone and use the symptom record to document the child's status
- d. Isolate the ill child in the director's office

13. The goal of exclusion is to:

- a. Provide a setting where the child can recover more easily
- b. Prevent other children from getting fever
- c. Keep certain specific diseases from spreading through the child care site
- d. A and C
- e. None of the above

Curriculum for Managing Infectious Diseases in Early Education and Child Care Settings Post-assessment and Answer Key

Instructions: If select modules were presented, participants should only fill out the questions related to those modules. Have participants circle the letter of the choice that best answers the question.

MODULE 1: Understanding Infectious Diseases

1. Children who attend child care are more resistant to infections after their first year of attendance.
a. True
b. False
2. Children's immune systems:
a. Get stronger as they are exposed to infectious diseases
b. Get weaker when they are exposed to infectious diseases
c. Are not affected by infectious diseases
3. Viruses should be treated with antibiotics.
a. True
b. False
4. The most important surface to clean to avoid spread of disease is our hands.
a. True
b. False
5. Children who attend child care are less likely to have antibiotic resistant ear infections and have tubes placed.
a. True
b. False

MODULE 2: Preventing Infectious Diseases

6. Which of the following is the best answer for how to reduce the number of germs in child care settings?
- a. Circulate fresh outdoor air, use right-size flushing toilets, wash hands, and clean and sanitize surfaces that have been in contact with body fluids
 - b. Clean and sanitize eating and diaper/underwear changing surfaces before and after each use, wash hands with antibacterial soap, and use germ-killing aerosol sprays to remove odors
 - c. Wear disposable gloves to change diapers; serve and prepare food and clean up blood; and teach everyone to cover their mouths with their hands when they sneeze or cough
 - d. Quickly remove children who seem sick from the facility and do not allow them to return until they have a note from a health care professional that says they are well
7. Mixing children from different groups together when staffing is short in the morning and late afternoon spreads infection from group to group.
- a. True
 - b. False

MODULE 3: Recognizing and Managing Infectious Diseases

8. A note from a child's health care professional to return to child care after an illness is not necessary for children who act and feel well.
- a. True
 - b. False
9. The daily health check is performed:
- a. When the parent is transferring care of the child to the care of facility staff
 - b. When the child leaves the facility to go on a field trip or has a new caregiver
 - c. When the caregiver notices that a child has symptoms of illness
 - d. A and C
10. Before the child actually starts receiving care in the program, child care staff should discuss the following with parents:
- a. The program's policy on caring for ill children
 - b. Parent's alternative care plans for child illness
 - c. Who makes the final decision about whether an ill child can be in child care
 - d. All of the above

11. Children should be excluded (sent home) from child care if they (Choose all the answers that apply):
- a. Have a fever
 - b. Cannot participate in activities**
 - c. Require more care than can be provided in child care**
 - d. Have a condition that the health department says requires exclusion**
 - e. Have any diarrhea
12. To care for an ill child, caregivers should (Choose all answers that apply):
- a. Adapt activities to the activity level of the ill child**
 - b. Provide extra attention to the ill child**
 - c. Inform parents of new symptoms by phone and use the symptom record to document the child's status**
 - d. Isolate the ill child in the director's office
13. The goal of exclusion is to:
- a. Provide a setting where the child can recover more easily
 - b. Prevent other children from getting fever
 - c. Keep certain specific diseases from spreading through the child care site
 - d. A and C**
 - e. None of the above

Certificate of Attendance

(Disclaimer: This is not a certificate of competency)

Presented to:

(Name of Participant)

For participating in:

**Healthy Futures: Improving Health Outcomes for Young Children
Curriculum for Managing Infectious Diseases in Early Education and Child Care Settings**

For a total of _____ **(# of hours to complete session)** contact hours on ____/____/____ **(Date)**
CDA Content Area: #1

Presented by: _____ **(Print Instructor Name)**

*Sponsored by:
The American Academy of Pediatrics
Healthy Child Care America*

Date

Instructor Signature

Certificate of Attendance

(Disclaimer: This is not a certificate of competency)

Presented to:

For participating in:

**Healthy Futures: Improving Health Outcomes for Young Children
Curriculum for Managing Infectious Diseases in Early Education and Child Care Settings**

For a total of _____ contact hours on ____/____/____
CDA Content Area: #1

Presented by: _____

*Sponsored by:
The American Academy of Pediatrics
Healthy Child Care America*

Date

Instructor Signature

Curriculum for Managing Infectious Diseases in Early Education and Child Care Settings

ADDITIONAL RESOURCES



**American Academy of Pediatrics
Curriculum for Managing Infectious Diseases
in Early Education and Child Care Settings**

**APPENDIX:
Preparing Child Care Programs for
Infectious Disease Outbreaks or Pandemic Influenza**

In 2008, the American Academy of Pediatrics (AAP) completed a needs assessment of 1,500 licensed child care centers. Results show that more can be done to prepare the early education and child care community for a pandemic influenza. The survey results also indicated that while knowledge of and preparation for a pandemic influenza was poor, child care center directors were willing to take steps to improve preparedness. The top choices for improving preparedness were use of print materials, participation in training sessions, and access to downloadable or interactive web-based tools. The purpose of this handout is to recommend topics, strategies, and resources that can be used to improve preparedness for pandemic influenza within child care settings.

Face-to-face training sessions are an effective way to help early education and child care program staff learn how to improve day-to-day preparedness and determine plans to respond when there is an active infectious disease outbreak or pandemic influenza. Asking a local pediatrician, health department representative or qualified child care health consultant to present a professional development session is a great way to engage these partners in child care health and safety activities. Also, such teaching activities help develop relationships that keep staff informed of current community preparedness efforts. A strong connection between child care and public health leaders is critical. During a pandemic, recommendations and communication strategies evolve rapidly. Early education and child care programs need to be aware of existing mechanisms for information dissemination and decision-making.

Instruction of early education and child care providers about infection control and pandemic influenza preparedness should include the following topics for discussion:

Infection Control During an Infectious Disease Outbreak:

- What constitutes an infectious disease outbreak, epidemic, pandemic, and public health emergency
- Role of hand washing, cough/sneeze etiquette, and personal hygiene/sanitation practices
- Protocols for effective cleaning, sanitizing, and disinfecting of toys and other objects/surfaces
- Use of symptom, illness, and absence records as well as daily health checks
- Importance of written infectious disease control, hygiene and sanitation, and immunization policies
- Importance of and options for collecting immunization record data for children and staff in child care and using the data to identify children and staff who need to be referred to their health care providers to fill gaps in the vaccines they have received to meet recommended schedules.
- Benefits of partnerships with child care health consultants and local health care professionals

Pandemic Influenza Topics:

- What constitutes a pandemic and when it becomes a public health emergency
- Difference between seasonal and pandemic influenza viruses (transmission, spread, and severity)
- Why young children are at increased risk during a pandemic
- Which children may be at highest risk during a pandemic
- Importance of annual seasonal influenza immunization for children and child care providers as well as approaches to supplemental vaccine when recommended by public health authorities (e.g. as in the H1N1 pandemic influenza)
- Importance of family preparedness, employer contingency planning, and business continuity strategies for early education and child care programs
- Lessons learned during the H1N1 pandemic influenza
 - Challenges of this pandemic; why the US was not prepared
 - How to respond to anti-immunization misinformation and vaccine refusals
 - Use of laboratory testing, hospitalization, and other data
 - Review of clinical trials for H1N1 vaccines; why children initially need 2 shots, etc.
 - Role of the media in providing updates (discussion of “the worried well”)
 - Why certain public health departments, primary care physicians, emergency hotline personnel, and hospital emergency departments were overwhelmed; how child care programs can help

Appendix: Preparing for Infectious Disease Outbreaks or Pandemic Influenza

Steps for Improving Preparedness

- Develop a written emergency/disaster plan that includes a process and timeline for updating this document
- Identify “trusted sources” of health information (CDC, health department, community pediatrician, and child care health consultant)
- Establish protocols/assignments for communication systems that can be used in an emergency. This would include a process to share key information as well as an immediate alert plan. Compile and maintain a list of community contacts and key phone numbers in advance to be ready to communicate during an emergency
- Determine who will monitor information and health alerts and report back on key findings
- Develop a process for sharing key information with staff, parents, and children during an emergency
- Prepare template handouts for staff and parents in advance
- Discuss the process for ordering supplies (and maintaining inventory) during times of staff absences or when there is an increased need for certain hygiene or cleaning supplies
- Use seasonal influenza as an opportunity to practice preparedness and response efforts
- Collaborate with community partners on preparedness activities or contingency planning
- Review criteria for and steps involved in facility closure
- Implement steps to support families and employees to develop personal preparedness plans

Strategies

In addition to the steps described above, encourage child care programs to implement one or more new strategies to enhance preparedness, such as:

- Provide seasonal influenza immunizations on site at the child care facility
- Collaborate with nearby centers on the use of substitutes, mass supply ordering, or training
- Create a Web site or answering service message to provide daily updates to clients
- Form a team that includes a child care health consultant and/or local public health representative to make decisions during an outbreak or pandemic

Resources

American Academy of Pediatrics

- AAP Children and Disasters Web site <http://www.aap.org/disasters/index.cfm>
- AAP Preparing Child Care Programs for Pandemic Influenza Web site <http://www.aap.org/disasters/pandemic-flu-cc.cfm>
- AAP Healthy Child Care America Web site www.healthychildcare.org
- Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide, Second Edition
- Hand Hygiene <http://aapredbook.aappublications.org/news/MIDCCS2hygiene.pdf>
- Outbreaks, Epidemics, and Other Infectious Disease Emergencies <http://aapredbook.aappublications.org/news/MIDCCSoutbreaks.pdf>

US Department of Health and Human Services

- H1N1 Flu: Resources for Child Care and Early Childhood Programs www.cdc.gov/h1n1flu/childcare
- FLU.gov <http://www.flu.gov/index.html>

Other

North Carolina Child Care Health and Safety Resource Center Pandemic Flu in Child Care Trainer's Manual: The Pandemic Flu and Child Care trainer's manual is designed to increase a trainer's knowledge of pandemic influenza and provides the trainer with the content, handouts, and a PowerPoint presentation that instructors can use to teach early care educators about pandemic flu. The curriculum covers an introduction to the flu, preventing the spread of flu in child care settings, preparing for pandemic flu in child care and responding to pandemic flu. For more information or to order a copy, contact the NC Child Care Health and Safety Resource Center at jackie_quirk@unc.edu.

California Child Care Health Program Preparing for Pandemic Flu in Child Care Programs http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/PandemicFlu_EN_020210.pdf

Healthy Child Care Pennsylvania

WellCareTracker™: an immunization tracking and child care health record quality improvement tool <http://www.wellcaretracker.org/index1.php>

Workshop on Pandemic Flu

<http://www.ecels-healthychildcarepa.org/section.cfm?subID=15&scope=all>

Additional resources

<http://www.ecels-healthychildcarepa.org/>

Minnesota Department of Human Services Handbook for Family Child Care Providers: Keeping Kids Safe, Your Home Child Care Emergency Plan. Materials are available in multiple languages. <http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5299-ENG>

Washington Coalition for Safety and Health in Early Learning Informational materials for child care providers and parents; available in multiple languages.

www.del.wa.gov/publications/development/#flu

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Parent/Guardian Alert Letter

Notice of Exposure to Communicable Disease

Name of Facility/School _____

Address of Facility/School _____

Telephone Number of Facility/School _____

Dear Parent or Legal Guardian:

A child in our facility/school has or is suspected of having _____.

Without violating the confidentiality of this child, the facts you need to know about your child's exposure in this situation are:

We want to inform you about this condition and the related exclusion and return-to-care practices at our facility/school. Please read the attached information sheet closely and call us with any questions.

Facility/School Staff Person's Name at _____
Telephone Number

Information About This Disease

Note: To be used if there is no applicable Quick Reference Sheet in Chapter 7. You may copy those pages for communications with families/health professionals.

The disease is spread by _____

The symptoms are _____

The disease can be prevented by _____

What the facility/school is doing to reduce the spread: _____

What you can do at home: _____

Is exclusion necessary? _____

When can an excluded child return? _____

Comments _____

Symptoms or Suspected Illness—Sample A
(See alternate type of form on page 178.)

Name of Child _____

Facility/School _____ Date _____

Dear Parent/Guardian:

Today at our facility/school, your child was observed to have one or more of the following signs or symptoms:

General

- ☐ Fever (101°F [38.3°C] or above orally or axillary)
- ☐ Complained of headache
- ☐ Swelling of or pus from _____

Eye

- ☐ Pinkeye
- ☐ Tears, redness of eyelid lining

Gastrointestinal

- ☐ Diarrhea _____ times in the last 24 hours (had an abnormally loose stool)
- ☐ Vomiting _____ times in the last 24 hours

Respiratory

- ☐ Difficult or rapid breathing
- ☐ Severe coughing
- ☐ Child gets red or blue in the face
- ☐ Trouble swallowing or complained of sore throat
- ☐ Earache or signs that suggested earache (specify) _____

Skin

- ☐ Infected skin patches
- ☐ Crusty, bright yellow, dry, or gummy areas of skin
- ☐ Severe itching of body/scalp
- ☐ Unusual spots or rashes
- ☐ Head lice or nits

Unusual behavior

- ☐ Loss of appetite
- ☐ Child cries more than usual
- ☐ Child feels general discomfort
- ☐ Cranky or less active
- ☐ Just seems unwell

Urine problem

- ☐ Specify _____

Other

- ☐ Specify _____

Contact your health professional if there is

- ☐ Persistent fever (above 101°F [38.3°C]) and child seems very sick
- ☐ Breathing so hard child cannot play, talk, cry, or drink
- ☐ Severe coughing
- ☐ Earache
- ☐ Sore throat with fever
- ☐ Thick nasal drainage that lasts more than 10 days
- ☐ Rash accompanied by fever
- ☐ Persistent diarrhea (more than 1–2 days)
- ☐ Severe headache and stiff neck with fever

- ☐ Yellow skin and/or eyes
- ☐ Considerable confusion or difficult to arouse
- ☐ Rash, hives, or welts that appear quickly
- ☐ Severe stomachache that causes child to double over and scream
- ☐ No urination over 8-hour period; mouth and tongue look dry
- ☐ Black stool or blood mixed with stool
- ☐ Any child who looks or acts very ill or seems to be getting worse quickly

We are excluding your child from attendance at our facility/school until

- ☐ The signs or symptoms that required exclusion have resolved.
- ☐ The child can comfortably participate in normal activities.
- ☐ We can provide the level of care your child needs.
- ☐ Other _____

Symptoms or Suspected Illness—Sample B
(See alternate type of form on page 177.)

Name of facility/school _____

Child's name _____

Date _____ Symptom(s) _____

When symptom began, how long it lasted, how severe, how often? _____

Any change in child's behavior? _____

Child's temperature _____ Time taken _____ (Circle one: Armpit Oral Rectal Ear canal)

How much and what type of food and fluid did the child take today? _____

How many urine and bowel movements today and how typical/normal were they? _____

Check the appropriate box(es) or write in other symptoms.

☐ Runny nose

☐ Sore throat

☐ Cough

☐ Diarrhea

☐ Wheezing

☐ Trouble breathing

☐ Stiff neck

☐ Trouble urinating

☐ Pain

☐ Itching

☐ Trouble sleeping

☐ Earache

☐ Headache

☐ Stomachache

☐ Rash

☐ Vomiting

Other symptoms _____

Any medications today? (name, time, dose) _____

Exposure to chemicals, animals, insects, soaps, or new foods _____

Exposure to other people who were sick (what sickness?—for confidentiality reasons, please do not identify individuals) _____

Child's other problems that might affect this illness (eg, asthma, anemia, diabetes, allergy, emotional trauma) _____

What has been done so far? _____

Parent/Health Professional Release Form

Authorization for Release of Information

I, _____, give permission for

(parent/guardian)

(health professional/facility)

to release to _____ the following information:

(facility/school)

(screenings, tests, diagnoses, treatments, recommendations)

The information will be used solely to plan and coordinate the care of my child, kept confidential, and only shared with _____

(staff title/name)

Name of Child _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____

Parent/Guardian Signature _____

Witness Signature _____

Staff Member to Contact for Additional Information _____

Medication Administration Packet

Authorization to Give Medicine PAGE 1—TO BE COMPLETED BY PARENT

CHILD'S INFORMATION

Name of Facility/School _____	____/____/____ Today's Date
Name of Child (First and Last) _____	____/____/____ Date of Birth
Name of Medicine _____	
Reason medicine is needed during school hours _____	
Dose _____	Route _____
Time to give medicine _____	
Additional instructions _____	
Date to start medicine ____/____/____	Stop date ____/____/____
Known side effects of medicine _____	
Plan of management of side effects _____	
Child allergies _____	

PRESCRIBER'S INFORMATION

Prescribing Health Professional's Name

Phone Number

PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

Parent or Guardian Name (Print)

Parent or Guardian Signature

Address

Home Phone Number

Work Phone Number

Cell Phone Number

Adapted with permission from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill, Connecticut Department of Public Health, and Healthy Child Care Pennsylvania.

Receiving Medication

PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child _____

Name of medicine _____

Date medicine was received ____/____/____

Safety Check

- ☐ 1. Child-resistant container.
- ☐ 2. Original prescription or manufacturer's label with the name and strength of the medicine.
- ☐ 3. Name of child on container is correct (first and last names).
- ☐ 4. Current date on prescription/expiration label covers period when medicine is to be given.
- ☐ 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.
- ☐ 6. Copy of Child Health Record is on file.
- ☐ 7. Instructions are clear for dose, route, and time to give medicine.
- ☐ 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.
- ☐ 9. Child has had a previous trial dose.

Y ☐ N ☐ 10. Is this a controlled substance? If yes, special storage and log may be needed.

Caregiver/Teacher Name (Print)

Caregiver/Teacher Signature

Medication Log

PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child _____ Weight of child _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.

Date/time	Error/problem/reaction to medication	Action taken	Name of parent/guardian notified and time/date	Caregiver/teacher signature

RETURNED to parent/guardian	Date	Parent/guardian signature	Caregiver/teacher signature
	/ /		
DISPOSED of medicine	Date	Caregiver/teacher signature	Witness signature
	/ /		

Medication Incident Report

Date of report _____ School/center _____

Name of person completing this report _____

Signature of person completing this report _____

Child's name _____

Date of birth _____ Classroom/grade _____

Date incident occurred _____ Time noted _____

Person administering medication _____

Prescribing health care provider _____

Name of medication _____

Dose _____ Scheduled time _____

Describe the incident and how it occurred (wrong child, medication, dose, time, or route?)

Action taken/intervention _____

Parent/guardian notified? Yes _____ No _____ Date _____ Time _____

Name of the parent/guardian that was notified _____

Follow-up and outcome _____

Administrator's signature

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name (Last) (First)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of Child's Health Insurance Carrier		
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number	
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number	
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.			
Signature/Date		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Abnormalities Noted:	<table border="1"> <tr> <td>Weight (must be taken within 30 days for WIC)</td> <td></td> </tr> <tr> <td>Height (must be taken within 30 days for WIC)</td> <td></td> </tr> <tr> <td>Head Circumference (if <2 Years)</td> <td></td> </tr> <tr> <td>Blood Pressure (if ≥3 Years)</td> <td></td> </tr> </table>	Weight (must be taken within 30 days for WIC)		Height (must be taken within 30 days for WIC)		Head Circumference (if <2 Years)		Blood Pressure (if ≥3 Years)	
Weight (must be taken within 30 days for WIC)									
Height (must be taken within 30 days for WIC)									
Head Circumference (if <2 Years)									
Blood Pressure (if ≥3 Years)									

IMMUNIZATIONS

- ☐ Immunization Record Attached
☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)

- **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
- **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
- **Head Circumference** - Only enter if the child is less than 2 years.
- **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health and Senior Services, Immunization Program at 609-588-7512.

- The Immunization record must be attached for the form to be valid.
- "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

- a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.state.nj.us/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

- b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

- c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

- d. **Special Equipment** - Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

- e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

- f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

- g. **Behavioral/Mental Health issues** - Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

- h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.

- For lead screening state if the blood sample was capillary or venous and the value of the test performed.
- For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
- Scoliosis screenings are done biennially in the public schools beginning at age 10.

This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)

- Print the health care provider's name.
- Stamp with health care site's name, address and phone number.

Return to Group Care Form

Note: To be used when program staff have questions for a health professional, not for routine return of every excluded or ill child.

Dear Health Care Professional,

_____ has been excluded from _____ for the following health reason(s):
(child's name) (name of facility/school)

Unable to participate in normal activities _____

Requires more care than the staff can provide _____

Has a specific acute illness that merits exclusion according to the American Academy of Pediatrics/
American Public Health Association/National Resource Center for Health and Safety in Child Care
and Early Education (available at <http://nrc.uchsc.edu/CFOC/index.html>) _____

Please assess this child by history and physical examinations (laboratory tests as needed) for

1. The **presence of harmful communicable illness**, such as enteric pathogens (eg, *Salmonella*, *Shigella*, *Escherichia coli*, *Campylobacter*, *Giardia*, hepatitis A), pertussis, measles, mumps, varicella, rubella, diphtheria, or tuberculosis
2. The **presence of signs or symptoms of severe illness** such as dehydration, respiratory distress, or lethargy
3. The **presence of any condition that would preclude the child from returning** to the routine program or, if a program for ill children is available, what the child needs in the way of care to be able to return while still ill

Please indicate

Harmful communicable disease No _____ Yes _____

Signs of severe illness No _____ Yes _____

Condition precluding return No _____ Yes _____

If yes for any, may return once _____ resolves.

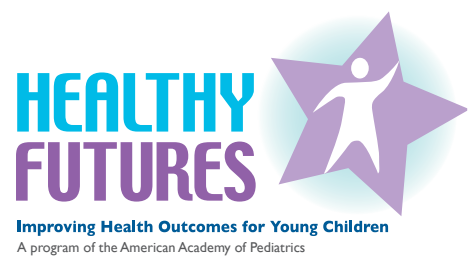
If no for all, may return once

1. Can participate fully in all activities
2. Does not require so much increased supervision that staff cannot properly care for child or other children in the program or school

Please **complete the attached medication administration form** if medication is necessary. Please consider the following suggestions:

- Include written recommendation for acetaminophen or ibuprofen (no medications can be given without orders).
- Avoid "as needed" (prn) orders (these may be confusing for caregivers/teachers); instead, describe the signs and symptoms teachers would see that determine when medication should be given.
- Include an asthma action plan for children with asthma.
- Include a care plan for any child with any other chronic condition.

Curriculum for Managing Infectious
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