HEALTH, SAFETY, AND NUTRITION
# Health, Safety, and Nutrition

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INTRODUCTION

Dane County Parent Council, Inc. is committed to promoting good health for children and adults involved in the program. Policies require that:

1. All children and staff have regular physical exams to ensure they are free of communicable disease.
2. Children and adults with potentially communicable diseases are excluded from program operations until no longer contagious.
3. Parents are notified of communicable disease occurring in the classroom. The Public Health Department and WI Child Care Licensing are also notified when appropriate.
4. Staff are trained both in Universal Precautions and in the handling of communicable disease.
5. Policies and procedures are in place for adults and children with long term, potentially communicable disease.
SAFETY POLICIES

Classroom Safety Requirements
Dane County Parent Council will ensure that all classroom sites are in compliance with state licensing requirements.

Teachers must complete a classroom Fire, Safety, and Health Checklist Form each month. The form must be posted in each site for inspection. Each group of children must practice fire drills, tornado drills and building evacuations. Monthly fire drills must be practiced and recorded, as well as Tornado Drills April through October each year. The building evacuation must be practiced at least annually. Record all drills on the Checklist.

Teachers are responsible for initiating corrections of any items that are not in compliance. Program Supervisor should be contacted for assistance in making corrections if needed.

DOCUMENTATION: FIRE, SAFETY, AND HEALTH CHECKLIST (#350)
### Fire, Safety, and Health Checklist (#350)

**FIRE and SAFETY DRILL Documentation for GROUP CHILD CARE CENTERS**

**Name of Program(s):** ___________________________ **YEAR:** ____________

1. Smoke detectors or fire alarms are in working order and are checked weekly. Enter date checked.

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2. Fire evacuation practice

   Enter monthly: Row 1 & 2 = date & time of practice (Dt/Tm); Row 3 – evacuation time (ET)

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3. Tornado drill practice: Enter date drill completed and time of drill.

   April: _______ May:_______ June:_______ July:_______ Aug:_______ Sept:_______ Oct:_______

4. Offsite Building Emergency Evacuation Practice: ________________________________

5. Lockdown Practice: ___________________________ 1 x/year

6. Staff completing form (please print)  Staff Signature  Date

   If applicable, Fire Department Official’s Signature  Date

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Page 1 of 1
Form 350 07/18
**Home Safety Education**

Performance Standards mandate parent education in health and safety. The Home Safety Checklist is completed by the parent(s) in order to help families become more aware of home safety.

Teachers and/or FOW’s may take the Home Safety Checklist on the second home visit to discuss with parents and fill out together if parents choose.

Home Visitation Teachers will complete the Home Safety Checklist together with parents, and record this on the HV Lesson Plan the week it is completed (Oct/Nov annually).

**DOCUMENTATION: HOME SAFETY CHECKLIST (#212)**
Home Safety Checklist

Whether you’re concerned about the youngest members of your household or the oldest, follow these checklists to make your home safer for everyone.

Check, if “Yes”:

- Are all guns or other weapons unloaded and dismantled and out of children’s reach? (Trigger locks only cost a couple dollars – and could save a life.)
- Are walkways in rooms clear of furniture?
- Have you removed or secured loose rugs?
- Are your rooms adequately lit?
- If an electrical cord runs along a wall, is it taped securely to the baseboard?
- Have you attached nonskid strips to wood stairs?
- Is your water heater set at a temperature to avoid scalding?
- Are outdoor pathways well lit?
- Does your babysitter know about keeping his/her medicines out of your child’s reach?
- Do you have candles lit only when someone will be in the room to keep an eye on them?
- Have all broken toys with sharp edges or loose parts been repaired or thrown away?
- Do you clean the dryer lint basket regularly and avoid putting articles containing foam rubber (a fire hazard) in the dryer?
- Are all your tools put away safely? Away from children?
- Are there any nails, broken glass, tin cans, or other things lying around outside that could cause injury?
- Do all family members use their head to save their fingers and toes around a lawn mower?
- Are outside steps, porches, patios, rails, and sidewalks in good repair?
- Is the play equipment sturdy and in good repair?
- Is the clothesline well away from the play area and traffic paths, and hung high enough to prevent walking into?
- Do you use a stepladder or step stool when you have to reach high places?
- Do you have birth certificates and other important papers stored in a fire-safe box?

Home Security Checklist

- Do you lock all doors and windows every time you go out, even if for a few minutes, and even upstairs?
- Are sliding glass doors secured with a locking bar?
- Are valuables stored out of sight, in a safe or in a safe-deposit box?
- Is your garage door closed and locked?
- Do you avoid hiding extra keys outside your home? (Burglars know all the hiding places.)
- Is there at least one smoke detector on each floor and one near each bedroom area?
Do you replace smoke alarm batteries twice a year with long-lasting, 9-volt lithium batteries?

Do you have a carbon monoxide detector to detect deadly gas produced by fuel-fired furnaces, space heaters, wood stoves and fireplaces?

Are trash and other items placed far from furnaces, space heaters, hot water heaters, stoves, fireplaces, and other sources of heat?

Do you turn off portable heaters when no one is in the room and at bedtime?

Do you have protective shutters or fire-resistant draperies on your windows?

Do you avoid overloading electrical circuits?

Are electrical cords kept out from under rugs or furniture?

Have you replaced frayed cords?

Do you unplug small kitchen appliances when they’re not in use?

Does everyone in the home know how to put out a small kitchen grease fire safely?

Never pour water on a grease fire!

Do you enforce a strict “no smoking in bed” policy?

Do you always unplug the toaster before reaching in with a knife, fork, or other object to remove toast (a shock hazard)?

Do you empty ashtrays or fireplace embers into metal containers when they are cold?

Do you keep matches and lighters out of children’s reach?

Do you store gasoline and other flammable liquids in the proper metal or non-flammable containers? Do you keep these containers away from heat sources?

Have you removed barbecue grills from wooden decks?

Have you discussed a fire safety plan with your family?

Do you store working flashlights in every bedroom?

Does everyone know where to meet after escaping a fire?

Have you had a home fire drill?

Do you have an escape route from a second floor (e.g. a foldable ladder)?

Do you keep all stairways, doors, and other exits clear of furniture or other obstructions?

Do you tell baby-sitters what to do in case of a fire?

Is there at least one “ABC” type fire extinguisher available in an easy-to-reach location where there is a potential for fire (kitchen, basement, and garage)?

**Child Safety Checklist**

Are your stairways made inaccessible by gates, complete with child-proof locks, installed at both the bottom and top of the stairs?

Have you installed window guards on all windows above the ground floor to prevent your child from falling out?

2 of 4   #212 (07/10)
Do you routinely scan your house for small objects that can choke a child: safety pins, coins, pop-tops from beverage cans, nails, tacks, crayon pieces, and chewing gum, among many others?

Are your electrical outlets protected by safety covers to keep objects and fingers out, and to keep electrical cords plugged in?

Are the cords on your blinds short enough so that young hands can’t reach them?

**In the kitchen**

- Have you locked up items that need to be out of children’s reach?
- Have you installed latches or locks on cabinets?
- Are poisonous cleansers, detergents and soaps stored properly? Are they kept in their original containers labeled with safety information? Are they stored out of reach of children?
- Do you keep insecticide and rat poisons away from food shelves, pots, pans, and dishes? Do you always read the instructions on the labels carefully before using these products?
- Are knives and matches out of reach of curious hands?
- Are alcoholic beverages stored up high?

**In the bathroom**

- Is the medicine cabinet locked? If not, do you store all drugs (laxatives, mouthwashes, sleeping pills, and other poisonous substances) in a locked cupboard or other place out of your child’s reach?
- Do you use nonskid mats or strips in the shower or tub? Is there a bath mat to help keep the floor dry?
- Is the medicine cabinet properly stocked for emergencies (with first-aid kit, etc.)?
- Do you keep cleansers, shampoos, soaps, toiletries, and cosmetics out of children’s reach? (Many are poisonous if swallowed.)
- Are medicines and vitamins stored in their original, labeled containers with child-proof lids?
- Do you discard unnecessary medications, or those that have expired, by flushing them down the toilet – not placing them in the trash can?
- Do you personally supervise bath times, never leaving toddlers unattended in the tub?

**In the bedroom**

- Are perfumes, cosmetics, and medicines far from children’s hands?
- Do you keep purses, jewelry, buttons, and small items where little children can’t touch them?
In the living room
- Are cigarettes, lighters, ashtrays, and alcoholic beverages kept out of children’s reach?
- Have you placed your plants where young children can’t reach them to eat their leaves?
- Do you know the names of your houseplants in case you must call a Poison Control Center to report your child has swallowed something?
- Is the Poison Control Center’s phone number clearly posted or pre-programmed on your phone? What about other emergency numbers? (The number for Poison Control in this area is 1-800-222-1222.)

In the garage and basement
- Are insect spray, fertilizers, and weed killers locked up?
- Have turpentine and paint been stored properly where children can’t reach them?
- Are windshield wiper fluid, rust remover, gasoline, antifreeze, and other solvents kept in a locked cabinet?

Outside
- Do you apply sun block of SPF 15 or higher every time you child goes out in the sun?
- Does your child wear a hat and T-shirt for sun protection?
- Is your child’s playground well-constructed? Is the equipment on a soft, resilient surface, rather than hard ground?
- Do your children know how to use the playground properly, and only when supervised?
DCPC Policy on Sunscreen and Insect Repellent
July 2004 (rev: Apr 2009)

DCPC Health Services Advisory Committee STRONGLY recommends that all children enrolled during summer programs have sunscreen and insect repellent provided and applied by DCPC.

SUNSCREEN
Babies under 6 months will avoid direct sun exposure. They should remain in the shade whenever possible. Wearing of hats and use of shade are important sun protection methods. If babies under 6 months cannot remain in the shade, they will wear hats and have sunscreen applied, with specific parent permission. Apply a small amount to all exposed skin including back of hands, face, neck and ears, avoiding eyes and mouth.

All children over 6 months of age should have sunscreen available to them. Parents may bring in sunscreen, if they prefer. DCPC will provide a generic sunscreen that is “broad spectrum” (meaning it screens out both Ultraviolet A and Ultraviolet B rays, is at least SPF 15, and is water-resistant or water proof. It will also be PABA free). If parents provide sunscreen, it must also meet these minimum requirements if requesting staff to apply the product during class time.

All children should be encouraged to wear hats outside. When possible, DCPC will provide these hats. Hats should not be shared between children and should be laundered regularly.

Whether the sunscreen is parent- or center-provided, individual authorization form #715 must be completed for each child. Each authorization must list the brand name of the sunscreen product. Parent-provided sunscreen must be labeled with the child’s full name and the date you accepted the product. In accordance with licensing rules, it is not necessary to record in the medical log each time you apply the sunscreen.

Keep all sunscreen out of reach of children!

Procedure:
Apply sunscreen even on cloudy days! The sun’s rays are strongest between 10:00am – 4:00pm – when possible, encourage play in the shade.

A DCPC staff person will rub the sunscreen in well, covering all exposed areas at least 30 minutes before going outside. (Children may not apply their own sunscreen) Use extreme care on the face to avoid eyes/nose/mouth. Staff must wash their hands in between each child’s application, or use separate white paper-towels to apply, to prevent passing germs between children. If either the child or adult has rough, cracked skin or sores, the adult should wear gloves when applying the sunscreen. (For children with extreme eczema, please contact the PNP/RN for guidance before needing to apply sunscreen). Sunscreen should be re-applied after swimming or excessive sweating (follow product directions).

Keep children indoors when the heat index is above 90 degrees Fahrenheit. Watch children carefully and offer plenty of water!
Parent-provided combined sunscreen/insect repellent will not be applied. It is not recommended for young children since the frequency it needs to be applied causes an unnecessary risk of additional DEET exposure, while decreasing the SPF effectiveness.

INSECT REPELLENTS
Mosquitoes are responsible for transmitting a variety of diseases, such as West Nile encephalitis. If children are going on field trips or play in areas where mosquitoes are found, DCPC strongly encourages parents to allow staff to apply bug spray when going outside where insect-borne infections may be a risk.

Parents may provide an insect-repellent; if they do not, DCPC will provide an approved insect-repellent.

Whether the bug spray is parent- or center-provided, individual authorization forms must be completed for each child. Each authorization must list the full name of the bug spray product. Parent-provided bug spray must be labeled with the child’s full name and the date you accepted the product. In accordance with licensing rules, it is not necessary to record in the medical log each time you apply the bug spray.

Keep all bug spray completely out of the reach of children!

The following precautions will be taken:
1. Read and carefully follow all directions before the DCPC staff person applies the product. (children may not apply insect repellents themselves)
2. Check files to be sure the child is not allergic to soy products. If allergic to soy, parent must consult with a physician regarding specific insect-repellent to use; and provide written documentation of doctor’s recommendation/prescription.
3. **Do not apply to children under 2 months of age (skin permeability becomes similar to adult values by the end of the second month of life)
4. Wear long sleeves and pants when possible and apply repellent to clothing. A long sleeve shirt with snug collar and cuffs is best. The shirt should be tucked in at the waist. Socks should be tucked over pants.
5. Staff should apply repellent to children’s exposed skin.
6. Do not use repellent on the hands of the children (so they don’t rub eyes or mouth).
7. Staff should apply repellent to the adult’s hands, and then apply to child’s face – taking care to avoid the eye and mouth areas.
8. Do not apply over cuts, wounds, or irritated skin. (contact PNP/RN about children with eczema before needing to apply product)
9. Avoid using sprays in enclosed areas. Do not apply product near food, toothbrushes, etc.
10. Wash the exposed area immediately with soap and water if an allergic reaction is suspected.

Parent-provided repellent must contain less than 10% DEET for DCPC staff to apply to a child. Also, combined sunscreen/insect repellent is not recommended for young children (and will not be applied at the center) since the frequency it needs to be applied causes an unnecessary risk of additional DEET exposure.

Parent/Guardian Authorization for Sunscreen/Insect Repellent

DCPC’s Health Services Advisory Committee requires children in care to use sunscreen & insect repellent before going outside, unless refused by the parent/guardian. If the parent declines, have parent circle “do not give permission” below and sign.

Sunscreen

I/we  give permission / do not give permission  (please circle one) for the DCPC center staff to apply the type/brand of sunscreen indicated below to my child before playing outside or before outdoor fieldtrips. As recommended by the American Academy of Pediatrics, sunscreen will be applied to all children.

Child’s Name: ________________________________

Classroom: ________________________________

Sunscreen brand/type/strength: ________________________________

Broad spectrum, blocks UVA & UVB, SPF 15 or higher, water resistant/proof, PABA free. Parent-provided sunscreen must also meet these minimum requirements for DCPC to apply to the child. Combination sunscreen/insect-repellent will not be applied.

Has child used sunscreen before? (please circle): Yes  No  Reacted to sunscreen before? Yes  No

Parent/Guardian Signature & Date: ________________________________

Signature  date

Authorization will remain in place for 1 year, unless parent/guardian requests a change. If the brand/type of sunscreen changes, a new authorization is needed before staff can apply the product to the child.

Insect Repellent

I/we  give permission / do not give permission  (please circle one) for the DCPC center staff to apply the type/brand of insect repellent indicated below to my child before playing outside or before outdoor fieldtrips, in accordance with label directions.

Child’s Name: ________________________________

Classroom: ________________________________

Insect repellent brand/type/strength: ________________________________

DCPC provides DEET-free repellent. Parent-provided repellent must contain less than 10% DEET, and label must indicate it is safe to apply to children of this child’s age. Repellent will not be applied to babies under 2 months of age w/o doctor’s written authorization. Combination insect-repellent/sunscreen will not be applied.

Has child used insect repellent before? (please circle): Yes  No  Reacted to repellent before? Yes  No

Parent/Guardian Signature & Date: ________________________________

Signature  date

Authorization will remain in place for 1 year, unless parent/guardian requests a change. If the brand/type of repellent changes, a new authorization is needed before staff can apply the product to the child.
Autorización de los Padres/Guardianes para Bronceador/Repelente de Insectos

El Comité Asesora de Servicios de Salud de DCPC requiere que los niños usen bronceador y repelente de insectos antes de salir afuera, a menos que el padre/guardián no lo permita. Si el padre no lo permita, debe hacer un círculo alrededor de “no autorizo” y firmar debajo.

 Bronceador

Yo **autorizo / no autorizo** que el personal de DCPC aplique bronceador del tipo/marca indicado abajo a mi hijo/a antes de salir afuera para jugar o antes de ir de excursión. Como recomendado por la Academia Americana de la Pediatría, se aplicará bronceador a cada niño.

Nombre del Niño: ________________________________

Clase: ________________________________

Tipo/marca/fuerza de bronceador: ____________________________________________

Amplio espectro, bloquea UVA y UBA, SPF 15 o superior, resistente al agua, sin PABA. El bronceador proveído por los padres tiene que cumplir con estos requisitos para que DCPC lo aplique al niño. Las combinaciones de bronceador/repelente para insectos no serán aplicadas.

¿Ha usado bronceador antes el niño?   Sí   No
¿Ha reaccionado al bronceador antes?   Sí   No

Firma del padre/guardián y fecha: ____________________________________________  __________

Firma                       Fecha

Esta autorización es válida por un año, a menos que el padre/guardián pida un cambio. Si el tipo/marca de bronceador cambia, se necesita una nueva autorización antes de que los empleados puedan aplicar el producto al niño.

Repelente de Insectos

Yo **autorizo / no autorizo** que el personal de DCPC aplique repelente de insectos del tipo/marca indicado abajo a mi hijo/a antes de salir afuera para jugar o antes de ir de excursión, de acuerdo con las instrucciones en la etiqueta.

Nombre del Niño: ________________________________

Clase: ________________________________

Tipo/marca/fuerza de repelente de insectos: ________________________________

DCPC provee repelente de insectos sin DEET. El repelente proveído por los padres tiene que contener menos de 10% DEET, y la etiqueta debe indicar que es seguro para aplicarlo a niños de esta edad. Repelente no será aplicado a los bebes menores de dos meses de edad sin la autorización escrita de un médico. Las combinaciones de bronceador/repelente para insectos no serán aplicadas.

¿Ha usado repelente de insectos antes el niño?   Sí   No
¿Ha reaccionado a repelente de insectos antes?   Sí   No

Firma del padre/guardián y fecha: ____________________________________________  __________

Firma                       Fecha

Esta autorización es válida por un año, a menos que el padre/guardián pida un cambio. Si el tipo/marca de repelente cambia, se necesita una nueva autorización antes de que los empleados puedan aplicar el producto al niño.
CAR SEAT TRAINING/REQUIREMENTS

Staff who transport children with car seats will attend annual car seat trainings. Staff that should be trained include: family advocates, family outreach workers, health manager, EHS supervisors, administrative services staff, and family engagement/mental health manager.

Upon hire, FOWs and FAs must be trained in car seat safety before they can transport a child. This training must be completed with the Safe Kids Coordinator or one of their staff. Car seats are kept at each site. Please follow the site’s car seat check-out policy when using a car seat to transport a child.

Listed below are the general guidelines for types of car seats. Please reference the car seat’s manufacturer or healthychildren.org for specific height and weight guidelines for each brand and model of car seat.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Type of Seat</th>
<th>General Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants/Toddlers</td>
<td>Rear-facing only seats and rear-facing convertible seats</td>
<td>All infants and toddlers should ride in a <strong>Rear-Facing Car Seat</strong> until they are at least 2 years of age or until they reach the highest weight or height allowed by their car seat's manufacturer.</td>
</tr>
<tr>
<td>Toddlers/Preschoolers</td>
<td>Convertible seats and forward-facing seats with harnesses</td>
<td>Any child who has outgrown the rear-facing weight or height limit for their convertible car seat should use a <strong>Forward-Facing Car Seat</strong> with a harness for as long as possible, up to the highest weight or height allowed by their car seat manufacturer.</td>
</tr>
<tr>
<td>School-Aged Children</td>
<td>Booster seats</td>
<td>All children whose weight or height is above the forward-facing limit for their car seat should use a <strong>Belt-Positioning Booster Seat</strong> until the vehicle seat belt fits properly, typically when they have reached 4 feet 9 inches in height and are between 8 and 12 years of age.</td>
</tr>
<tr>
<td>Older Children</td>
<td>Seat belts</td>
<td>When children are old enough and large enough for the vehicle seat belt to fit them correctly, they should always use <strong>Lap and Shoulder Seat Belts</strong> for optimal protection. All children younger than 13 years should be restrained in the rear seats of vehicles for optimal protection.</td>
</tr>
</tbody>
</table>


1. Children must be in a car seat until they reach age 4 and 40 pounds, and in a booster seat until they reach age 8, more than 80 pounds in weight, or more than 4ft. 9in. tall.
2. Tiered structure applies:
- Less than 1 year old, or less than 20 lbs. must be in a rear-facing child seat in the back seat (if so equipped)
- If at least one year old and 20 pounds, but less than four years old or less than 40 pounds, must be a in a forward- or rear-facing child seat in the back seat (if so equipped)
- Age 4 to age 8, and between 40-80 lbs., and no more than 4 ft. 9 in. must be in a forward- or rear-facing child seat in the back seat (if so equipped) or a booster seat

3. Penalty for non-compliance depends on the age of the child
   - If less than four years of age, the total penalty is $175.30
   - If between ages 4 and 8, the total penalty is $150.10 for the first offense, $200.50 for a second offense, and $263.50 for third and subsequent offenses

Additional Guidelines:
1. If the car seat requires a harness: ensure that the harness is snug and that the harness clip is placed at the mid-chest level. (Rear-facing car seats: Bulky clothing, including winter coats and snowsuits, can compress in a crash and lead to increased risk of injury. Ideally, dress your baby in thinner layers and tuck a coat or a blanket around your baby over the buckled harness straps if needed.)
2. Do not take any car seat donations – we do not know the car seat history.
3. Do not use a car seat that has been in an accident. If a car seat has been in an accident, please bring it to Red Arrow to have it disposed of.
4. Check the car seat for expirations. If a seat has expired return it to Red Arrow to be disposed of.
5. Do not use a car seat if it has been recalled. The administration staff will notify a site if a car seat has been recalled.

Disposal of car seats:
1. Before disposing of car seats, straps must be cut from the seat.
2. Kohl’s Safety Center has an annual day of recycling old car seats and disposing of them properly.
EMERGENCY PROCEDURES – STAFF RESPONSIBILITIES
(to be reviewed at Team Meetings at least twice per year)

Every member of the team is important to ensure the safety of the children, parents, volunteers, and other staff members.

Teams MUST define which staff person(s) will assume responsibility for any child(ren) who may need additional assistance to safely leave during an emergency. This should be identified on the evacuation plan using the staff name or title and the child’s initials.

The following are general guidelines – each site develops its own specific emergency evacuation plans. Be sure to review with all team members.

IN CASE OF FIRE
The Teacher Assistant (TA) will lead the children out of the building, to the designated area, following the evacuation plan posted in the classroom. Any volunteers or parents will assist the TA.

The designated staff person will call 911 and then assist the TA.

The Teacher will be the last staff member to leave the building to ensure that all children and staff are out safely. The Teacher will take the children’s emergency cards (including Health Condition Alert forms), the First Aid kit, and the tracking sheet to check roll (counting children is not enough, names will be called).

IN CASE OF TORNADO
The TA will lead children to the designated safe place. The NSP, volunteers, parents, and other staff will assist the TA. The Teacher will be the last to leave the room and will ensure that all children and staff are out of the room. The Teacher will bring the children’s emergency cards (including Health Condition Alert forms), the First Aid kit, a flashlight, and the tracking sheet. (Counting children is not enough, names will be called).

IN CASE OF BUS EMERGENCY
See the Transportation section for details.
NOTE: Teachers are to observe the practice bus evacuations each quarter before signing the evacuation form.

IN CASE OF OTHER EMERGENCIES REQUIRING EVACUATION
In general, TA and other site staff will exit building with lead teacher checking the room(s) for children before joining the group. In all circumstances, the staff and children’s emergency cards (including Health Condition Alert forms), first aid kit, and the tracking sheet will be taken. Sites with cell phones should also take those.

All sites are to develop master emergency plans. These are to be reviewed at least twice annually at team meetings and kept in a location that all site staff know.
PLANNING FOR EMERGENCIES
(updated Summer 2009)

The following guidelines are meant to ensure that everything possible will be done in a timely and efficient manner if there is an emergency. In case of an emergency, the following will be required:

**Emergency Contact Cards**
Prior to attending a DCPC program, an Emergency Contact Card will be completed for each child, which, by virtue of parental signature, allows permission for emergency medical treatment in the event a parent/guardian cannot be reached.

**Weather Radios**
All DCPC sites have weather radios which are to be left plugged in. Programs are also to replace batteries at least twice per year at the fall/spring “time change”.

**Telephone Numbers**
The following emergency telephone numbers will be clearly posted near every telephone: Fire Department, Police/Sheriff Department, Poison Control, and Child Protective Services. Be sure to note on the posting if dialing a “9” is required.

**First Aid Training/CPR Training**
All staff with regular access to children will attain CPR certification within 6 months of hire and retain this certification as current. Training monies are available for staff who are also interested in First Aid certification.

**Fire/Tornado/Severe Weather Plans** – *detailed policies follow*
Fire exit route and a plan for protection in a tornado/severe weather will be posted in a readily observable location in each classroom. It will show with clear diagrams the best exit route from the building in case of a fire and the safest location to go to during a tornado/severe weather. Monthly fire drills and tornado drills will be held as required by state law and Agency procedures.
Each program’s emergency plans will include planning for children with special needs (i.e.: physical impairments, special emergency medications, social/emotional needs, etc)
In all emergencies, staff are to take attendance not just count children, to ensure staff know location of every child.

**Flood Plans**
Few, if any, DCPC sites are in areas generally at risk for flood. However, each site may find itself in this emergency situation. Because each DCPC site has so many variations, individual sites are to plan for and include in their master evacuation plans their plan for floods.
**Loss of Building Services (no heat/water/electricity/phone)**

If the site is a DCPC owned site, contact the site director or a member of management for assistance. If the site has a landlord, follow the expectations of the site, and then contact the site director or Administrative Services Director to problem-solve alternatives. If the heat or electricity is to be off for over one hour, or immediately if the water is not working, alternative arrangements must be made (i.e.: transportation to another site). If the site phone is not working, use the agency cell phone, contact both the main office and parents to give them the temporary cell number. All sites should have an agency cell phone but if needed walk to your emergency “host facility” site to call the main office. Using the emergency card copies at the main office, office staff will begin contacting families.

**Lost or Missing Children**

See full policy in Child Development section. Immediately notify all center staff members and solicit their help in looking for the child (ensure appropriate staff remain with the rest of the group). Call the main office front desk and ask them to page a member of management – do NOT leave a message.

If the child is not quickly found, contact 911 and the parent.

Complete the Missing/Abducted Child Report within 24 hours and submit this to the Education and Compliance Manager (ECM). The ECM or assigned site director will notify licensing within 48 hours.

**Extreme Outdoor Heat or Cold**

In all cases, staff are expected to know which of the children in their care have asthma or other health conditions that may make adjustment to temperature extremes difficult for the child to breathe, even if the temperature is not as high/low as defined below. Precautions should be taken to protect the children at all times, including while walking to/from the bus. If needed, plans should be in place to keep that child inside with an appropriate staff person.

Whenever the outdoor temperature or wind-chill is 0° or lower, children 2-5 years of age will remain indoors. For children under 2 years of age, they will not go outside if temperature or wind-chill is less than 20°.

NOTE: teachers must make every attempt to get parents to supply cold weather attire, and should minimally have some hats/mittens available for children who do not bring these. In addition, teachers need to make accommodations outside for children who do not have snow pants/boots/etc. – (i.e.: sidewalk activities)

Hot weather, over 90 degrees, requires significant care to ensure the children are not outside and are well hydrated. Whenever the heat index is 90° or higher, the children will be kept inside. In addition, when the DNR has issued an Air Quality Alert/Ozone Alert, children should not be outside during the alert. The front desk will notify sites if there is an Air Quality Alert/Ozone Alert.

If a parent brings written documentation from a medical professional that a child should not go outside as required, it should include the medical reason for the restriction and the specific circumstances (i.e.: the restricted temperatures) the child is to be kept inside. Please work with the health manager/nurses to develop plans if a child has medical restrictions and must stay
inside.

**Medical Emergency Guidelines**
Guidelines for the handling of any emergency are made available to all staff through the Policy and Procedure Manual and are part of official agency policy.

**Yellow Health Action Plan Binder** – this binder will be kept near the Medications in each classroom and will include specific plans for children with health conditions requiring special care.

**Review of Accident Reports/Medical Logs**
All Medical Logs in a program are reviewed at least twice yearly by the program supervisors to determine if there are any areas within the center, on the grounds, or bus, that need to be looked at further because they may be a potential source of danger to children and staff. In addition, logs may be periodically reviewed by the assigned PNP/RN.

Each child’s accident report will be reviewed by the program supervisor and Education and Compliance Manager to determine if there are any areas that need to be looked at further because they may be a potential source of danger to children and staff.

**Bus Accident Procedures (see Transportation Section)**
Drivers are expected to understand these procedures, for the safety and welfare of their passengers.

1. Keep calm, don’t panic. Ensure an adult stays with the children and tries to keep them calm.
2. Stop the bus in a safe position
3. Prevent additional accidents and injury:
   (a) Turn on hazard lights
   (b) Set brakes
   (c) Turn off ignition
   (d) Set reflectors
   (e) Evacuate if:
       (1) There is a fire
       (2) It smells like gas
       (3) There is smoke
       (4) There is a danger of drowning
       (5) The bus is at a dangerous position in roadway
4. Send for help
   (a) Either the bus driver or aide must stay with the children at all times.
   (b) Radio the office for assistance. Have them call 911 if necessary.
   (c) Use the tracking sheet to monitor attendance of children
5. Aid the injured
   (a) **DO NOT MOVE ANYONE INJURED, UNLESS ABSOLUTELY NECESSARY**
6. Collect factual information
   (a) List all passengers.
   (b) Gather information from other driver (police must be contacted if another driver was involved in the accident)
   (c) Investigating officer
(1) Give clear and concise answers
(2) Get name and badge number
(d) Write up all above information (see Administrative Services Director for format).
Sign and date your report.

It is a Wisconsin law that each school bus accident must be reported to both the Division of Motor Vehicles and the Department of Public Instruction, if anyone has been injured, or if there is total property damage of more than $200. Every accident involving your bus must be reported to the Administrative Services Director/Transportation Manager, regardless of the amount of damage. Every accident in which children are on the bus, regardless of any injuries, must also be reported to the Education and Compliance Manager and the Executive Director– who will then file a report with Child Care Licensing within 48 hours of the accident.

**HEAD INJURIES – general guidance**

Whenever there is an injury to the child’s **face**, the parent/guardian is to be contacted right away – the injury should be described to the parent/guardian, who may or may not choose to come to the center. If you believe the injury may require medical attention, please be sure to state that to the parent.

Whenever there is a **head injury, or blow to the head**, contact a parent immediately and encourage parent to seek medical attention. If you believe the injury may require medical attention, please be sure to state that to the parent.

First Aid Care for a Head Injury:
1. Follow standard precautions for any bleeding
2. Apply gentle pressure to control any bleeding – gentle pressure is better than heavy pressure if there is any chance of a skull injury or fracture
3. Put a clean bandage on the wound once the bleeding has stopped – if the bleeding does not stop with continuous pressure, call 911
4. Put a cool ice pack on the injured area for 10-15 minutes. Wrap ice or frozen pack in a thin cloth so that direct contact with skin does not cause further injury.
5. Observe the child for any abnormal behavior that might indicate internal head injury

**Additional Information:**
- Allow the child to sleep if there are no other signs or symptoms of internal head injury and if it is a normal bed or naptime
- If the child is acting normally before the regularly scheduled bed or naptime, allow the child to sleep for up to 2 hours without being awakened. After 2 hours of sleeping, when awakening the child, check to see if the child wakes up as easily as usual. Get medical help if the child is not acting normally
- Sleep does not worsen a head injury. The concern is that a child sleeping longer than 2 hours cannot be observed for changes in behavior or level of consciousness.
MEDICAL EMERGENCY FIRST AID PLAN (TO BE POSTED)

The following guidelines are for staff to follow in case of a medical emergency:

**Assess the situation and remain calm**
1. Decide if medical care is immediately needed.
2. If medical care is crucial to life, call 911 immediately. If the child’s physical exam has pertinent data on it about allergies, drugs, epilepsy, diabetes, etc. take it to the hospital. The Emergency Contact Card must be taken to the hospital.
3. Whenever there is a head injury, contact a parent immediately and encourage parent to seek medical attention.
4. Whenever there is an injury to the child’s face, the parent/guardian is to be contacted right away – the injury should be described to the parent/guardian, who may or may not choose to come to the center. If you believe the injury may require medical attention, please be sure to state that to the parent.
5. If you are in doubt about whether the injuries require the services of emergency personnel, call the rescue squad for guidance.

If poisoning is suspected, take along the bottle or pills or any emesis (vomit) that may be available. **GIVE NOTHING TO THE CHILD TO EAT OR DRINK!**

**Contact the parent/guardian**
1. If medical care is not crucial to life, always call the parent/guardian first. Emphasize to the parent/guardian the need for further medical attention if you believe it necessary. Contact an agency PNP/RN or the Health Manager for guidance, if needed.
2. A minor child requires parental permission for treatment beyond what is absolutely critical for life. Continue to make every effort to contact parent/guardian or other emergency contact person.

**Remain with the injured child**
1. One staff person must remain with the injured child at all times. The adult's attention should be directed to the child.
2. Proceed with the accepted medical first aid procedures as the situation dictates.
3. Comfort and reassure the child.

**Supervise other children**
1. A second staff person must supervise the other children. If possible, remove them from the scene of the accident and/or out of the way of necessary personnel.
2. Request additional staff from another classroom or the main office if needed.

**Notify the Administrative Office**
1. Complete/submit a Child Accident Report form the same day.
2. Record incident in the Medical Log Book the same day.
3. Notify the site director and/or the Health Manager the same day the accident occurs if the child requires any medical attention. Also notify the nurse working with the program.
4. For accidents/injuries on site requiring professional medical treatment, the Education and Compliance Manager or Site Director shall report the accident to the licensing specialist within 24 hours.

**DOCUMENTATION: CHILD ACCIDENT REPORT (#206), MEDICAL LOG**
DENTAL EMERGENCY FIRST AID PLAN (TO BE POSTED)

To ensure a plan-of-action in the event of an accident to the tongue, lips, cheeks or teeth.

If injury to the cheek, lips or tongue occurs:
1. Attempt to calm the child. All incidents should be handled quietly and calmly. A panicked child is likely to create problems for treatment and may cause further trauma.
2. Check for bleeding.
   a. Rinse affected area and/or apply pressure if necessary to stop bleeding.
   b. Apply ice to reduce swelling.
   c. Evaluate need for further dental or medical care and proceed with other emergency measures.
3. If unable to look carefully in child’s mouth, calm the child and then evaluate for source of bleeding or injury.

If injury to a tooth occurs:
1. Attempt to calm the child. All incidents should be handled quietly and calmly. A panicked child is likely to create problems for treatment and may cause further trauma.
2. If a tooth is loosened:
   a. Rinse out child’s mouth.
   b. Do not attempt to move teeth or jaw.
   c. Take child to the dentist immediately.
3. If tooth is fractured: Call the dentist for treatment guidance. Staff can do little for a fractured tooth except to calm the child.
4. If tooth is knocked out (extruded):
   a. Recover tooth.
   b. Rinse both the mouth and tooth with tap water.
   c. If the tooth is permanent replace in socket. If primary tooth, do not replace.
   d. If not possible to replace the tooth in the socket, the tooth should be placed in a salt solution of one teaspoon of salt in a glass of water, or place the tooth in a clean cloth soaked in salt-water solution. Bring it with you.
   e. Take the child to the dentist immediately. It is most important that the tooth be replanted within 30 minutes by the dentist.
5. If the tooth is knocked into the gum (intruded):
   a. Do not attempt to free or pull on the tooth.
   b. Rinse out the child's mouth.
   c. Call the child’s dentist immediately.
FIRE DRILLS

Fire drills are to be practiced within each program site to stay in compliance with the State requirements and to familiarize all adults and children with evacuation procedures.

Fire Drills Guidelines
1. Plan a primary escape route and an alternate route from every room. Mount the plan in a conspicuous spot in each classroom.
2. Call the plan to the attention of volunteers and other adults. Teach the children that they are to stop anything they are doing when they hear the signal and meet the adult immediately at the designated place. Emphasize keeping together and being as quiet as possible. Speed is important, of course, but do not tolerate running, shouting, shoving, etc. Getting the children out safely is our real goal.
3. Pre-plan who will stay with the children and who will go for help. In a case of an actual emergency, these pre-arrangements will ensure a calming atmosphere. Children react as you do, so remind them where they go in a distinct, forceful, but calm, voice.
4. If your facilities do not have their own fire alarm system, use a whistle or a battery operated smoke detector. It must be kept out of the children's reach and used for nothing else.
5. Take the TRACKING sheet with the group on every drill and emergency. Accurately and quickly take attendance of the children assembled in the room and again when they assemble in the yard.
6. Practice required for fire drills: The teacher sounds the signal only once, loudly! Children line up at the door which you will use. Leaving the building, the TA and volunteers go first, children following in an orderly line, with the teacher at the end. After going outside, everyone gathers far away from the building. The teacher should check quickly all areas of the room, including the bathrooms and lofts. The teacher or other designated staff should close all windows and doors they can safely and quickly reach.
7. Staff are to take on every drill/emergency the daily attendance (and tracking sheets), first aid kit, and emergency cards/Health Condition Alert forms.

Site Responsibilities
1. Each staff member needs to know the evacuation route as well as the nearest fire extinguisher's location and how to operate it.
2. The Emergency number is to be posted on/near each phone.
3. Classroom and Walk-In Programs: Fire drills will be carried out monthly.
4. Home Based Programs: Fire drills will be carried out first and third quarters at the clusters and second quarter in the child's home using the home safety checklist.
5. The fire drill will be recorded on the "Fire and Safety Checklist for Group Day Care" the same day as the fire drill occurs. This should be posted in clear view.
6. Smoke detectors are to be checked weekly and recorded on the safety checklist log sheet.
7. Children/Staff with Disabilities: Special evacuation procedures may be necessary to accommodate children or adults with disabilities (social, cognitive, or physical) in an emergency. PLAN FOR THESE within the center team, including individual staff responsibilities, and post these plans with the evacuation route/plan.

8. Children who need one-on-one attention should be listed on evacuation plan and sought out by staff members during a drill.

9. Sleeping children: Full day programs should practice some drills during naptime. DO NOT TAKE TIME FOR CHILDREN TO PUT SHOES ON before exiting.

DOCUMENTATION: RECORD OF FIRE DRILL, SMOKE ALARM TEST CHECKOFF, EMERGENCY POLICIES
SEVERE WEATHER AND TORNADOES

Ninety-five percent of Wisconsin tornadoes occur from April through September. Wisconsin averages twenty tornadoes a year. The major cause of death and injury is from building collapse and flying glass or debris.

The responsibility of protecting and reassuring children during a severe storm is a serious one, especially in sites where the children are usually very young and easily frightened. Use Tornado Awareness Day to practice and discuss procedures with the children in a non-frightening manner.

Weather radios have been purchased for each site – these are to be kept on at all times – be sure they are located in an area of the center where someone is most likely to hear the alert (for most sites, this means the kitchen). Discuss with the program supervisor if you have questions about the best location for this.

Careful plans should be made far in advance. A shelter must be selected according to the location of your center. The following planning guide should be utilized:

**Planning Ahead: Responsibility of Center Staff**

1. Learn the direction that your building faces: north, south, east or west.
2. Determine where your shelter will be.
3. Know exactly the quickest way to get there from both inside and outside.
4. Discuss it with all staff members. Know who will be responsible for what. Post the evacuation plan.
5. Practice drills with each group of children, monthly April - October.
6. TAKE ATTENDANCE and TRACKING SHEET to ensure all children are accounted for – take attendance, not just head count.
7. Know the difference between a WARNING and a WATCH.
8. Staff are to take on every drill/emergency the daily attendance and tracking sheets, first aid kit, and emergency cards (including Health Condition Alert forms).

**Shelter Selection: How to Determine the Best Spot**

1. The lower the floor, the more desirable the protection. Basements are the safest shelter. In a basement, use the corner closest to the tornado (usually the southwest corner).
2. If there is no basement, the location should near the center of the building, away from west or south windows or doors. Centrally located bathrooms, storage rooms or large closets are good.
3. The more protection from flying debris and glass, the better.
4. The more massive the overhead protection, and the shorter the span of ceiling, the better. AVOID large open rooms and structures such as gymnasiums, libraries, auditoriums, and church sanctuaries. These are much more likely to collapse.
5. Children lined up against the walls of a central hallway are not always in the safest place.
If there is an outside door at either end of the hallway, children could be in serious danger; high winds could crash in the west doors and push out the opposite end.

6. If a tornado hits suddenly, with little warning:
   A. Don't try to get to the safest spot if it is far away - unless you know there is time.
   B. Get down and under something - a table is better than nothing.
   C. Sit down and cover exposed portions of the body. Tuck head down between legs.
   D. If crowded together in a very small area, stand facing the walls.
   E. If outdoors, lie flat in a ditch or ravine.

7. A tornado watch means that weather conditions in a large area make tornadoes possible.
   A. Keep listening to the radio or TV.
   B. Be ready to go to your designated shelter on very short notice.
   C. Check for objects which might become flying missiles if blown about a high wind.
   D. If conditions seem to look so threatening and ominous that you feel a severe storm is imminent, you may want to take the children to the shelter without waiting for an alert.

8. A tornado warning means a tornado has actually been sighted or been detected by radar.
   A. The warning is a steady siren blast of 3-5 minutes.
   B. Go to your shelter immediately.
   C. Take your radio, flashlight, Emergency Contact cards/Health Condition Alert forms, daily attendance/tracking sheet and 1st aid kit.
   D. Stay put until an all-clear has been determined. **

Most likely each teacher will have to ascertain whether the warning for your area has, in fact, ended. Crunched together in a small, tight place for even a few minutes can become a burden. This is particularly true if your immediate local conditions do not seem to be increasing in severity. Therefore, continued monitoring of portable radios is a necessity. Call the main office for further guidance, if needed.

Severe Weather or Tornado Drill
Teachers can develop their own teaching methods to prepare children. Children should be prepared to:
1. Go to a shelter at a pre-arranged signal.
2. Go quickly and in an orderly manner.
3. Understand it could be dark as the lights may go out.
4. Know how to sit with head tucked down between legs.
5. The shock of a real emergency will be lessened if the children have learned to consider the shelter as a familiar refuge.

Equipment
(Nota: Batteries in weather radios and flashlights should be checked monthly)
The lights often go out. Have your flashlight/lantern with you. Take a first aid kit, daily attendance and tracking sheet, and the Emergency Contact cards (including Health Condition Alert forms) to your shelter area. All centers should have portable weather radios. Keep it going
at all times to monitor bulletins. If no radio is available, you may be able to get information by calling the following numbers:

- Dane County Sheriff: 266-4970
- Green County Sheriff: 328-9400
- State Patrol: 266-7626 (or local police)

**Bus or Car**

**Options for dealing with Tornadoes:**

**Delay Bus Departures:** Buses provide no protection from severe storms, buildings are far safer places.

**If there is a Warning:** Do not leave the Center until the Warning is over. Shelter in the site.

**If there is a Watch:** Proceed on but keep extremely vigilant of the weather.

1. Have a plan: know what to do the minute the Watch turns into a Warning.
2. Monitor: Keep an eye on the weather, make sure the radio is working.
3. Be ready to act: Take immediate action, you may have only minutes to react.

Please see the transportation section for more details.

**Children/Staff with Disabilities**

Special evacuation procedures may be necessary to accommodate children or adults with disabilities in an emergency. PLAN FOR THESE within the center team including individual staff responsibilities, post these plans with the evacuation route/plan.
FIRST AID KIT

Each program will have a first aid kit and fanny pack accessible to teachers in the classroom but out of reach of the children.

The first aid kit will include:

<table>
<thead>
<tr>
<th>First Aid Kit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First Aid Book</td>
<td>1</td>
</tr>
<tr>
<td>Adhesive Tape Roll</td>
<td>1</td>
</tr>
<tr>
<td>Band Aids</td>
<td>30</td>
</tr>
<tr>
<td>Cold Pack</td>
<td>2</td>
</tr>
<tr>
<td>Gauze Roll</td>
<td>1</td>
</tr>
<tr>
<td>Gauze Pads 2” x 2”</td>
<td>5</td>
</tr>
<tr>
<td>Gauze Pads 4” x 4”</td>
<td>5</td>
</tr>
<tr>
<td>Scissors</td>
<td>1</td>
</tr>
<tr>
<td>Thermometer</td>
<td>1</td>
</tr>
<tr>
<td>Thermometer sheaths</td>
<td>25</td>
</tr>
<tr>
<td>Toilettes – water based</td>
<td>10</td>
</tr>
<tr>
<td>Gloves</td>
<td>2 sets</td>
</tr>
</tbody>
</table>

This first aid kit (or fanny pack) containing all necessary supplies will be taken:

- Outside during play time
- On walks
- During tornado drills
- On field trips
- During fire drills
- During any other emergency evacuation

*Children should never carry the first aid kit.

*Please be sure to use gauze pads, not paper towels, on children’s injuries!
   If gauze package is torn or yellow, dispose of the gauze pads and order new ones.

Use the following order form to replace supplies as needed:
### FIRST AID / HEALTH SUPPLIES RE-ORDER FORM

*One Sheet Per Class—Please*

<table>
<thead>
<tr>
<th>SITE / PROGRAM:</th>
<th>CLASSROOM STAFF:</th>
<th># NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. First Aide Book</td>
<td>Circle please ➤</td>
<td>1</td>
</tr>
<tr>
<td>2. Adhesive Tape Roll</td>
<td>Circle please ➤</td>
<td>1  2</td>
</tr>
<tr>
<td>3. Band Aids</td>
<td>Circle please ➤</td>
<td>30  60</td>
</tr>
<tr>
<td>4. Cold Pack</td>
<td>Circle please ➤</td>
<td>1  2</td>
</tr>
<tr>
<td>5. Gauze Roll</td>
<td>Circle please ➤</td>
<td>1  2</td>
</tr>
<tr>
<td>6. Gauze Pads 2” x 2”</td>
<td>Circle please ➤</td>
<td>5</td>
</tr>
<tr>
<td>7. Gauze Pads 4” x 4”</td>
<td>Circle please ➤</td>
<td>5</td>
</tr>
<tr>
<td>7a. <strong>Gauze Pads 2” x 2” (FOR INFANTS)</strong></td>
<td>Circle please ➤</td>
<td>50</td>
</tr>
<tr>
<td>8. Scissors</td>
<td>Circle please ➤</td>
<td>1</td>
</tr>
<tr>
<td>9. Thermometer —return old one to Karin</td>
<td>Circle please ➤</td>
<td>1</td>
</tr>
<tr>
<td>10. ** Sheaths</td>
<td>Circle please ➤</td>
<td>25</td>
</tr>
<tr>
<td>11. Toiletes—water base</td>
<td>Circle please ➤</td>
<td>20</td>
</tr>
<tr>
<td>12. Vomit Powder (Per Class)</td>
<td>Circle please ➤</td>
<td>1</td>
</tr>
<tr>
<td>13. Sun Screen (Full Day classes only)</td>
<td>Circle please ➤</td>
<td>1</td>
</tr>
<tr>
<td>14. Bug Spray (Full Day classes only)</td>
<td>Circle please ➤</td>
<td>1</td>
</tr>
<tr>
<td>15. Tooth Paste (Per class)</td>
<td>Circle please ➤</td>
<td>1</td>
</tr>
<tr>
<td>16. Tooth Brushes— replacements</td>
<td>Circle please ➤</td>
<td>10</td>
</tr>
<tr>
<td>17. First Aid Lock Box (have to order)</td>
<td>Circle please ➤</td>
<td>1</td>
</tr>
<tr>
<td>18. Gloves: Small</td>
<td>Circle please ➤</td>
<td>2</td>
</tr>
<tr>
<td>19. Gloves: Medium</td>
<td>Circle please ➤</td>
<td>2</td>
</tr>
<tr>
<td>20. Gloves: Large</td>
<td>Circle please ➤</td>
<td>2</td>
</tr>
<tr>
<td>21. Case of Gloves: Small Medium Large (← Circle)</td>
<td></td>
<td>1 CASE</td>
</tr>
</tbody>
</table>

*Please DO NOT TAKE YOUR OWN CASES OF GLOVES* from upstairs at Red Arrow: if you need them ASAP - ask Karin to give you a box (or case). Thank you!

Please Return to Karin Gunderson at 2096 Red Arrow. (04/16)
EMERGENCY BACKPACK

Each program will have an emergency backpack accessible to teachers in the classroom, but out of reach of the children.

EMERGENCY BACKPACK SUPPLIES RE-ORDER FORM

<table>
<thead>
<tr>
<th>Preschool Contents</th>
<th>✓ if needed</th>
<th>Infant/Toddler Contents</th>
<th>✓ if needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Working Flashlight w/ batteries</td>
<td>✓</td>
<td>1. Working Flashlight w/ batteries</td>
<td>✓</td>
</tr>
<tr>
<td>2. Weather Radio w/ batteries</td>
<td>✓</td>
<td>2. Weather Radio w/ batteries</td>
<td>✓</td>
</tr>
<tr>
<td>3. Whistle</td>
<td>✓</td>
<td>3. Whistle</td>
<td>✓</td>
</tr>
<tr>
<td>4. First Aid Kit (Band-Aids and Gauze)</td>
<td>✓</td>
<td>4. First Aid Kit (Band-Aids and Gauze)</td>
<td>✓</td>
</tr>
<tr>
<td>5. Walkie Talkie w/ batteries</td>
<td>✓</td>
<td>5. Walkie Talkie w/ batteries</td>
<td>✓</td>
</tr>
<tr>
<td>6. Paper Cups</td>
<td>✓</td>
<td>6. Paper Cups</td>
<td>✓</td>
</tr>
<tr>
<td>8. 2-3 Pairs of Gloves</td>
<td>✓</td>
<td>8. 2-3 Pairs of Gloves</td>
<td>✓</td>
</tr>
<tr>
<td>10. Note Pad and Pen</td>
<td>✓</td>
<td>10. Note Pad and Pen</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11. Wipes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12. Disposable Diapers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>13. Changing Pad</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>14. Ziploc Bags</td>
<td></td>
</tr>
</tbody>
</table>

Please return to Site Director. Thanks

This emergency backpack containing all necessary supplies will be taken:

- During fire drills
- During any emergency evacuation

*Children should never carry the emergency backpack.

*During evacuations, children are to be wearing DCPC orange vests.
BLOOD / BODILY FLUID SPILL KIT

Each site will have a Blood/Bodily Fluid Spill Clean-Up Kit accessible to teachers, but out of the reach of children.

Each Clean-Up Kit will have the items listed in the re-order form below. These kits should be used whenever there is a spill of blood or other potentially infectious material. (Refer also to the Blood Borne Pathogens Control Plan and the Controlling the Spread of Infectious Disease policy.)

All sites should also have an empty laundry detergent bottle available, near their kit, to be used to dispose of broken glass that is contaminated with blood. This detergent bottle must have a biohazard label.

** Note: the RED BAG is only to be used for SIGNIFICANT QUANTITIES of blood spilled.

<table>
<thead>
<tr>
<th>CONTENTS</th>
<th>if needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Plastic Bucket</td>
<td></td>
</tr>
<tr>
<td>2. Permisorb Clean-Up Kit (incl. shovel / etc.)</td>
<td></td>
</tr>
<tr>
<td>3. Protective Gown/Mask</td>
<td></td>
</tr>
<tr>
<td>4. Goggles</td>
<td></td>
</tr>
<tr>
<td>5. Small Spray Bottle of Germicide</td>
<td></td>
</tr>
<tr>
<td>6. (2) Germicidal Moist Towelettes</td>
<td></td>
</tr>
<tr>
<td>7. Gloves</td>
<td></td>
</tr>
<tr>
<td>8. Tongs (for picking up broken glass)</td>
<td></td>
</tr>
<tr>
<td>9. Laundry Detergent Bottle (empty – for broken glass)</td>
<td></td>
</tr>
<tr>
<td>10. Exposure Incident Forms</td>
<td></td>
</tr>
<tr>
<td>11. Pink Laminated Directions</td>
<td></td>
</tr>
<tr>
<td>12. Supply Re-Order Form</td>
<td></td>
</tr>
<tr>
<td>13. Fluid Absorbent</td>
<td></td>
</tr>
<tr>
<td>14. (2) Red Bio-Hazard Bags**</td>
<td></td>
</tr>
<tr>
<td>15. Biohazard Sticker (for laundry detergent bottle)</td>
<td></td>
</tr>
<tr>
<td>16. Bleach</td>
<td></td>
</tr>
</tbody>
</table>

Please return to Program Specialist @ 2096. Thanks

See Blood Spill/Bodily Fluid Spill clean-Up Procedure in bucket or in Procedures to Control the Spread of Infectious Disease policy located later in this section.

Form 414, 06/18/2014
BLOODBORNE PATHOGENS EXPOSURE CONTROL PLAN
for
Dane County Parent Council, Inc.
(Revised 8/09)

In accordance with the OSHA Blood borne Pathogens Standard, 29 CFR 1910.1030, the following exposure control plan has been developed.

a. **Purpose**
   The purpose of this exposure control plan is to:
   1. Eliminate/minimize employee occupational exposure to blood or certain other body fluids;

b. **Exposure Determination**
   OSHA requires that the agency determines which employees could be exposed to body fluids containing blood in the course of their work. Dane County Parent Council, Inc. has determined that the following job classifications could be exposed to blood borne pathogens in the course of fulfilling their job requirements:

   **Lead Teachers, Site Directors, Openers/Closers, Home Visitation Teachers, Family Advocates, Associate Teachers, Child Care Teachers, Transportation Specialists and Receptionist.**

   A list of tasks and procedures performed by employees in the above job classifications in which exposure to blood borne pathogens may occur is required. This exposure determination shall be made without regard to the use of personal protective equipment. Tasks and procedures may include, but not be limited to, the following examples:

   1. Care of minor injuries that occur, *i.e.* bloody noses, scrapes, minor cuts.
   2. Initial care of injuries that require medical or dental assistance, *i.e.* damaged teeth, broken bone protruding through the skin, severe laceration.
   3. Care of students with medical needs such as colostomy, *etc.*
   4. Care of students who need assistance in daily living skills, *i.e.* toileting, dressing, feeding.
   5. Care of students who exhibit behaviors that may injure themselves or others, *i.e.* biting, scratching.
   6. Cleaning tasks associated with body fluid spills.

   - **Classroom volunteers should never perform the above listed tasks.**

c. **Implementation Schedule and Methodology**

   1. **Compliance Methods**
      a. Standard precautions will be observed at all times in order to prevent contact with blood or other potentially infectious materials (OPIM). All blood or other potentially contaminated body fluids shall be considered to be infectious.
      b. The standards contained in this Blood borne Pathogens Control Plan apply to blood or other bodily fluids containing blood, semen and vaginal secretions, but not to feces, nasal secretions, sputum, sweat, tears, urine, saliva and vomits unless they contain *visible* blood.
      c. Hand washing facilities will be readily accessible to employees. Employees shall wash
hands or any other skin with soap and water or flush mucous membranes with water immediately or as soon as possible following contact of such body areas with blood or other potentially infectious materials. Copious amounts of water should be used to flush the contact site. This dilutes the organism. Site directors shall ensure that after the removal of personal protective equipment, employees shall wash hands and any other potentially contaminated skin immediately or as soon as feasible with soap and water. Employees must also wash hands immediately or as soon as feasible after removal of gloves. DO NOT REUSE GLOVES.

2. **Personal Protective Equipment (PPE)**
   a. The Health Manager is responsible for ensuring that the following provisions are met. Personal protective equipment which will be provided by the agency are gloves, goggles, and disposable gowns. Gloves shall be worn whenever it can be reasonably anticipated that the employee may have hand contact with blood, other potentially infectious materials, mucous membranes, and non-intact skin; and when handling or touching contaminated items or surfaces. Disposable gloves shall be replaced as soon as practical when contaminated. They shall not be washed or decontaminated for re-use. All PPE is located in the center’s Blood/Fluid Spill Clean-up Kit.
   
   b. Disposable gowns should be worn to protect clothing whenever possible if it is anticipated that an employee's clothing may come into contact with blood or other potentially infectious materials in the performance of the tasks previously outlined. The Health Manager shall insure that appropriate PPE in the appropriate sizes is readily accessible at the work site. Hypoallergenic gloves, glove liners, powderless gloves or similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided. When PPE are removed, they shall be placed in an appropriately designated container for disposal.
   
   c. If a garment is penetrated by blood or other potentially infectious materials the garment should be removed and placed in an appropriate container as soon as possible. Supervisors shall ensure that the employee uses appropriate PPE. If an employee temporarily and briefly declines to use PPE because it is his or her judgment that in the specific instance it would have posed an increased hazard to the employee or others, the agency will investigate and document the circumstances in order to determine whether changes can be instituted to prevent such occurrences in the future.

3. **Housekeeping**
   a. The agency shall determine and implement an appropriate written schedule for cleaning and method of decontamination based on the location and type of surface to be cleaned, type of soil present, and tasks or procedures being performed. See the DCPC Cleaning, Sanitation, and Disinfecting policy in Policy/Procedures Manual.
   
   b. A Blood/Bodily Fluid Spill clean-up kit will be provided for each site and bus which contains all supplies necessary to safely clean up any potentially infectious spill. Disposable gloves, goggles, and gown should also be used. If any disposable item is soaked, caked or dripping with blood, place in red bag with biohazard label. Gloves must always be worn.
   
   c. Decontamination (disinfection with a hospital grade EPA approved disinfectant) will be
accomplished by utilizing the following materials: Sanicloth Plus Germicide and SafeTech Sanitize Pump. A bleach solution of ¼ Cup to 1 gallon water can also be made up as needed.

d. All equipment, materials, environmental and working surfaces shall be cleaned and decontaminated after contact with blood or other potentially infectious materials following the directions accompanying the germicide.

e. Broken glass contaminated with blood or OPIM shall not be picked up directly with the hands. It must be picked up using mechanical means, such as brush and dust pan or tongs and placed in a liquid laundry detergent bottle which will be provided to each site. This bottle will need a biohazard label.

f. If any needles may be used at the site (Epi–pen, insulin injections, etc.), staff must contact the Pediatric Nurse Practitioner/Registered Nurse immediately to determine if a red biohazard container is needed.

4. Hepatitis B Vaccine
   a. Dane County Parent Council, Inc. shall make available the Hepatitis B vaccination series to all employees who have occupational exposure.

   b. DCPC contracts with Concentra Medical Centers, Junction Point Shopping Center, 358 Junction Road, Madison, Wisconsin 53713, and 1619 North Stoughton Road, Madison, Wisconsin, 53704, to provide the Hepatitis B vaccination program. Hepatitis B vaccination shall be made available after the employee has received the training in occupational exposure and within 10 working days of initial assignment to all employees who have occupational exposure unless the employee has previously received the complete Hepatitis B vaccination series, or the vaccine is contraindicated for medical reasons.

   Participation in a prescreening program shall not be a prerequisite for receiving Hepatitis B vaccination. If the employee initially declines Hepatitis B vaccination, but at a later date, while still covered under the standard, decides to accept the vaccination, the vaccination shall then be made available.

   All employees who decline the vaccination offered must sign the OSHA required waiver indicating their refusal. If a routine booster dose of Hepatitis B vaccine is recommended by the U.S. Public Health service at a future date, such booster doses shall be made available.

   c. The Human Resources Manager shall ensure that all medical evaluations and procedures including the Hepatitis B vaccination series and post-exposure follow-up, including prophylaxis are:

      1. Made available at no cost to the employees.
      2. Made available to the employee at a reasonable time and place.
      3. Performed under the supervision of a licensed healthcare professional; and
      4. Provided according to the recommendations of the U.S. Public Health Service.
5. **Post Exposure Evaluation and Follow-up**
   a. DCPC shall make available post-exposure follow-up to employees who have had an exposure incident.
   
b. All exposure incidents shall be reported, investigated, and documented. Exposure Incident Investigation forms shall be kept in all first aid kits. When the employee incurs an exposure incident, it shall be reported to the Nursing Consultant and the Human Resources Manager. Following a report of an exposure incident, the exposed employee shall immediately receive a confidential medical evaluation and follow-up, including at least the following elements:
      1. Documentation of the route of exposure, and the circumstances under which the exposure incident occurred.
      2. Identification and documentation of the source individual.
      3. The source individual’s blood shall be tested as soon as feasible, after consent, in order to determine HBV, HCV, and HIV infectivity. If consent is not obtained, the Human Resources Manager shall establish that legally required consent cannot be obtained.
      4. When the source individual is already known to be infected with HCV, HBV or HIV, testing need not be repeated.
      5. Results of the source individual’s testing shall be made available to the exposed employees, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.
   c. Collection and testing of blood for HBV, HCV and HIV serological status will comply with the following:
      1. The exposed employee’s blood shall be collected as soon as feasible for testing after consent is obtained;
      2. The employee will be offered the options of having their blood collected for testing of the employee’s HCV/HIV/HBV serological status. The blood sample will be preserved for up to 90 days to allow the employee to decide if the blood should be tested for HIV serological status.
   d. All employees who incur an exposure incident will be offered post-exposure evaluation and follow-up in accordance with the OSHA standard. All post-exposure follow-ups will be performed by Concentra Medical Centers, Junction Point Shopping Center, Junction Road, Madison, Wisconsin, 53713, and 1619 North Stoughton Road, Madison, Wisconsin, 53704.
   e. The Human Resource Manager shall ensure that the healthcare professional responsible for the employee’s post exposure evaluation is provided with the following:
      1. A copy of 29 CFR 1910.1030
      2. A written description of the exposed employee’s duties as they relate to the exposure and circumstances under which exposure occurred;
      3. Written documentation of the route of exposure and circumstances under which exposure occurred.
      4. Results of the source individual’s blood testing, if available; and
      5. All medical records relevant to the appropriate treatment of the employee including
vaccination status.

f. The Human Resources Manager shall obtain and provide the employee with a copy of the evaluating healthcare professional’s written opinion within 15 days of the completion of the evaluation.

The healthcare professional’s written opinion shall be limited to whether HBV vaccination is indicated for any employee and if the employee has received such vaccination.

The healthcare professional’s written opinion for post exposure follow-up shall be limited to the following information:

1. A statement that the employee has been informed of the results of the evaluations; and
2. A statement that the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

All other findings or diagnosis shall remain confidential and shall not be included in the final report.

6. **Information and Training**

   Training shall be provided at the time of initial assignment to task where occupational exposure may occur and shall be repeated within 12 months of the previous training. Training shall be tailored to the educational and language level of the employee and offered during the normal work shift. The training will be interactive and cover the following:

   a. A copy of the standard and an explanation of its contents;
   b. A discussion of the epidemiology, symptoms, and hazards of blood borne diseases;
   c. An explanation of the modes of transmission of blood borne pathogens;
   d. The recognition of tasks that may involve exposure.
   e. An explanation of the use and limitations of methods to reduce exposure, for example, engineering controls, work practices and personal protective equipment (PPE).
   f. Information on the types, use, location, removal, handling, decontamination and disposal of PPEs.
   g. An explanation of the basis of selection of PPEs.
   h. Information of the Hepatitis B vaccination, including efficacy, safety, method of administration, benefits and that it will be offered free of charge.
   i. Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
   j. An explanation of the procedures to follow if an exposure incident occurs, including the method of reporting and medical follow-up.
   k. Information on the evaluation and follow-up required after an employee exposure incident.
   l. An explanation of the signs, labels and color coding systems.
   m. An explanation of DCPC’s Blood borne Pathogens Exposure Control Plan and a method of obtaining a copy.

The person conducting the training shall be knowledgeable with the subject matter.

Employees who have received training on blood borne pathogens in the 12 months preceding the effective date of this policy shall only receive training in provisions of the policy that
were not covered.
Additional training shall be provided to employees when there are any changes of task or procedures affecting the employee’s occupational exposure.

7. Recordkeeping
   a. Medical Records
      The Human Resource Manager is responsible for maintaining medical records as indicated below. These records will be kept at the Administrative Office in a designated file.

      Medical records shall be maintained in accordance with OSHA Standard 29CFR 1910.1030. These records shall be kept confidential and must be maintained for at least the duration of employment plus 30 years. The records shall include the following:
      1. The name and social security number of the employee.
      2. A copy of the employee’s HBV vaccination status, including the dates of vaccination.
      3. A copy of all results of examinations, medical testing and follow-up procedures.
      4. A copy of the information provided to the healthcare professional, including a description of the employee’s duties as they are related to the exposure incident and documentation of the routes of exposure and circumstances of the exposure.

   b. Training Records
      The Human Resources Manager/Administrative Assistant are responsible for maintaining the following training records. These records will be kept in the training files. The following information shall be documented.
      1. The dates of the training sessions
      2. An outline describing the material presented
      3. The names and qualifications of persons conducting the training
      4. The names and job titles of all persons attending the training

   c. Availability
      All employee records shall be made available to the employee in accordance with 29CFR 1910.20.
      All employee records shall be made available to the Assistant Secretary of Labor for the Occupational Safety and Health Administration and the Director of the National Institute for Occupational Safety and Health upon request.

   d. Transfer of Records
      If this facility is closed or there is no successor employer to receive and retain the records for the prescribed period, the Director of the NIOSH shall be contacted for final disposition.

8. Evaluation and Review
   The Executive Director and Human Resources Director are responsible for annually reviewing this program and its effectiveness and for updating this program as needed.
Dane County Parent Council, Inc.
Head Start

EXPOSURE INCIDENT INVESTIGATION FORM

Date of Incident: ____________________  Time of Incident: ____________________

Location: ________________________________

Person(s) Involved: ________________________________

Potentially Infectious Materials Involved:

Type: ____________________  Source: ____________________

Route: How did employee come in contact with the blood? ____________________

Circumstances (what was occurring at the time of the incident): ____________________

How was the incident caused: (accident, equipment malfunction, etc.  List any tool, machine, or equipment involved) ____________________

Personal protective equipment being used at the time of the incident: (e.g. glasses, gloves, aprons) ____________________

Actions taken: (decontamination, clean-up, reporting, etc.) ____________________

Recommendations for avoiding repetition of incident: ____________________

* Return completed form to the HR Director within 2 days.  336 (07/04)
Safe Sleep Policy for Infants Under 1 Year of Age

Head Start Performance Standard 1304.53(b)(3) To reduce the risk of Sudden Infant Death Syndrome (SIDS), all sleeping arrangements for infants must use firm mattresses and avoid soft bedding materials such as comforters, pillows, blankets or stuffed toys.

Head Start Performance Standard 1304.21(c)(1) Grantee and delegate agencies, in collaboration with the parents must implement a curriculum that: (i) supports each child’s individual pattern of development and learning.

Providing infants with a safe place to grow and learn is very important. For this reason, Dane County Parent Council has created a policy on safe sleep practices for infants up to 12 months of age. Safe sleep and napping practices reduce the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the unexpected death of a seemingly healthy infant under one year of age for whom no cause of death can be determined. It is the leading cause of death in children from one to twelve months of age. The chance of SIDS occurring is highest when an infant first starts child care.

Guidelines to promote safe sleep

**Sleep position**

- Place infants up to twelve months of age wholly on their backs, rather than on their stomachs or sides for every nap or sleep time (AAP, 2011) An alternate sleep position will only be allowed if the infant’s primary care provider has completed a signed statement indicating that the child requires an alternate sleep position
- When an infant can easily turn over from back to front and front to back, the infant will be put to sleep on his/her back but will be allowed to assume a preferred sleep position
- Devices such as wedges or infant positioners will not be used since such devices are not proven to reduce the risk of SIDS
- Raising a mattress may only occur if the infant’s primary care provider has completed a signed statement indicated this need. Elevating the head of the infant’s crib while the infant is supine is not recommended (AAP, 2011)
- Infants will be burped properly during and after a feeding, before they are put to sleep
- Any infant who falls asleep in a place other than his/her crib (e.g. car seat, swing, bouncy seat) must be placed in the crib as soon as possible
- Infants who use pacifiers can be offered their pacifier when they are placed to sleep, and it will not be put back in should the pacifier fall out once they fall asleep. Pacifiers will not be attached to clothing or tied around a child’s neck. Pacifiers attached to stuffed animals are not allowed
- Pacifiers will be cleaned between each use, checked for tears, and will not be coated in any sweet or other solution
- Parents will be asked to provide pacifiers as needed, DCPC does not provide or purchase pacifiers
Sleep environment

- Our program will use Consumer Product Safety Commission guidelines for safety-approved cribs and firm mattresses
  - Crib slats will be less than 2 3/8 inches apart
  - Infants will not be left in bed with drop side down
  - Playpen weave will be less than ¼ inches

- Only one infant will be placed to sleep in each crib. Siblings, including twins and triplets, will be placed in separate cribs

- The crib will have a firm tight fitting mattress covered by a fitted sheet and will be free from loose bedding, toys, and other soft objects (cushions, pillows, blankets, comforters, sheepskins, stuffed toys, etc.)

- To avoid overheating, the temperature of the rooms where infants sleep will be checked and will be kept at a level that is comfortable for a lightly clothed adult. Please contact site supervisor or Ed. & Compliance Manager if room temperature needs adjustment

- Infants should not have hats on while they sleep. For programs licensed for 4 week olds, physicians may order that hats be placed on premature babies at risk for not keeping their temperatures stable

- Infants may not wear bibs when they are placed in their crib for sleep

- AAP recommendations state that blankets may be hazardous, and use of blankets is not advisable. Blankets will not be allowed at DCPC. Sleep sacks will be provided for children under 12 months of age

- Swaddling can only be used in accordance with DCPC swaddling guidelines

- Smoking will not be allowed in or near DCPC

Supervision

- When infants are in their cribs, they will be within sight and hearing of staff at all times

- A staff member will visibly check on the sleeping infants frequently

- When an infant is awake, they will have supervised “tummy time.” This will help babies strengthen their muscles and develop normally

Training

- All staff, substitute staff, and volunteers working with children less than 12 months of age must read and sign the SIDS Prevention Information Sheet at the time of hire-- Form 411(English) 411.1(Spanish)

- In addition to reading the SIDS Prevention Information Sheet, employees must submit documentation stating the employee received SIDS/Safe Sleep training

- If employee has not had additional training, DCPC will offer training throughout the year

- Documentation that staff, substitutes, and volunteers have read and understand these policies will be kept in each individual’s human resource file
• This policy will be discussed with the employee by his/her supervisor during the new hire process

• Wisconsin childcare regulation effective September 1, 2001: All licensees, employees, and volunteers providing care and supervision for children in a center licensed to care for children under 1 year of age must have training in SIDS risk reduction

Communication Plan for Staff and Parents

• Counseling enrolled pregnant mothers to obtain early and medical recommended prenatal care, to avoid the use of drugs and alcohol, to refrain from smoking during pregnancy, and to breast feed whenever possible

• Encourage infants receive regular well-baby health visits, and that they are immunized on the recommended schedule

Parents will review this policy when they enroll their child in Dane County Parent Council and a copy will be provided in the parent handbook. Information regarding safe sleep practices, safe sleep environments, reducing the risk of SIDS in child care as well as other program health and safety practices will be shared if any changes are made. A copy will also be provided in the staff agency blue book. There will be ongoing communication with parents regarding their child’s sleeping.

I have reviewed the Safe Sleep Policy with my supervisor
Name of employee: ___________________________
Signature of employee: ___________________________
Date of review: ___________________________
HEALTH POLICY

The overall goal of DCPC’s health policy is health promotion and illness prevention. This is accomplished in a multitude of ways including, but not limited to, personal hygiene practices such as hand washing, maintaining immunization records and physical exams on all children. It is also necessary to have guidelines to recognize emergency situations; situations that necessitate immediate parent contact and guidelines to minimize the impact of communicable disease in the child care setting. Despite the best efforts of parents and child care providers, children in child care often get sick and it is important to have guidelines to know how to proceed.

Daily Health Check

To best assess the child’s health it is important upon arrival to observe the child and to check in with the parent. The teacher should discuss with the parent if the child has been experiencing symptoms or has visited a health care provider within 72 hours. This discussion must occur daily. The importance of a daily health check or observation cannot be understated; it provides a baseline from which it is easier to recognize symptoms of illness. Since a child’s health status can change within hours of arriving at child care it is important to differentiate the need for immediate care requiring emergency transport, situations that require immediate contact with families and the role communicable illness plays in child care settings.

Situations that Require Medical Attention Immediately (adapted from “Caring for Our Children”)

You may encounter medical emergencies or urgent situations as a child care provider. To prepare for such situations:

1. Know how to access Emergency Medical Services (EMS) in your area.
2. Educate staff on the recognition of an emergency.
3. Know the phone number for each child’s guardian and primary health care provider.
4. Develop plans for children with special medical needs with their family and physician.

At any time you believe the child’s life may be at risk, or you believe there is a risk of permanent injury, seek immediate medical treatment.

Call Emergency Medical Services (911) immediately if:

- You believe the child’s life is at risk or there is a risk of permanent injury.
- The child has difficulty breathing – the child breathes so fast that he or she cannot play, talk, cry, or drink.
- The child’s skin or lips look blue, purple, or gray.
- The child has rhythmic jerking of arms or legs and a loss of consciousness
- The child is unconscious.
- The child has any of the following after a head injury: decrease in level of alertness, confusion, headache, vomiting, irritability, difficulty walking, or continuous clear drainage from the nose.
• The child has increasing or severe pain anywhere.
• The child has a cut or burn that is large, deep, or won’t stop bleeding.
• The child is vomiting blood.
• The child has a severe stiff neck, headache, and fever.
• The child is vomiting blood.
• The child has a severe stiff neck, headache, and fever.
• The child is significantly dehydrated: sunken eyes, lethargic, not crying tears, not urinating.
• The child has blood red or purple rash made up of pinhead-sized spots or bruises that are not associated with injury.

After you have called EMS remember to call the child’s parent/guardian.

Some children may have urgent situations that do not necessarily require an ambulance but still need medical attention.

Parents should be notified and told the child needs medical attention within 1 hour for the following:
• Fever in any child who looks more than mildly ill and seems to be getting worse quickly.
• Fever in a child less than 4 months old (16 weeks).
• Projectile vomiting in an infant (forceful vomiting in an infant as opposed to “spitting up”).
• A large volume of blood in the stool.
• A cut that may require stitches.
• Any medical condition specifically outlined in a child’s health action plan requiring parental notification.

If you cannot reach the parent/guardian or emergency contact, contact the child’s medical provider for further direction.

**Symptoms Requiring A Child to be Sent Home**

Children in child care will present symptoms of diarrhea, vomiting, fever, and a variety of other symptoms. In each of these situations the child must be closely monitored to determine if the child can safely stay in the classroom or if they should be sent home. Each one of these symptoms alone or in combination with another could possibly influence the child’s ability to participate or be a potential communicable disease symptom. Follow the guidelines in the policy COMMUNICABLE DISEASE, and EXCLUSION GUIDELINES to assist you in assessing the child. Further discussion with one of the agency’s nurse practitioner/registered nurse is recommended to determine if the child should be sent home. Once that determination is made, the teacher should contact the parent/guardian.

It is important when a child is sent home to give them a Health Visit Follow Up Form (503). This form is to be used if the child is seeking medical care and can provide important information about if the child can attend or return to school.
Communicable Disease Policy – (Updated 2015)

COMMUNICABLE DISEASE is a category of illness, which is easily spread through normal social contact. Schools and child care centers are settings where germs are easily spread. Young children have developmental, personal, and play habits which increase the sharing of any virus, bacteria, or parasites the child may carry from home.

There are three steps required for transferring communicable germs from an infected person to an uninfected person.

1. The infected person must give off the germ from a carrying site such as the nose, mouth, and feces. Excretion does not occur through the skin – (except from boils, impetigo, chicken pox) - or through clothing.

2. The germ must be transferred to the well person. Transfer could be by air, direct contact, or intermediary contact.

3. The germ must reach an acceptable place to infect (usually mouth, nose, skin, or eye). A germ on the skin cannot infect until it reaches an acceptable place to grow.

NOTE: In accordance with the program closing policy: Programs may not cancel classes or close programs without Executive Director approval. If staff have concerns about potentially serious communicable outbreaks, they should be discussing these concerns with the program supervisor and nurse right away.

Reportable Communicable Disease

Communicable disease control is based on state law and communicable disease measures are maintained in cooperation with state CC Licensing and local health departments. One method to minimize spread is through reporting to the local health department. Certain serious illnesses, which are easily spread, must be reported to local health departments. If you know a child has contracted a communicable disease or believe a child has symptoms of a serious illness, please contact a PNP/RN to report the illness, she will determine if the illness is reportable to the local health department.

Exclusion guidelines from the WI Division of Public Health (5/14) will be followed. All classes must have a complete set of guidelines for the exclusion of children and staff from child care centers (found in yellow health action binder).

Children with Long Term Serious Communicable Disease

In most cases, children with long term serious communicable disease, which is not transmitted through casual social contact (i.e., AIDS, Hepatitis B) who are toilet trained, do not have a tendency to bite, have no draining lesions, and are otherwise in control of their body fluids, will be allowed to attend programs in an unrestricted manner. Decisions regarding the type of educational placement for a child with these illnesses, seeking admission to Dane County Parent Council programs will be based on behavior, neurological development, and physical condition of the child and the expected type of interaction with others in that setting. This decision will be made on a case-by-case basis with a team approach. This support team will include the physician, the child’s parents/guardian, an authorized program staff representative, the program assigned PNP/RN, and a local health official. In each case, risks and benefits to both the infected
child and to others in the setting will be weighed. See also AIDS/HIV Policy and Procedure.

**Adults with Communicable Disease**
Participation of program staff, volunteers or parent/guardians, who are known to have a long term serious communicable disease, in a classroom, home base program or office setting shall be handled in an individual manner. Employees known to have HIV infection or AIDS shall not be restricted from work solely because of their HIV status. See AIDS/HIV Policy in Personnel Policies and AIDS/HIV Procedure this manual.

**Confidentiality and Legal Issues**
Medical records of all children/staff shall remain confidential as required by Wisconsin State statutes. General informational notice will be sent to parents in the event that their child has been exposed to a communicable disease transferred by casual contact. The names of the infected children and adults are to be held in confidence. Parents or staff members will not receive notification or information about children or staff with life threatening diseases that are not transferred by casual contact, except when possible treatment and/or follow-up is necessary in the event that contamination has occurred. Any violation of these confidentiality provisions could result in criminal consequence, according to state law.

**Access to Education and Training**
Dane County Parent Council, Inc. will continue to provide for a wide range of staff training and development, which will include health topics and diseases.

Dane County Parent Council, Inc. will work to maintain healthful and safe environments; to promote the health of participants and their families and all employees; to educate children, families and staff in preventative medicine and good health practices and to help everyone develop a sense of responsibility for personal and community health.

**Non-Discrimination Statement**
Dane County Parent Council, Inc. recognizes that it is has a responsibility for preserving the safety, protecting the welfare, and promoting the physical and emotional health of all enrolled children and staff persons of this agency. Programs and services shall be made available to all participants with equal opportunities for all. The rights and responsibilities of parent/guardians, children and agency employees shall be recognized. However, these rights and responsibilities will be balanced with the general welfare of all participants and staff.
There are only 3 reasons to exclude an ill child from a child care setting:

1. The illness prevents the child from participating comfortably in the program’s activities.
2. The illness requires the caregiver to provide more care than the caregiver can provide without compromising the care of the other children.
3. The child has a specific condition that is likely to expose others to a communicable and/or reportable disease.
   a. State of WI child care regulations identifies certain diseases that are reportable to LHD and also give permission to child care centers to send a child home for the purpose of diagnosis and treatment of suspected communicable disease or any condition that has potential to affect the health of other students or staff. Each site should post the WI Communicable Diseases Chart, May, 2014.

Diseases which require exclusion from child care from WI Communicable Diseases Chart, May, 2014:

1. Chicken pox (varicella)
2. Conjunctivitis (pink eye- bacterial or viral) – exclude with fever
3. Diarrheal illnesses of unknown origin or caused by one of the following organisms: campylobacter**, cryptosporidiosis**, E. coli**, giardia, salmonella**, shigella, Norovirus, Rotavirus, Clostridium difficile infection
4. Hand, Foot and Mouth Disease – exclude with fever
5. Hepatitis A**
6. Hepatitis B**
7. Herpes simplex (cold sores) – exclude until fever free, able to control drooling, blisters resolved
8. Impetigo
9. Influenza
10. Lice (pediculosis)
11. Measles (Rubeola)**
12. Meningitis **
13. Mumps**
14. Pertussis (whooping cough) **
15. Pinworms
16. Ringworm of the body (tinea corporis) and of the scalp (tinea capitis)
17. RSV (Respiratory syncytial virus)
18. Roseola (Exanthum subitum)
19. Rubella (German measles) **
20. Scabies
21. Shingles
22. Staphylococcal infections (including MRSA)** - Exclude if wound drainage cannot be contained
23. Strep throat/Scarlet fever
24. Tuberculosis**

** Contact PNP/RN or Health Manager immediately.** PNP/RN or Health Manager will provide Communicable Disease Exposure Notice for the classroom to post and send home with families and contact Public Health if necessary.

A. If a child or staff member is diagnosed with a communicable disease, the specific Communicable Disease Exposure Notice should be posted and sent home to all families whose children may have been exposed. The site is to contact a PNP/RN or the Health Manager immediately if a child has a diagnosed communicable disease.

1. Communicable Disease Exposure Notices are stored on the DCPC Shared Drive in the Communicable Disease Exposure Notices folder and on the Blue Book USB drives.

B. The length of time to exclude varies with each disease; check with PNP/RN, Health Manager or the WI Communicable Disease Chart, May, 2015 to determine when child may return to child care.

C. For suspected communicable disease, children should go home as soon as possible, but not to exceed one hour after the communicable disease is suspected. Send the child home with a Health Visit Follow-up Report (#503). Complete the top half of the form listing the symptoms observed while in care. The bottom half of the form must be completed by a health care provider before the child may return to child care. The site is to contact a PNP/RN or the Health Manager immediately if a child has a suspected communicable disease.

Exclusion Guidelines

A child is excluded from child care and should be seen by their primary care provider for:

1. Persistent Abdominal Pain
2. Blood in stools, not explained by hard stools
3. Diarrhea - Exclude for 24 hours after last episode of diarrhea.

a) Diarrhea is defined as more watery, less formed, more frequent stools not associated with a diet change or medication

i. 3-5 year olds: two or more large watery stools in 8 hours or one loose uncontrolled stool for which preschooler cannot make it to the toilet in time.

ii. Infants/toddlers: two or more large stools that cannot be contained in a snug fitting diaper.

b) A child with diarrhea may remain in child care if he/she has no other symptoms and has a letter from a health care provider stating the child should not be excluded from
child care (consider new foods, teething, medications, etc.) If diarrhea is caused by a chronic condition contact a PNP/RN or the Health Manager.

c) For diarrhea caused by *E Coli* or *Shigella* infection the child may not return to child care until the diarrhea resolves and the test results of 2 stool cultures performed by a health provider or public health are negative.

4. **Fever with other signs of illness** such as sore throat, vomiting, diarrhea, earache, behavior change, etc. - Exclude until 24 hours fever-free without the use of fever reducing medicine.
   
a) Fever is defined as temperature of 100.5 degrees either under the arm or by mouth (3-5 yr. olds). Do not add a degree when reporting the temperature.

5. **A fever of 99.0 degrees axillary (with or without other sign of illness) in infant younger than 4 months of age**
   
a) Exception - Infant with fever is behaving normally on the day after an immunization is given and has no other symptoms.

6. **Rapidly rising fever (with or without other sign of illness)** – Temperature > 100.5 degrees and rising rapidly within 15 minutes

7. **Vomiting** - Exclude for 24 hours after last episode of vomiting
   
a) Defined as vomiting 2 or more times in 24 hours unless determined to be caused by non-infectious condition and child remains adequately hydrated. With infants, not just spitting up. Child should not be excluded if vomiting is suspected due to teething, stressful situations, or introduction to new foods.

8. Child appears to be severely ill: Lethargic, uncontrolled coughing, inexplicable irritability or crying, difficulty breathing, or other unusual signs

**Specific Conditions Clarification**

A. **Herpes Zoster (Shingles)** – Child may remain in child care if rash is covered by clothing or bandage until rash has crusted. If rash cannot be covered, consult health care provider.

B. **Lice** – Head Lice does not require immediate exclusion. Children found to have head lice may stay until end of day if a cap is worn. Children may return to the classroom after the first treatment with an effective pediculicide (medicated shampoo used to treat head lice). Children with treated nits can remain in the classroom.
   
   1. If a child is found to have live lice or nits the site must machine wash clothing and cloth toys at 129 degrees and dry at highest setting. Store clothes or toys that cannot be washed in sealed plastic bag for 10 days.

C. **Mouth sores** – Exclude when inflammation of oral membranes without control of oral secretions is present. Children with “cold sores” need not be excluded.
D. **Pink eye** (Purulent Conjunctivitis): Pink or red conjunctiva (whites of the eyes) with white or yellow mucous drainage, often with matted eyelids after sleep and eye pain or redness of the eyelids or skin around the eye. Children are excluded with fever, behavior change, or unable to avoid touching eyes. Antibiotics not required for return.

E. **Rash** – Children are excluded for rash with fever or behavior change. Children with a rash thought to be caused by a communicable disease will be excluded until they return with a physician’s note.

F. **Ringworm of Body** (tinea corporis) - itchy, flat circular-shaped rash. Ringworm of the body does not require immediate exclusion. Children found to have ringworm of the body may stay until end of day if area is covered with a bandage. If cannot be covered, contact nurse. Child may return when anti-fungal treatment has been started.

G. **Ringworm of the scalp** (tinea capitis) - itchy, patchy areas of dandruff-like scaling with possible hair loss and fluid filled blisters. Ringworm of the scalp does not require immediate exclusion. Children found to have Ringworm of the scalp may stay until end of day if a cap is worn. Over the counter medication is not acceptable anti-fungal treatment unless prescribed by a health care provider.
Health Visit Follow-up Form

To: Health Care Provider

The child listed below attends a DCPC childcare program, which follows state childcare health guidelines. The child has the following symptoms. Please evaluate and make recommendations.

__________________  ____________________  __________________
Child’s name        Child’s DOB        DCPC program / classroom

Reason for potential exclusion: ☐ diarrhea    ☐ fever    ☐ skin rash (location): ____________________
☐ vomiting        ☐ scalp lesion ☐ lice / nits
☐ Other: ____________________

Additional comments: ________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Staff name: __________________________ Date: __________________________

Health Care provider’s response to DCPC staff:

____________________________________________________________________________________
Date of exam  Diagnosis

Exclusion from child care? ☐ Yes    ☐ No    If yes, for how long? __________________________
If no, what is the reason for the symptom? _________________________________________________

Length of time this symptom can be expected without further medical re-evaluation:

☐ 1 week    ☐ 2 weeks    ☐ 1 month    ☐ other: ______________________________

Were medications given? ☐ Yes    ☐ No    If yes, name of medication? ______________________________

Were immunizations given? ☐ Yes ☐ No

What symptoms might arise in child care as a result of above interventions? __________________________

____________________________________________________________________________________
Name of Health Care Provider  Signature

Clinic

White – master file
Yellow – nurse
Pink – classroom

#503 (06/03)
**DCPC BED BUGS POLICY – Center Based**

Purpose: Decrease the risk of transporting bed bugs into DCPC classrooms.

Bed bugs are experts at hiding. Their slim flat bodies allow them to fit into the smallest of spaces and stay there for long periods of time, even without a blood meal. Bed bugs are transported from place to place in the seams and folds of bags, folded clothes, blankets, and anywhere else where they can hide. Children may bring belonging carrying bed begs into a DCPC child care or Head Start classroom.

Bed bug resources for staff, including bed bug information, parent handouts, can be found on the Blue Book USB flash drive.

**Guidelines for Child Care Center/Head Start Classroom**

- When a suspected bed bug is found in a child’s belongings, the child will be discreetly removed from the classroom and his/her clothing, shoes and belongings along with the area in which they were stored, will be inspected. The same will be done for other children living in the home.

- Different kinds of insects might look like bed bugs. Suspected bed bugs should be compared with good reference images to confirm their identity, see Appendix 1.

- If a bed bug is found on a child’s clothing, the child will change into new clothing and his/her clothing will be in a tightly sealed container such as a plastic bag or plastic bin with a lid and sent home with the child at the end of the day.

- After inspection, potentially infested belongings (ie: diaper bag, backpack, coat, hat, etc.) will be placed in a tightly sealed container such as a garbage bag or plastic bin with a lid. The belongings will be left there except when they are needed or when the child leaves for home.

- Found bed begs should be removed from a surface using a wet wipe and disposed of in a sealed plastic bag.

- Parents or guardians will be informed by phone call that a bed beg was found on their child’s belongings and that the home may be infested. Educational material will be sent to the parents about bed bugs and the need for a professional pest control specialist to confirm and control bed bug infestations. Tenet resource regarding bed bugs will be given to families who rent.

- A generalized letter (Bed bugs – Exposure notice) will be sent to parents of the entire classroom, alerting them that a bed bug was found so they can heighten their awareness and protect themselves at home.

- Children suspected of bringing bed bugs to a child care center or school, will not be excluded from child care or school.

- Staff should notify a DCPC PNP/RN with concerns of possible bed bug bites on a child.
• Children living in a home with a known bed bug infestation:
  o Are not excluded from child care or school
  o Car seats, diaper bags, back packs and unnecessary personal affects cannot be brought into the DCPC facility.
  o Necessary personal affects (i.e. coats, hats, gloves a change of clothing) will be stored in a plastic container while the child is at daycare.
  o The child’s clothing and shoes will be discreetly inspected for bed bugs.
    ▪ If a bed bug is found on a child’s clothing, the child will change into new clothing and his/her clothing will be in a tightly sealed container such as a plastic bag or plastic bin with a lid and sent home with the child at the end of the day.

• If a bed bug infestation is suspected within a classroom, that classroom will be quarantined until a professional pest control specialist can check the room to rule out an infestation. A control plan will be made on a case by case basis by the pest control specialist. Items will not be removed from a room until after the inspection has taken place.
HEALTH ACTION PLANS

Health Action Plans are forms which must be completed whenever a parent identifies one of the following:

- A child requires adaptation in daily activities because of a medical condition; daily activities to be considered include feeding, playing, sleeping, and toileting.
- A child needs medication for more than 10 days.
- A child requires a specialized emergency plan.

Whenever possible, these plans should be developed prior to attendance, by the parent/guardian, teacher, and one of the Nurses or the Health Manager. In all cases the plan must be developed within 15 days of attendance.

The plans should include the child’s diagnosis, conditions that typically trigger medical problems, signs and symptoms, medications, health care procedures routinely needed or needed on an emergency basis and an emergency response plan. The Health Action Plans will be reviewed and revised as needed.

Specific health action plans are for 3 conditions: 1) Seizure 2) Asthma 3) Non-Food Allergies. A Generic Health Action Plan is used for all other health conditions requiring modification of care. A Food Allergy/Intolerance plan is completed by the nurses or health manager.

Collaboration by the parent/guardian, health specialists, and classroom teacher is important in the development of the individualized health action plan. The Health Action Plan should provide guidance in:

- What accommodations in daily programming are needed, including meals and snacks, playing, sleeping, and toileting.
- When and how to give medication.
- When and how to perform any required medical procedures and who may perform them.
- What procedures to follow in the event of a medical emergency.

Each classroom will have a yellow Health Action Plan three ring binder. In the classroom 3 ring binder, place individualized health action plans for children in the classroom.

Use the Health Action Plan to guide staff in delivering care to children in need of individualized health care. All classroom staff must be informed which children have a health action plan and how the plan should be implemented. The 3 ring binder will be located in each classroom close to the medications and will be labeled as Health Action Plan Binder. In this binder, the DCPC Cleaning, Sanitizing, Disinfection Checklist (#218) will also be filed by center staff.

All medical information about enrolled children and their families is confidential. Records must be handled and stored in a way that protects confidentiality. Confidential information should be shared only with those DCPC staff who “need to know” in order to care for the child. Health Action Binders will be reviewed by PNP/RN’s and the site director during classroom visits.
Infants and young children sometimes have food allergies or are intolerant of certain foods. An allergic reaction occurs when a child is sensitive to a particular food and the immune system produces increased amounts of antibodies. The allergic reaction can be avoided only by avoiding the food.

The most common food to cause allergic reactions is peanuts, but other common causes are tree nuts, eggs, cow’s milk protein, wheat, fish, shellfish, citrus fruits, and berries. Some of these products are present in very small quantities in ordinary foods where you might not suspect them to be present. For example, peanut oil is used in some spaghetti sauces. When a child has a food allergy, scrutinize every food and read every food label very carefully. DCPC classrooms and anywhere children are present are peanut free.

When allergic children eat or even touch a surface that has a small amount of a food to which they are sensitive, they may develop symptoms such as diarrhea, vomiting, abdominal pain, rash, irritability, breathing problems, and even death. Reactions may be immediate or delayed, and symptoms may be mild to severe. Staff must work with families, the PNP/RNs, Registered Dietitian, and the Health/Nutrition Manager to protect the allergic child from exposure to the problem food.

A food intolerance is present when a person has some metabolic factors (for example, lack of an enzyme or chemical) that make it difficult or impossible to digest or use certain food. Sometimes foods can be modified so that the child can tolerate them. Intolerance to the sugar in cow’s milk (lactose) is a common problem in infants and children. Sometimes the intolerance is affected by the amount of the food the child takes. Some children can have a small amount of the food to which they are intolerant without difficulty.

1. **Food Allergy or Intolerance is identified from the Health Condition Alert form**

If food allergy or intolerance is identified, the PNP/RN or Health/Nutrition Manager must be contacted immediately and talked with, please don’t leave a message. Be prepared to tell PNP/RN/Health Nutrition Manager the best way to reach the parent (including phone numbers). Program staff must obtain signed Health Consent for provider who diagnosed the allergy and forward this immediately to PNP/RN (for children with a history of anaphylaxis or disabilities that impact the child’s food intake).

   a. If a child has a history of anaphylaxis, an individual protocol must be developed prior to the child’s start date. The site director and NSP must also be told of the food allergies one week prior to the child’s start date.

   b. Parents will be asked to meet with staff prior to the child’s start date to assist in the development of an individual plan.

   c. PNP/RN will send the plan to the Health/Nutrition Manager. The Health/Nutrition Manager will forward it on to key staff listed in the health manager section below.

2. **PNP/RN will:**

   a. Contact parent to initiate and ensure completion of FOOD ALLERGY IMPLEMENTATION PLAN for all identified children
b. If child has history of anaphylaxis, PNP/RN will obtain immediate order from physician to identify specific allergies and medical treatment (verbal or written – if verbal, to be followed by written) using the CHILDREN with SPECIAL NEEDS or ANAPHYLAXIS FOOD EVAL FORM.

c. If child has a disability requiring menu accommodations, the PNP/RN will send to the MD the CHILDREN with SPECIAL NEEDS or ANAPHYLAXIS FOOD EVAL to be completed and signed by licensed physician.

d. PNP/RN will call child’s teacher and route FOOD ALLERGY IMPLEMENTATION PLAN to the Health Manager.

e. Schedule site staff training for EpiPen use (per teacher’s request).

3. Dietitian will:

   a. For all children with food allergies, RD will clarify food allergy implementation plan as needed and develop food allergy communication sheet.

   b. Communicate this information by fax to 608-275-6756 or email Attn: Health Manager.

   c. For all I/T with allergies, develop alternative menu identifying all foods child cannot eat, and specifying appropriate substitutes using master menu for that age group within the time frame of 24-48 hours.

   d. RD will do individualized NSP training as needed.

   e. Edit food allergy order form as needed

4. Teacher will:

   a. Be aware of food allergy and required substitutes. For children with severe allergic reactions, discuss with PNP/RN or Health/Nutrition Manager specific classroom accommodations and notifications needed – including whether any food not prepared at DCPC will be allowed.

   b. Teacher will develop communication plan with NSP to ensure correct food is provided for each meal.

   c. With parental permission, photograph the allergic child, and place the picture on the FOOD ALLERGY IMPLEMENTATION PLAN from PNP/RN.

   d. Place the FOOD ALLERGY IMPLEMENTATION PLAN in designated location in the Yellow Health Action Binder.

   e. Add the child’s name, allergy info, and small photo to Class Allergy Form

   f. Be responsible when snacks are brought into classroom to ensure safety regarding the child’s allergy. Teacher may wish to send letter to parents regarding the food allergy.

   g. Incorporate specific children’s food allergy status into site orientations for new staff, substitutes and volunteers. This is to ensure that every adult involved with children and food is aware of the specific problems.

   h. Schedule site staff training with PNP/RN for EpiPen and ensure EpiPen is in the med box.
i. Ensure that all staff providing services has proper NSP training.

5. NSP will:
   a. Prepare the food ensuring that substitutions are made for identified allergies and ensure no cross-contamination with allergens in preparation or transport.
   b. Order food allergy foods two weeks in advance along with supply orders as needed (using food allergy order form).
   c. Check ALL ingredient lists to check for allergens. If no ingredient list arrives with a product, do not serve the food.
   d. Each site will create an NSP Allergy Action Plan to address who will be responsible for reading the ingredient labels. The NSP Allergy Action Plan will be readdressed at each NSP training.
   e. The NSP and the second individual required to check the ingredient labels will complete the Inventory Allergy Ingredient List and Substitution twice a week as inventory arrives and submit them with production records every Friday.
   f. Participate in classroom curriculum activities relating to food allergies.
   g. Have available a DCPC “emergency allergy free meal” to be used for unexpected circumstances – request this from Food Manager.
   h. Post first name, program, and picture of children with food allergies in an obvious location with a cover sheet.
   i. NSP will develop communication plan with teacher to ensure correct food is provided for each meal.

6. Food Manager will:
   a. Purchase and distribute allergy free foods from approved list as requested.
   b. Contact the Health/Nutrition Manager to check-in allergy free foods.
   c. Work with NSPs to ensure each site maintains an “emergency allergy-free meal”.

<table>
<thead>
<tr>
<th>Breakfast/Snack</th>
<th>Lunch</th>
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<tbody>
<tr>
<td>Rice Chex</td>
<td>Rice</td>
</tr>
<tr>
<td>Small jar applesauce</td>
<td>Canned Chicken (with water only)</td>
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<tr>
<td></td>
<td>Canned Green Beans</td>
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</tbody>
</table>

d. All food sent to the site will have ingredient labels.

7. Site Director will:
   a. Review posting of Class Allergy Form monthly in classroom and kitchen
   b. Review Food Allergy/Intolerance Action Plan in yellow Health Action Binders
   c. If a child with food allergies will be transferring to another program, the site director must either fax or email the FOOD ALLERGY IMPLEMENTATION PLAN to the
PNP/RN and Health Manager prior to the transition.

d. If a child is starting new in a classroom, the site director will check Child Plus to see if any food plan is listed. If the site director has the child’s file, they may check the file for more information in addition to reviewing Child Plus.

e. Site Director will orient all staff substitutes to site specific communication plans between the NSP and the individual program.

8. **Health Manager will:**

   a. Distribute food allergy communication sheet to the RD, classroom staff, NSP, Site Director, and Food Manager.
   
   b. Scan and email the dietitian the Food Allergies/Intolerances Action Plan. RD will determine foods to avoid and foods to substitute, based on review of current menu.
   
   c. Enter data from the Food Allergy Implementation Plan into Child Plus.
   
   d. Check ingredient labels for allergy free foods and place labels with initials.
   
   e. Please contact Health Manager with any questions related to food allergies.

9. **Teaching/NSP substitutes will:**

   a. Substitutes will review the Yellow Health Action Binder for food allergies.
   
   b. Substitutes will always ask about children in the class with food allergies.
   
   c. Substitutes will go to designated area and review class allergy forms.
   
   d. Speak with kitchen staff as to how safe food for children with food allergies will be presented at meal times.

**Failure to follow necessary protocol will result in disciplinary action up to termination**

PNP/RN: Nurse

RD: Dietitian

NSP: Nutrition Service Provider

ESCS: Enrollment Specialist/Child Services
<table>
<thead>
<tr>
<th>Photo/Name</th>
<th>Allergy</th>
<th>Signs or Symptoms</th>
<th>What to Do</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
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</table>
NSP Allergy Action Plan

1\textsuperscript{st} Checker_______________________________ Time of day___________________
2\textsuperscript{nd} Checker_______________________________ Time of day___________________
Substitute Checker_______________________________ Time of day___________________

Action Plan:

______________________________________________________________________________
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1\textsuperscript{st} Checker Signature_______________________________ Date________
2\textsuperscript{nd} Checker Signature_______________________________ Date________
Substitute Signature_______________________________ Date________
Site Director Signature_______________________________ Date________

*Please bring a new updated form to each NSP meeting
**Inventory (Allergy Ingredient) Check and Substitutions**

**Purpose:** For Nutrition Service Providers to outline specific kitchen plan to inspect ingredients, make secure substitutions in order to ensure the safety of children.

Date ________________  
1<sup>st</sup> Checker______________________________  
Site__________________

Time ________________  
2<sup>nd</sup> Checker______________________________

<table>
<thead>
<tr>
<th>Meal</th>
<th>Allergy</th>
<th>Class</th>
<th>Child’s Name</th>
<th>Product</th>
<th>Substitution</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Checker</th>
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1<sup>st</sup> Checker Signature________________________________________  
2<sup>nd</sup> Checker Signature________________________________________

Site Director Signature________________________________________

*Please send form with production records each Friday*
DCPC Non-Food Allergies Procedures – Updated 2007

Insect bites, pet dander, etc.

1. Non-Food Allergy is identified from the Health Condition Alert form – EpiPen Prescribed
   If non-food allergy is identified that requires the child to have an EpiPen at the center, PNP/RN or Health/Nutrition Manager must be contacted immediately and talked with, please don’t leave a message. Be prepared to tell PNP/RN/Health Nutrition Manager the best way to reach the parent (including phone numbers).
   a. Staff must obtain signed Health Consent for provider who diagnosed allergy and forward immediately to PNP/RN (for children with history of anaphylaxis or disabilities that impact the allergic condition).
   b. Staff must complete Medication Authorization Form with parent/guardian and plan for receipt of EpiPen.
   c. The site director must also be told of the allergy(ies) prior to the child’s start date.

2. Non-Food Allergy is identified – no EpiPen
   Forward the Health Condition Alert form to the assigned PNP/RN.
   a. Add child to posted CLASS ALLERGY FORM.
   b. Ensure all involved staff are aware of the child’s allergies and exposure action plan.
   c. The site director must also be told of the allergy(ies) prior to the child’s start date.

3. For non-food allergy requiring EpiPen, Teacher will:
   Be aware of allergy and symptoms of exposure.
   a. discuss with PNP/RN or health manager specific classroom accommodations and notifications needed for children with severe allergic reactions,
   b. With parental permission, photograph the allergic child, and place the picture on the ALLERGY Non-Food ACTION PLAN from the PNP/RN
   c. Place the ALLERGY ACTION PLAN in the Yellow Health Action Binder.
   d. Add the child’s name, allergy info, and small photo to Class Allergy Form
   e. Incorporate specific children’s allergy status into site orientations for new staff, substitutes, and volunteers. This is to ensure that every adult involved with children is aware of the specific conditions and potential problems.
   f. Be responsible when allergy inducing items are brought into classroom or the children are outside to ensure safety regarding the child’s allergy.
   g. Ensure the TA is aware of all allergies and necessary action plans.

4. For non-food allergy requiring EpiPen, PNP/RN will:
   a. Contact staff and/or parent to initiate and ensure completion of ALLERGY NON-FOOD ACTION PLAN
   b. If child has history of anaphylaxis, PNP/RN will obtain immediate order from physician to identify specific allergies and medical treatment (verbal or written – if verbal, to be followed by written).
   c. PNP/RN will call child’s teacher and date/route copies of ALLERGY ACTION PLAN to:
      i. Teacher - responsible to ensure that an epi-pen is available, if prescribed. Also responsible to ensure all staff are aware of allergy and action plan.
      ii. Parent
      iii. Master File (original)
   d. Submit ALLERGY ACTION PLAN to data entry (Data will enter plan date)
e. Schedule site staff training for EpiPen use (as needed).

**HUMAN BITES: First Aid**

There are a tremendous number of bacteria in the mouth. Human bites can become infected very easily. Bites can be either very superficial (indentation marks), abrasions, bruises, puncture wounds or lacerations (cuts). To care for these wounds and to reduce the chances of infection, the following steps are expected:

**INITIALLY**
1. **Intervene immediately:** Stay calm – don’t overreact or yell or give a lengthy explanation. Find out what happened? Who did it? Where are they now? Follow behavioral procedures listed later.

2. **Check the wound.** Where is the bite wound? Is there a break in the skin? Is it bleeding? How big is it? Check the mouth of the biter, was there blood-to-blood contact?

3. **Provide treatment** for bite:
   a. **If no break in skin:** Cleanse the wound thoroughly with soap and water to remove saliva. Flush the bitten area with running water for 5 minutes. Apply gauze square and tape to area, loose enough so that air can reach surface. Apply ice to bite area.
   b. **If there is a break in skin:** Cleanse the wound thoroughly with soap and water to remove saliva. Flush bitten area with running water for at least 5 minutes. If the wound continues to bleed despite holding pressure, the child should be taken to the doctor right then. Apply a gauze dressing to area. **If the wound is involving blood to blood contact, you must inform the parent immediately and tell them that the child should be taken to the doctor that day.** A staff person may need to go with the child. DCPC will pay for this doctor’s visit. Check the status of the bitten child’s tetanus immunization (same as DPT). If not up to date, the child must receive a tetanus shot within 72 hours of bite. Do recommend parents contact their health professional if the skin is broken, as preventive antibiotics may be indicated.

4. If staff is bitten and there is a break in the skin, s/he should contact their primary provider or the Agency Occupational Health Clinic (through Human Resources) for guidance. S/he should complete the Exposure Incident Investigation Report and record the injury in the medical log, including First Aid given.

**AFTERCARE**
1. As with all incidents that occur when a child is under our care, the parents must be notified about the occurrence. Let them know what happened, but do not name or label the child who bit. Reassure them by telling how you handled the incident and wound. The victim’s parent should be told to have the wound checked by their regular doctor.
   a. Notify the parents of both children if the bite causes bleeding. Instruct them to consult with their child’s health care provider for any needed follow-up.

2. **An accident form and medical log entry must be filled out for the victim,** and just a medical log entry for the biter. Each child (the biter and the victim) should each have separate entries in medical log – only one name per entry. The victim’s entry should include the 1st aide given (see above)
3. Teach parent and child signs of infection to watch for: redness, pus, extreme pain or tenderness, warmth, fever or red streaks leading from wound. If any of these signs or symptoms occur, tell the parent that the child must be taken to the doctor. You should also continue to watch for these signs for several days.

4. Teach the parent to care for the wound.

   If no break in skin: The skin should be inspected and washed daily with soap and water.

   If there is a break in skin: The doctor should provide specific instructions regarding wound care. If not, the wound should be washed daily and antibiotic ointment applied by the parent to prevent infection. Apply gauze dressing, loose enough so air can reach the surface.

Please see the Mental Health section for further guidance on responding to biting.
If biting continues, consult PNP/RN/Health and Nutrition Manager to rule out underlying medical issues. Also contact the site director for support and consider a referral to the ITHAD team or PBST.

Procedure for Controlling the Spread of Infectious Disease

Prevention and control of infections in child care settings are influenced by the caregivers’ personal hygiene practices and immunization status, environmental sanitation, food-handling procedures, ages and immunization status of the children, ratio of caregivers to children, physical space and quality of facilities and the use and frequency of antibiotics in child care.

“The best weapons against increased risk of infection in child care are hand washing, surface sanitation, immunization …” Susan Aronson, MD, Healthy Child Care America, Winter 2001

PREVENTION

Prevention of Exposure to Blood and Bodily Fluids

All staff will receive training in routine precautions to prevent transmission of blood-borne pathogens. DCPC Human Resources monitors this training. The following precautions are meant to provide simple and effective precautions against the transmission of disease for all persons potentially exposed to blood or body fluids in the classroom or on the bus. The procedures for handling body fluids apply in all situations, regardless of the health status of the child involved.

Standard Precautions: is the term used to describe the procedures which will be followed at all times when there is potential for exposure to any and all body fluids, secretions, and excretions, except sweat. The practical rule of thumb is if it is wet and human, use barriers. See DCPC Cleaning, Sanitation, and Disinfection Checklist which should be completed by Teachers with program staff in Oct, Feb, and June annually, and placed in Health Action Plan Binder.

The body fluids of all persons should be considered to contain potentially infectious agents. The term “body fluids” includes: blood, semen, drainage from scrapes, cuts and open lesions, feces, urine, vomitus, respiratory secretions (e.g. nasal discharge) and saliva. Contact with body fluids presents a risk of infection.

It must be emphasized that the body fluids with which one may come into contact usually contain many organisms, some of which may cause disease. Furthermore, individuals who have no symptoms of illness may carry many infectious agents. These individuals may be at various
stages of infections: incubating disease, mildly infected without symptoms, or chronic carrier of certain infectious agents such as carriers of hepatitis viruses.

The Occupational Safety and Health Administration (OSHA) requires workers who might come into contact with blood and other body fluids to practice the following: (see Blood Borne Pathogens Control Plan)

1. **Hand washing**…see Hand washing policy later in this section

   **Remember: wearing gloves does not mean that you don’t have to wash your hands!**

2. **Gloves should be worn:**
   - During contact with blood or body fluids which may contain blood (i.e.: vomit or feces)
   - During diapering, or assisting a child with toileting
   - When staff have cuts, scratches, or rashes which may cause breaks in the skin of their hands

3. **Environmental Disinfection** should be done regularly and as needed. In the child care setting, this means cleaning toys, surfaces, and diapering areas as scheduled (see DCPC Cleaning Sanitation, Disinfecting Checklist (#218) for more info.)
DAY-TO-DAY SANITATION AND DISINFECTING (#1 - #6)

1. **WI Child Care Licensing Requirements:**
   To **sanitize** means to reduce the bacterial count to safe levels. Sanitizers are used in food service areas.

   Bleach is a commonly used, approved sanitizer. DCPC has also approved a Quaternary Sanitizer for this purpose. (If using bleach for sanitizing, it must be prepared daily at 1 ½ T to 1 gallon of water.)

**Key Licensing Regulations regarding sanitation:**
1. Eating surfaces shall be washed and **sanitized** before and after each use.
2. Infant bottle and nipples may not be reused without first being cleaned and **sanitized**
3. All kitchen utensils and food contact surfaces used for preparation, storage or serving food shall be thoroughly cleaned and **sanitized** after each use.
4. For mechanical washing of dishes **sanitize** at 180º F
5. For hand washing, or home dishwashing machines… **sanitize** by submerging dishes and utensils for at least 2 minutes in a bleach/water solution
6. For washing in commercial spray type dishwashing machines using a chemical **sanitizer** in the final rinse, according to the manufacturer’s operating instructions

To **disinfect** means to destroy harmful germs. Generally disinfection is used to decontaminate surfaces which have come into contact with blood, feces, urine, vomit, etc.

Bleach is a commonly used, approved disinfectant. DCPC has also approved a quaternary sanitizer for this purpose. (If using bleach for disinfecting, it must be prepared daily at ¼ cup to 1 gallon of water). Note that it requires a much higher concentration for disinfecting).

**Key Licensing Regulations regarding disinfecting:**
1. Change each child on an easily cleanable surface which is cleaned with soap and water and a **disinfectant** solution after each use with a chlorine bleach solution of 1T bleach to 1qt water, made fresh daily…or another agency approved **disinfectant**
2. Remove soiled diapers from container as needed but at least daily for disposal. Containers shall be washed and **disinfected** daily
3. A crib or playpen shall be washed and **disinfected** between changes in occupancy.
4. A wading pool may be used if the water is changed and the pool **disinfected** daily

2. **Water Table and water table toys**
   In accordance with NAECYC accreditation standards of best-practice, and in an effort to minimize the spread of infections, water tables will be cleaned and sanitized daily.
   - After the end of each day’s use, drain the table
   - Wash the inside of the table and play things with a detergent soap and drain table again
   - Wash inside of table for at least 2 minutes with an agency approved sanitizer using a sponge or clean cloth being sure to touch all inside surfaces. Utensils and toys should be immersed in the mixture for 2 minutes, or run through a full cycle in the dishwasher with sanitizer
   - Drain the table and allow it to air dry overnight (do not wipe it dry). Air dry utensils. Refill the table in the morning.
• Additional precautions:
  o Have children wash their hands well with soap before and after using the table
  o Do not allow bubble blowing in the water
  o Do not allow children who have open wounds, rashes, band aids on their hands to use
    the table
  o If 2 or more children are diagnosed with an illness spread by “fecal-oral” or “close-
    contact means”, discontinue water table (and pool) use until after incubation period
    from the date of the last case.

3. Diapering Table
   Clean and disinfect the diaper-changing table after EVERY change. This is a two-step
   process. Spray the table using a bottle of soapy water. Wipe table with disposable towel.
   Toss. Spray with the disinfectant solution. Allow to air dry.

4. Food Preparation
   Refer to the Nutrition Section, and Hand washing policy for specific important details.
   The major source of food-borne illness from food handlers is a result of unwashed or
   poorly washed hands. Always wash hands thoroughly, even when gloves are used.
   Always exclude sick workers from food handling, particularly those with diarrhea,
   fever, infected wounds or nails, purulent conjunctivitis, etc. Food handlers with mild
   upper respiratory infections (colds, sore throats, etc.) should wear masks.

5. Hand-washing and Personal Cleanliness
   Hand washing and personal cleanliness are so critical to maintaining day-to-day sanitation
   and safety, a separate specific policy/procedure follows this policy.

6. DCPC Cleaning, Sanitation and Disinfection Checklist
   Maintaining a clean environment is a significant precaution against the spread of infectious
   diseases. OSHA requires, as part of the Blood-Borne Pathogens Control Plan, that agencies
   determine a cleaning/sanitizing schedule based on the type of area to be cleaned. The DCPC
   Cleaning, Sanitation, and Disinfection Checklist should be completed by program teams
   3x/year to protect both staff and children.

   Objects and Toys, which are dishwasher safe, may be disinfected by running through the
   complete dishwasher cycle. Cloth toys and play cloths can be disinfected in the washing
   machine with detergent and hot soapy water, followed by drying in a hot dryer.

   Objects that cannot be placed in the dishwasher or washing machine, should be disinfected
   by spraying with the disinfectant solution and allowing to air dry (i.e.: bouncy seats, blocks,
   etc.).
**DCPC Cleaning, Sanitation, and Disinfection Checklist**

*To be completed by program team (October, February, June) and filed in the Health Action Binder.*

<table>
<thead>
<tr>
<th>Program name/date:</th>
<th>Do we do it?</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Classrooms/Kitchens</td>
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<tr>
<td>Countertops/tabletops, floors are cleaned &amp; sanitized daily and when soiled.</td>
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<tr>
<td>Light switches, door and cabinet handles are cleaned and sanitized weekly and when soiled.</td>
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<tr>
<td>Before and after meals, tabletops are washed first with soapy water, wiped with disposable towel. Then sprayed with a sanitizer which is allowed to air dry.</td>
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<tr>
<td>Food preparation &amp; service areas are cleaned and sanitized before and after contact with food activity…and between preparation of raw &amp; cooked foods.</td>
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<tr>
<td>Carpets and large area rugs are vacuumed when children are not present.</td>
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<tr>
<td>Carpets are cleaned when children are not present, and allowed to dry before children return. (at least 2x/year in preschool rooms, at least quarterly in I/T rooms).</td>
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<tr>
<td>Small rugs are shook outside or vacuumed daily and laundered monthly (or more often if soiled).</td>
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<tr>
<td>Water tables are cleaned and disinfected daily (in accordance with the Procedure to Clean Water Table in the DCPC Policy &amp; Procedure Manual).</td>
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<tr>
<td>Toys or surfaces which have been in children’s mouths are cleaned and sanitized before the next use.</td>
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<tr>
<td>Surfaces which have been in contact with saliva or other body fluids are cleaned and disinfected immediately. Blood spill clean-up bucket is available.</td>
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<tr>
<td>Toys and dress-up clothes are cleaned weekly and when visibly soiled.</td>
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<tr>
<td>Bedding is cleaned weekly and when soiled.</td>
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<tr>
<td>Cots, cribs, &amp; crib mattresses are cleaned weekly, and before use by a different child, and whenever soiled or wet.</td>
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<td>Phone receivers are cleaned and sanitized at least 2x/month</td>
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<tr>
<td>Classroom waste containers are cleaned and sanitized weekly or when visibly soiled.</td>
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</table>

**Toileting & Diapering Areas**

Bathroom fixtures and sinks are cleaned & disinfected daily.
<table>
<thead>
<tr>
<th>Hand-washing sinks, faucets, surrounding counters, and soap dispensers are cleaned &amp; disinfected daily, or immediately if visibly soiled.</th>
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</thead>
<tbody>
<tr>
<td>Toilet seats, toilet handles, door knobs/cubicle handles are cleaned and disinfected daily, or immediately if visibly soiled.</td>
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<tr>
<td>Toilet bowls are cleaned and disinfected daily.</td>
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<tr>
<td>Changing tables and potty chairs are cleaned and disinfected after each child’s use. (2 step process)</td>
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<tr>
<td>Diaper containers are cleaned and disinfected daily or when visibly soiled.</td>
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</tbody>
</table>

**Other Cleaning**

- Mops and cleaning rags are cleaned and sanitized after each day of use by washing the mops and rags in detergent and water, rinsing in water, immersing in sanitizing solution. After cleaning & sanitizing, hang mops and rags to dry.
- If the center uses a plastic swimming pool, it will be cleaned and sanitized daily. Use cleaning procedure similar to recommended water table cleaning procedure.
- Tooth brushes are stored separately. (See toothbrush policy)
- Tooth brush holders are cleaned and disinfected monthly or when visibly soiled.

**Hand-washing**

- Liquid soap is available at each sink.
- Block or step stool is available at each wash basin
- Disposable paper towels are available and within children’s reach.
- Disposable tissues are readily available and consistently used for runny noses. Children are expected to wash hands after blowing his/her nose.
- Staff who primarily prepare food do not diaper children.
- Staff wash hands upon beginning work, and at all other times in accordance with the Hand washing/Personal Cleanliness Policy.
- Staff who prepare or help in food delivery wash hands well before food preparation.
- Staff regularly and consistently supervise the hand washing of children before and after meals and after toileting.
BODY FLUID SPILLS

When spills of body fluids, urine, feces, blood, saliva, nasal discharge, eye discharge, injury or tissue discharges, and human milk occur, these spills shall be cleaned up immediately, and further managed as follows:

1) For spills of vomit, urine, human milk and feces, (with no sign of blood or other potentially infectious material) all floors, walls, bathrooms, tabletops, toys, kitchen countertops and diaper changing tables in contact shall be cleaned and disinfected as for the procedure for diaper changing tables.

**Waste Management:** to clean spills of vomit, urine, feces (no obvious blood) use the sanitary agent/product specifically intended for cleaning fluid spills. Disposable gloves should be worn when using these agents. The dry material should be applied to the area. Leave it on for a few minutes to absorb the fluid and then vacuum or sweep up. The vacuum bag or sweepings should be disposed of in a plastic bag. The broom and dustpan should be rinsed in disinfectant. No special handling is required for vacuuming equipment.

2) **When visible blood (Blood that is drippable, pourable or flakeable), or other potentially infectious materials are present,** get Blood/Bodily Fluid Spill Clean-Up Kit and follow the directions contained in the bucket. In these cases, a disinfectant registered as a *tuberculocidal* by the EPA is required. (i.e.: bleach at 1T bleach to 1qt water, made fresh daily)

3) Floors, rugs, and carpeting that have been contaminated by body fluids shall be cleaned by blotting to remove body fluids as quickly as possible, then disinfected by spot-cleaning with the germicidal spray, and shampooing or steam-cleaning the contaminated surface.

4) Outdoor spills: Cleaning bodily fluid spills from dirt or grass is difficult, but since there is still a potential for exposure there are a few measures to take. The easiest step is to re-locate whatever outdoor activity caused the exposure and to block off the affected area.

The area should still be disinfected as completely as possible with a disinfectant solution by pouring 1oz. house bleach to 10 oz. of water. Flood the spill area with the bleach and water solution allowing it to stand for fifteen minutes and then thoroughly rinse with water. Take care to keep the exposed area contained. As with all blood cleanup procedures make sure to wear appropriate PPE and to dispose of it properly after cleanup.

Refer to Blood Spill Cleanup Procedure and BLOOD-BORNE PATHOGENS CONTROL PLAN
BLOOD SPILL/BODILY FLUID SPILL CLEAN UP PROCEDURE
FOR DRIPPING, POURING, and FLAKING BLOOD

(These directions are to be kept in Spill Clean-Up Kit Bucket)

Any surface or non-disposable item that has been contaminated with blood or other potentially infectious materials needs to be cleaned and disinfected.

1. Put on GLOVES before handling any bodily fluid
2. Open and put on goggles and gown, as needed
3. Get child safe (eg: off equipment, seated or lying down out of harm’s way)
4. Provide first aid and care for the child/staff in need and assign another adult to remove other children from the spill area
5. Clean up spill
   - Use paper towel to remove body fluids if small amount
   - Use absorbent product in the clean-up bag to solidify the spill if needed
   - Cover the spill completely with the absorbent powder
   - Pick up the solidified spill with shovel and place in red biohazard plastic bag
6. Remove all visible blood with detergent/soap and water. Use paper towels to clean. Rinse the area with clean water. Wipe the area with the germicidal Towelettes and let air dry. Place all used clean-up products in the red biohazard bag.
7. Floors, rugs, and carpeting that have been contaminated by body fluids shall be cleaned by blotting to remove body fluids as quickly as possible, then disinfecting by spot-cleaning the contaminated surface.
8. If the item is not disposable and is saturated, and belongs to the child (clothing), staff should contact the parent to determine whether to soak the item in the bucket with bleach solution for 30 minutes or to discard the item in the red biohazard bag.
9. Broken glass or other sharp items contaminated with blood are also bio-hazardous. Use the tongs and/or sweep these “sharps” and place them in the liquid detergent container. This container must be labeled as bio-hazardous
10. If gloves become soiled at any point, remove gloves and put on another pair.
11. After clean-up: remove gloves, discard in red biohazard bag, and securely tie the bag.
12. Call Health Manager to dispose of red biohazard bag.
13. Fill out Exposure Incident Investigation Form (#336) and return it to Human Resources.
HANDWASHING / PERSONAL CLEANLINESS

Germs can be spread on the hands of children and caregivers so frequent hand washing is recommended to prevent spread of both diarrhea and respiratory illnesses. The most important considerations for a successful hand-washing program are:

1. A consistent approach
2. A readily available supply of soap and water
3. Close supervision given to children when they wash their hands

Hand Washing Facts

- Friction and lather remove germs (bacteria, viruses, larger organisms) from skin.
- Hand washing should include soap and running water.
- Liquid soaps are less likely to be contaminated by handling than bar soaps. Liquid soap containers need to be disinfected before being refilled. Use a disinfecting procedure or put the container through a dishwasher using hot water and a hot drying cycle.
- Running water washes away loosened germs from the skin.
- Water should be free flowing, as from a faucet.
- Filled sinks or communal buckets used for rinsing hands further contaminate hands rather than rinsing away-loosened germs. This is unsafe.
- Cuts or cracks on hands provide a place for germs to grow.
  - Hand lotion pump containers should be readily available near the hand washing site for staff use after hand washing to reduce dry and cracked skin.
  - Cuts should be covered after washing and before caring for children or handling food.
- Fingernails and the area under them harbor many germs.
  - Keep fingernails trimmed short.
  - Wash under the fingernails at least two times each day, ideally after toileting or helping children with toileting.
  - Clean the nails of one hand with the fingernails while the running water rinses away the loosened germs.
- Unwashed hands are one of the most common sources for the spread of germs.
- Adults should wash their hands:
  - Upon arrival at the center
  - After either using the bathroom or assisting a child in the bathroom or changing diapers
  - Before preparing or serving meals/snacks/bottles
  - Before and after eating
  - After wiping a child’s nose
  - After coughing or sneezing into your hands
  - Before and after giving medications
  - After touching wounds with bare hands (always wear gloves when possible)
  - After smoking
  - After removing disposable gloves
  - After contacting a child’s body fluids including wet or soiled diapers, spit, vomit, etc
  - Whenever hands are visibly dirty or after cleaning up a child, the room, bathroom items or toys, or any other times deemed necessary
  - After cleaning or handling the garbage
• Kitchen staff/volunteers are to wash their hands
  o After arrival
  o Before beginning work responsibilities
  o After cleaning tables with sanitizing solutions

• Children shall wash their hands:
  o After toileting or diapering
  o Children’s hands and faces will be washed before and after meals
  o After coughing or sneezing into hands
  o Before and after involvement in sensory activities (playing with clay-like materials, playing in a water table, playing in sand, coming in from outside, etc.)
  o After playing with animals
  o Before they help prepare food or snacks
  o At other times deemed necessary e.g. whenever hands are visibly dirty or contaminated with blood or other body fluids

ALCOHOL-BASED HAND RUBS (liquid, gel, or foam-based hand sanitizers) will NOT be used. Most of these products say “Keep out of the Reach of Children” and will not be used in classrooms. Adults may use these products on their own hands after hand washing, but the containers must be kept high and out of reach of children at all times.

In accordance with Licensing, running water must be used to wash hands. If running water is not immediately available, alcohol-free wipes may be used. Children’s hands will be washed upon returning indoors, or as soon as running water is available.

**HANDWASHING PROCEDURE**

1. Turn water on with elbow control or hand control.
2. Wet hands thoroughly.
3. Apply soap from a dispenser
4. Lather well and move hands and fingers back and forth, paying attention to the thumb and areas between fingers. Wash the whole hand including the area under the fingernails, the wrists, and the back of hands, for at least 10 seconds.
5. Rinse hands of all remaining soap.
6. Drip hands downward into the sink.
7. Dry hands with a paper towel from a dispenser or with a clean, dry cloth towel individually assigned; or air dry.
8. Turn off faucet with the used towel.
9. Throw the used towel into a lined trash container.

**NOTE:** A hand washing poster or sign indicating “all adults must wash their hands before leaving the restroom” must be posted in each adult bathroom in a conspicuous location.
WET AND SOILED CLOTHING
Wet and soiled clothing will be changed promptly from an available supply of clothing. Wet and soiled clothing, according to child care licensing, cannot be rinsed, but will be placed in a plastic bag and sent home.

Non-latex gloves are provided for all staff to use when handling blood or bodily fluids. See Procedure for Controlling the Spread of Infectious Disease. Employees are kept informed of all new hygiene and cleanliness procedures.

CHILDREN WHO NEED HELP WITH HYGIENE
Staff are expected to assist a child as needed. Often, due to health and/or developmental issues, young children need assistance with properly and completely cleaning themselves after using the toilet. All children who need assistance with toilet hygiene will receive support in learning and maintaining toilet hygiene skills. In order to ensure the health and safety of children, a staff person will assist a child if needed. If a child needs diapers or pull-ups, please refer to the diaper changing policy DIAPERING PROCEDURE. For children who need assistance in cleaning themselves of fecal material, staff shall wear gloves and use wet paper towels or baby wipes to clean the child’s perinea area. The wipes/paper towels must be disposed of in the step-on covered wastebasket. Both children’s hands and staff hands must then be thoroughly washed.

Please note that there may be health reasons for soiling underpants, such as constipation, or developmental/emotional reasons that children have not yet learned to appropriately care for themselves after toileting. For whatever reason a child needs assistance, staff are to respond to children in a non-judgmental, calm voice.

If you have concerns or ideas about a child’s toileting needs, please contact your PNP/RN or Health/Nutrition Manager. For children with general hygiene issues, staff should discuss their concerns with their program supervisor, PNP/RN, parents, and others as appropriate before developing an action plan.

Diapering: staff should ask their site supervisor for the equipment/materials needed for diapering- step-on covered wastebasket, baby wipes, gloves, changing mat.
**DIAPERING PROCEDURES**

Diapers are changed routinely every hour-and-a-half to two hours, or whenever necessary. Caregivers follow strict procedures to ensure proper hygiene and sanitation during this process.

If the child requires the use of skin protective products during diaper changes (e.g., Desitin, Vaseline, etc.) a parent signed Medication Authorization form (#182) allowing DCPC staff to use these products must be completed. Powder is only used with a doctor’s order.

Note: Long-term medication authorizations, including diaper creams, are reviewed quarterly.

Preschool or child care classroom staff should request, from their Site Supervisor, the necessary diapering equipment and supplies whenever a child in the program needs diapering.

**Diapering and Toileting**

1. Change wet or soiled diapers and clothing promptly.

2. Clean and disinfect the diaper-changing table. This is a two-step process. Spray the table using a bottle of soapy water. Wipe table with disposable towel. Toss. Spray with disinfectant solution and allow to air dry.

3. If the diapering surface is above floor level, provide a barrier or restraint to prevent falling. A child may not be left unattended on the diapering surface.

4. Give child a verbal warning of time to change diaper. When you pick the child up, let them know what you will be doing.

5. Staff will wear clean, disposable gloves during each diaper change.

6. During changing talk to child about what you are doing, sing a song, talk about what child is doing or playing with today and what is going to happen next.

7. Clean child’s bottom with a baby wipe. Be sure to wipe from front to back.

8. Replace diaper

   a. Apply lotions or ointments to a child during diapering only at the specific written direction of the child’s parents or physician. The directions shall be recorded and posted in the diapering area. Parents must sign a Medication Authorization Sheet for each diaper ointment.

   b. Diaper lotions/ointments must be kept out of reach of children. Keep a list of children who need diaper lotions/ointments posted near diaper changing area.

9. Dress child; again talking about the steps you are taking.

10. Place disposable soiled diapers and gloves, in a plastic-lined, foot activated, covered container immediately. If cloth diapers are used, request a separate, foot operated container to hold soiled cloth diapers in labeled plastic bag. This is kept separate from other clothing.

11. Wash child’s and adult’s hands with soap and running water after each diapering or assistance with toileting routines. For children under one year, hands may be washed with soap and a paper towel or baby wipe.
12. After returning the child to play, spray changing table with soap and water and wipe with paper towel. Then spray with disinfectant and allow to air dry. Adult should then wash their hands with soap and running water.

13. Remove soiled diapers from containers as needed but at least daily for washing or disposal. Containers shall be washed with a single-use paper towel and disinfected daily.

14. Plan toilet training in cooperation with the parent so that a child’s toilet routine is consistent between the center and the child’s home, except that no routine attempts may be made to toilet train a child under 18 months of age.

**TOOTHPRESSING PROCEDURES**

According to Performance Standards 1304.23 (b) (3), staff must promote effective dental hygiene among children in a safe and sanitary manner daily. Oral hygiene will be a daily part of classroom curriculum and routine. Oral hygiene opportunities in the classroom are the foundation for each child’s oral health development and education.

**General Principles:**

All children will participate in their oral care according to their developmental abilities. Children will typically require some level of assistance with their oral care until 8 years of age.

Any surface of the tooth, which is not routinely brushed, will have plaque build-up, eventually leading to caries and/or gum disease.

All tooth surfaces need to be brushed (upper, lower, front, back, and chewing surfaces). Small, gentle, circular motions should be completed using a soft-bristled child-size brush angled toward the gums.

**Age/Developmental appropriate tooth cleaning:**

**Infants**

Teeth are cleaned, beginning with the eruption of the first tooth at about five or six months of age. Use a clean moistened gauze pad for infants less than one year, and switch to a toothbrush at one year. Use only water to clean the infant’s teeth (not toothpaste) since an infant will likely swallow toothpaste. Good oral hygiene is as important for a six-month old with one tooth as it is for a six-year-old with many teeth!

- Wash hands and glove hands
- Always speak to the child and explain what you are doing and why
- Daily wipe all surfaces of the gums with clean, moistened gauze
- Baby oral care should occur directly after one meal or snack per day
- Offer education to parents to do the same at bedtime
- Wash hands and change gloves between each child
- Staff are encouraged to serve as role models and brush their teeth in the classroom, using similar sanitary precautions
Child with teeth (1-2 years old)

- Wash hands and glove hands
- Children are unable to brush properly even when told, so prepare to assist and always speak to the child, explain what you are doing and why
- Do NOT use toothpaste for children under 1 year of age or developmentally not ready
- For children 1 year or older who are developmentally ready use a smear of fluoride toothpaste ¼ to ½ size of a pea.
- Parental permission to use fluoride toothpaste for 1 year old must be obtained.
- Toothpaste tube may NOT be placed to the child’s toothbrush. The toothpaste must be placed on wax paper squares or an easy to use small paper cup may be used to put toothpaste in
- Children must brush teeth after one meal or snack per day
- Brush all surfaces of the teeth with the assistance of the child
- Offer education to parents to do the same at bedtime
- Wash hands and change gloves between each child
- Staff are encouraged to serve as role models and brush their teeth in the classroom using similar sanitary precautions
- Follow toothbrush care procedure

2-3 year olds:

- Wash hands and glove hands
- Children this age are usually able to brush their front teeth and the sides of chewing surfaces. Always speak to the children and offer oral hygiene instruction.
- Use a flat ½ pea-sized smear of fluoride toothpaste
- Toothpaste tube may NOT be placed to the child’s toothbrush. The toothpaste must be placed on wax paper squares or an easy to use small paper cup may be used to put toothpaste in.
- Children must brush teeth after one meal or snack per day
- Children should spit out toothpaste, not rinse their mouth or swallow the toothpaste.
- Let children brush their own teeth and assist with missed surfaces
- Offer education to parents to do the same at bedtime
- Wash hands and change gloves between each child
- Staff are encouraged to serve as role models and brush their teeth in the classroom using similar sanitary precautions
- Follow toothbrush care procedure

3 – 5 year olds

- Wash hands and glove hands if necessary
- Children this age usually can brush their teeth quite well with daily instruction and assistance when offered or requested. Tooth brushing time must still be supervised.
- Children with disabilities are supported with any needed adaptations.
- Use a flat pea-sized smear of fluoride toothpaste
• Toothpaste tube may NOT be placed to the child’s toothbrush. The toothpaste must be placed on wax paper squares or an easy to use small paper cup may be used to put toothpaste in
• Children must brush teeth after one meal or snack each day
• Children should spit out toothpaste, not rinse their mouth or swallow the toothpaste.
• Let children brush their own teeth and assist with missed surfaces
• Offer education to parents to do the same at bedtime
• Encourage the parent to be the one to ensure a thorough brushing daily with the parent assisting the child with oral care until around age 8
• Wash hands and change gloves between each child as necessary
• Staff are encouraged to serve as role models and brush their teeth in the classroom using similar sanitary precautions
• Follow toothbrush care procedure

**Toothbrush Care Procedure**

Saliva, blood, bacteria and more can contaminate toothbrushes and transmit illness and infection. Maintaining toothbrushes and toothbrush holders in a proper way is critical.

- Every child will have his/her own-labeled toothbrush. (Include last name if needed).
- The hard surfaced holder must also be labeled with a permanent marker as to where each brush goes.
- The tube of toothpaste must never touch the brush. Place the paste on wax paper squares (not construction paper!) or on a small Dixie cup.

**Brushes:**

1. No toothbrushes should touch
2. Allow the brush to dry with free flowing air circulation (No individual bristle covers)
3. The holder should then be placed back in the mesh sleeve and stored where no objects are above the holder or can fall or drip onto the holder
4. Replace toothbrushes if bristles become badly chewed, toothbrush looks dirty or the child has infectious mouth disease (i.e.: strep throat).
   a. Minimally, 9 month programs will replace toothbrushes two times per year and 12 month programs three times per year.

**Holder:**

1. Label toothbrush slots with permanent marker
2. Racks used to hold toothbrushes shall be washed and sanitized monthly or whenever they are visibly soiled and after contamination with blood or bodily fluids (i.e.: sneeze).
AIDS/HIV POLICY AND PROCEDURES FOR ENROLLED PROGRAM PARTICIPANTS

Policy for enrolled participants
1. The Agency will not discriminate against HIV-infected children, parents, or other adult participants in the enrollment process.

2. The family needs of an HIV-infected child/parent or guardian will be evaluated using the same criteria as all other families.

3. All Centers and Programs shall provide a sanitary environment and establish routines for handling body fluids that are recommended by the Center for Disease Control (CDC).

4. On-going education and updates shall be provided to all staff, including volunteers when appropriate. Training will be provided to all staff annually regarding the nature, cause, transmission and prevention of Hepatitis B, HIV, and AIDS.

5. Testing
Mandatory screening for communicable diseases that are not spread by casual everyday contact (such as HIV infection) shall not be a condition for entry or attendance. A copy of these procedures shall be provided to every employee and reviewed annually. Training will be provided to all staff annually on effective sanitation and hygiene practices.

6. Infection Control
All employees and volunteers shall follow the procedures described in the Agency's Procedures for Controlling the Spread of Infectious Diseases and Communicable Disease Policy.

7. A copy of these procedures shall be provided to every employee and reviewed annually. Training will be provided to all staff annually on effective sanitation and hygiene practices.

Procedure for enrolled children
Each HIV-infected child shall have a decision-making Support Team. The Team shall consist of the child's parents/guardian, personal physician, the Agency's Health Manager, the program Pediatric Nurse Practitioner/Registered Nurse, Executive Director and a public health representative.

It is recommended the Lead Teacher of the classroom and/or Program Supervisor be on the Team; however, this decision shall be made by the parents/guardian. Any changes in the child's program, needed because of the HIV infection, shall be recommended and/or approved by the Support Team.

Evaluation of students infected with HIV
a. No child shall be removed from a classroom solely because she/he is HIV-infected. In the case of an HIV-infected person with a secondary infection (such as TB) that presents recognized risk of transmission, the Support Team shall be consulted.

b. The Team shall discuss ways that the Program may help anticipate and meet the needs of the infected child.
c. If there is no secondary infection, which constitutes a medically recognized risk of transmission, no alteration in program shall be made. The Health/Nutrition Manager shall periodically review the case with the Support Team.

d. Any consultation or notification outside of the Support Team must have the consent of the HIV-infected child's parent/guardian.

e. Confidentiality shall be observed throughout this process, defined as follows:

**Confidentiality**
The Support Team, as identified above, will be the only individuals made aware of the child’s HIV status. The parents/guardian may be encouraged to notify other personnel for support purposes; however, this is not required. Consent to notify persons other than those listed above must be given in writing by the parent/guardian.

All persons shall treat all information related to a child's HIV infection confidentially. No information pertaining to or in any way related to a child's HIV infection shall be divulged, directly or indirectly to any other individuals or groups (including other classroom/program team members) outside of those stated above.

- All medical information and written documentation related to a child’s HIV infection shall be kept by the Health/Nutrition Manager in a locked file. Access to this file will be granted only to those persons who have the written consent of the infected child's parents/guardian.

- To further protect confidentiality, names will not be used in documents except when this is essential. Any person who breaks confidentiality will be subject to dismissal according to the Agency's Personnel Policies.

**Procedure for Adult Program Participants**
If a parent/guardian disclosed his/her HIV status to staff, that staff person will discuss with the parent the need to involve the program PNP/RN. He/she will NOT discuss this with any other staff member. The PNP/RN and parent will determine the appropriate Support Team members. The Support Team, at the adult program participant’s discretion, may include the PNP/RN, assigned FA/FOW, public health representative, and personal physician.

All written documentation regarding this parent/guardian’s HIV infection will be maintained exclusively in a locked file in the PNP/RN’s office. Access to this file will be granted only to those persons who have the written consent of the involved adult participant.

All persons shall treat all information related to an adult participant’s HIV infection confidentially. No information pertaining to or in any way related to his/her HIV infection shall be divulged, directly or indirectly, to any other individuals or groups (including other classroom/program team members) outside of the parent decided Support Team. Any person who breaks confidentiality will be subject to dismissal according to the Agency's Personnel Policies.
AIDS/HIV PROCEDURES FOR STAFF

A. Education
1. All staff shall receive education on effective sanitation and hygiene practices.
2. The staff shall receive sufficient education to understand the nature, cause, transmission and prevention of Hepatitis B, C, Human Immune Deficiency Virus (HIV), AIDS-Related Complex (ARC), and Acquired Immune Deficiency Syndrome (AIDS). The education shall include the legal, social, and psychological aspects as they apply to the above conditions.
3. Whenever possible, this training shall be made available to parents and volunteers.

B. Evaluation of staff infected with HIV
1. No staff member shall be removed from their position solely because he/she is HIV infected.
2. In the case of an HIV infected person with a secondary (such as TB) which presents recognized risk of transmission, the Support Team shall be consulted.
   a. The Support Team shall consist of 1) infected employee, 2) Personal Physician of infected person, 3) Agency representative (Human Resource Manager), and 4) a public health official.
   b. This Team shall discuss ways the Agency may help anticipate and meet the needs of the infected staff member and any modifications needed while ensuring the Agency’s mandate to ensure the health and safety of all staff and participants.
   c. Failure by the infected employee to follow the Support Team recommendations will result in a recommendation for dismissal.
3. If there is no secondary infection which constitutes a medically recognized risk of transmission, no modification will be made. The case shall be periodically reviewed by the Support Team.
4. Confidentiality shall be observed throughout this process, defined as follows in Part C.

C. Confidentiality
1. The people who shall know the identity of the staff member who is HIV infected will be the Support Team.
2. The infected person may choose to notify other personnel for support purposes; however, this is not required.
3. Any consultation or notification outside the Support Team must have the written consent of the HIV infected staff person.
4. All persons shall treat all information related to a person’s HIV infection confidentially.
   a. No information pertaining to a person’s HIV infection shall be divulged directly or indirectly to any other individual or groups except those stated previously above in Section B.
   b. All medical information and written documentation related to HIV infection shall be kept by the Agency representative (Human Resource Manager) in a locked file.
   c. To further protect confidentiality, names will not be used in documents except when
essential.

d. Any person who breaks confidentiality will be subject to dismissal according to the Agency Personnel Policies.

D. Testing

1. Mandatory screening for communicable diseases that are not spread by casual everyday contact (such as HIV infection) shall not be a condition for employment or continued employment.

E. Infection Control

1. All employees and volunteers shall follow the Procedures for Controlling the Spread of Infectious Diseases for the handling of body fluids.

2. Training will be provided to all staff annually on effective sanitation and hygiene practices.
CHILD’S ACCIDENT/INCIDENT REPORT POLICY

A Child Accident/Injury Report will be filled out whenever an injury happens to an enrolled child while in the care of a DCPC program. Reports should only be filled out for the child that was injured. All information should be filled in completely. Parent or guardian should be notified the day of injury and the pink copy of the form should be sent home with the child that day. If a child receives any head injury, parent/guardian should be called immediately.

The form (white and yellow copies) is submitted to the site director within 24 hours of the accident. The site director will review/sign the form and submit BOTH copies to the Education and Compliance Manager. After review, the Education and Compliance Manager will return the yellow copy to be placed in the child’s file and file the white copy in the master file. The accident/incident reports will be tracked through a database system by areas children are injured in the classroom and the playground. Reports will be sent to site directors and classroom staff to discuss zoning for the classroom and playground to help prevent injuries.

Remember to record all injuries in the Medical Log.

Notify the Site Director, Education and Compliance Manager, and Health/Nutrition Manager the day the accident occurs if the child requires any medical attention. In addition, notify the nurse assigned to the program.

For accidents/injuries on site requiring professional medical treatment (such as but not limited to a broken bone, a burn, a contusion, a wound requiring stitches, or the ingestion of poison) the Site Director, along with the Education & Compliance Manager shall report the accident via email or phone call with supporting documentation to the licensing specialist within 24 hours.
# Child’s Accident/Incident Report

Complete at time of accident/incident and record in medical log book. For even a minor head injury, parents must be called immediately and encouraged to seek medical attention.

<table>
<thead>
<tr>
<th>Injured Child’s Name</th>
<th>Date of Birth</th>
<th>MT</th>
<th>DCPC Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian</td>
<td>Address (Street, City, Phone)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Accident Incident</th>
<th>Supervising Teacher</th>
</tr>
</thead>
</table>

|------------------|------|-------|----------|

<table>
<thead>
<tr>
<th>Specific Part of Body Injured</th>
<th>Time of Incident</th>
<th>Staff present:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Location where incident occurred</th>
<th>AM / PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Playground</td>
<td>Classroom</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1. Classroom Tracking</th>
<th>2. Outside Tracking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black area</td>
<td>Dramatic Play Area</td>
</tr>
<tr>
<td>Gross Motor Area</td>
<td>Climber</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cause of Injury</th>
<th>Estimated height of fall</th>
<th>Type of surface</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall to surface</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall from running or tripping</td>
<td>Bitten by child</td>
<td>Hit or pushed by child</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Describe in detail what happened</th>
<th>(Examples: punched (by object or child), scratched cut, collision with a child, bumped head)</th>
</tr>
</thead>
</table>

What did the wound/injury look like? Size of wound?

Describe first aid given:

Was child taken home due to injury? ○ No ○ Yes - By whom?

EMS (911) or other medical professional notified? ○ No ○ Yes

Conveyed to hospital? ○ No ○ Yes - By whom?

If medical treatment was needed, which program supervisor was contacted?

How/when: ______________ Date Licensing notified: ______________

Clinic Hospital:

Describe treatment provided by medical professional:

What steps, if any, will be taken to prevent a similar accident/incident?

Signature of Person Completing Form: __________________ Date: ______________

Lead Teacher Signature (if necessary): __________________ Date: ______________

Site Director Signature: __________________ Date: ______________

Ed. Compliance Manager Signature: __________________ Date: ______________

Follow up parent contact, if any:

Page in Medical Log Book: ________

206 (07/16)
MEDICATION IN THE CLASSROOM – (Updated 2008)
We encourage parents to administer medication at home whenever possible. On the rare occasion that medication must be administered at school, the Medication Authorization Sheet must be completed. All medications, creams, ointments, etc. need a signed Authorization Sheet before DCPC staff can administer any product. (Only soap, water, band aid, or ice can be applied without written parent permission)

1. The Medication Authorization parent letter will be given to the parent with the Medication Authorization Sheet attached.
2. Complete the Medication Authorization Sheet with the parent – review the directions on the medicine/ointment/etc. or the written health care professional’s recommendations to ensure the Authorization Sheet accurately reflects these dosing instructions.
3. Turn in yellow copy of Medication Authorization Sheet to program nurse immediately.
6. Keep all medications locked in specified medication box.
7. Immediately inform parents of any observations of changes in child’s behavior while taking meds; and review long term medication authorization and observations at least quarterly.
8. Return all medicines to parents when the length of time to administer is ended.

Wisconsin State Licensing Rules and Head Start Performance Standards Require:

1. Center staff may give prescription or non-prescription medication to a child only under the following conditions:
   a. A written medication authorization dated and signed by the parent/guardian is on file.
   b. Any prescription medication in the classroom must have a pharmacy prescription label containing student’s name, dosage, route, administration instructions, beginning and end dates, and date medication was filled at the pharmacy. If a pharmacy label is unable to be obtained, the medication must have a doctor’s medication order form including student’s name, date, dosage, route, administration instructions, beginning and end dates.
   c. Non-prescription medication must be in original container (labeled with child’s name) that includes the full instructions and dosage instructions. OTC medicines (other than topical emollients/barriers like Vaseline, Desitin) must have a written recommendation with specific written dosing instructions from a health care provider. See also Bug Spray/Sunscreen Policy for specific guidance for these products.
   d. All labels and dosing instructions must be dated within last 12 months and kept current.
   e. All medications, prescription or non-prescription, must be recorded on both the medication authorization form and medical log book. Documentation in the medical log book must include: child’s name, date, name of medication given, dosage, route, time, and staff member administering the medication. Only the application of sunscreen, insect repellent, diaper cream, and emollients do not need to be documented in the medical log book.
f. Note: DCPC staff will not administer any rectal medicines.

2. Staff must wash their hands before and after administering any medications.

3. All medication shall be labeled and stored under lock and key including those required for staff and volunteers. This is true for both prescription meds and OTC meds such as aspirin, cough drops, etc.

4. Medication requiring refrigeration shall be kept in the refrigerator in a separate locked, covered container clearly labeled "medication".

5. Program staff will maintain an individual record of all medications administered, including the amount of medication given, the time/date, and the initials of the person administering the meds.

6. Special circumstances, such as spills, responses, reactions, and refusals to take medication should also be recorded on the medication authorization sheet. If there are consistent problems with administering the medication to the child, contact the program nurse.

7. Teachers will review any long-term medication authorizations with the parents regularly (at least quarterly) including discussion of any observations noted while administering the medication. A new Medication Authorization sheet will then be completed.

8. Observations may include recording changes in a child's behavior that may have implications for drug dosage or type, and assisting parents in communicating with their physician regarding the effect of the medication on the child.

9. Medications must be administered according to the pharmacy medication label. If a parent requests medication to be administered in a different way than is listed on the label, a doctor’s note is required to indicate the change.

10. Medications needing more than 10 consecutive days of administration need a specific Health Action Plan describing why the daily medication is needed – involve the program nurse in this plan development.

11. Each program must communicate about medications. Lead Teachers are typically the designated staff member(s) to administer, handle, and store child medications. TAs/SNAS/FOWs are back-up designated staff and must be kept informed by the teacher of all current procedures (teachers may request assistance in training staff from their program nurse). Trained staff members should be noted on Health Condition Alert form and/or Health Action Plan, if necessary. Annually, the lead teacher plans, with the team, how staff will remind each other of medications that need to be administered. This plan is placed in the Health Action Binder.

12. EHS center based staff are to review all medication authorizations with their PNP/RN.

13. Prior to administering any over-the-counter medications and for oral/by mouth meds, staff must minimally review the Medication Administration Checklist. Staff with questions should contact their PNP/RN.

Training for all other medications (salves, ear/eye drops, epipens, nebulizers, etc.) will be individually reviewed with the assigned program nurse PRIOR to administration. Program staff are to contact their nurse or Health/Nutrition Manager whenever these meds are received at the site.
EHS FA who have children with on-going medications are expected to review this child’s meds with their assigned nurse to be sure the FA understands the administration expectations, side-effects, etc.

14. Program supervisors will ensure that designated staff members can demonstrate proper techniques for administering, handling, and storing medication, including the use of any necessary equipment to administer the medication.

15. Hands-on practice is important for all staff involved with the child, particularly for rescue medications. Program staff should do actual frequent practice on how to administer meds.

16. If a medication dose is missed or administered off schedule during the child’s time in care, staff must notify the program nurse, Health/Nutrition Manager, and parent/guardian.

17. EHS FAs will review meds with parents/guardians of assigned children in DCPC child care programs. FA’s will reinforce the expectation that meds are administered at home whenever possible. However, if it is necessary to give meds at the center, FAs will assist parents in understanding DCPC’s med policies.
MEDICATION ADMINISTRATION CLARIFICATION

To ensure safety of children:

Prescribed Medications:
Prescription medication is in the original container with a pharmacy prescription label or a doctor’s note with the child's name and the label includes dosage, beginning and end date, and directions for administration (physician's instructions). For medications such as vials used for nebulizers, a label from a pharmacist must accompany the vials to include name of child, name of medication, dosage, and frequency.

Over-the-Counter Medications:
All OTC medicines (other than topical emollients/barriers like Vaseline, Desitin) must have a written recommendation from a health care provider, which includes the dosing instructions. OTC medications must be in the original container, labeled with the child’s full name – with clearly visible dosing and warning directions.

PRN “as needed” Medications:
PRN medicines must have specific directions for administration (criteria for administering, dosing instructions/time between, etc.)

Storage and inaccessibility to children:
Medications of any kind need to be kept away from food, and stored in locked containers. This includes medications needed for staff and volunteers. If medication requires refrigeration, a small lock box designated and labeled for storing medication may be kept in the refrigerator.

Transportation of Medications:
Efforts should be made to minimize the transportation of medication. If medications do need to be transported, staff must ensure medicines are given to the bus monitor/TA or TS, and never left in children’s backpacks/etc. Staff then ensure medications are immediately locked upon arrival at the center.

Expiration Dates:
Staff must check the medicine’s expiration date – meds may not be used beyond the date of expiration on the container, or beyond the expiration of the instructions provided on the prescription label/written order.

EpiPens for Bee Stings
Staff will work with the parent to get an additional EPI PEN to be kept with an adult on the bus. Program staff should discuss with their PNP/RN the logistics of this.
Medication Authorization – Parent Letter

Dear Parent / Guardian:

We occasionally have a child come with a medication which needs to be given while the child is at the center. If medication is prescribed for a child once or twice a day, it is preferable that the medication be given at home. If the medication cannot be given at home, DCPC can give the medication with the following rules in place:

WHAT DO I NEED TO DO:

1. Medication cannot be accepted without a signed Medication Authorization Sheet. We cannot give any medicine or ointment at any time without written permission. 
   (authorizations are required for prescription medicines, over-the-counter meds, lotions, diaper creams, chapstick, sunscreen, bug spray, etc.)
2. Medication must be given directly to a staff person, never in backpacks, diaper bags or pockets.
3. Please allow time to discuss the medicine with the staff person and complete the Authorization, so staff are clear about the directions.
4. Each medicine (prescription or non-prescription) must be in the original container and clearly labeled with the child's name, name of medicine, dosage, directions for giving. All medications/ointments (except barriers or emollients) require a prescription label or healthcare provider’s order – including hydrocortisone cream, Tylenol, etc.
5. All labels and dosing instructions must be dated within last 12 months and kept current
6. If two children in the family are taking the same medication, each child must have their own properly labeled bottle/container.
7. If the dosage instructions are different than what the label says (prescription or non-prescription), the medication must be accompanied by a medical provider’s instructions.
8. Program/Center staff will give your child the medicine, in the correct dosage, at the designated time, for only the period of time specified.
9. Long-term medications (e.g. epi-pens, topical eczema cream, inhalers, etc.) will be reviewed (parent/teacher) quarterly to ensure no changes have occurred.
10. Medications that come as multiples (such as vials for nebulizers) must have a pharmacy label just like the label on the box. If you are not going to be bringing the box, ask your pharmacist to make this label for you to bring it to school.
11. If 2 attempts to reach the family have been unsuccessful, unused meds will be discarded 2 weeks after the child leaves the program.

WHY IS IT IMPORTANT FOR ME TO DO THIS?

Following the guidelines helps make sure your child will be given the medication safely.
Autorización de Medicación – Letra a los Padres

Estimados Padres/Guardianes:

En ocasiones tenemos un/a niño/a que ha venido con un medicamento que debe darse cuando el/la niño/a está en el centro. Si la medicación se receta para un/a niño/a que debe darse una o dos veces al día, es preferable que el medicamento se dé en el hogar. Si el medicamento no se puede dar en casa, DCPC puede dar el medicamento con las siguientes reglas en lugar:

¿QUE TENGO QUE HACER YO?:
1. Medicación no puede ser aceptada sin una forma de Autorización de Medicación firmada. No podemos dar ninguna medicina o pomada en cualquier momento sin permiso por escrito (se requieren autorizaciones para medicamentos recetados, medicamentos sin receta, lociones, crema para pañales, chapstick, protectante contra el sol, protectante contra insectos, etc.).
2. La medicación se debe dar directamente al personal, nunca en las mochilas, bolsas de pañales, o bolsas de los pantalones/chaquetas.
3. Por favor deje tiempo para hablar de la medicina con el personal y completar la autorización, por lo que el personal este claro sobre las instrucciones.
4. Cada medicamento (con receta o sin receta) deben estar en su envase original y claramente etiquetadas con el nombre del niño/a, el nombre del medicamento, dosis, e indicaciones para dar. Todos los medicamentos/ungüentos (excepto las barreras o emolientes) requieren una etiqueta de prescripción u orden del proveedor de servicios de salud, incluyendo crema de hidrocortisona, Tylenol, etc.
5. Todas las etiquetas y las instrucciones de dosificación deben fecharse en los últimos 12 meses y mantenidas en curso.
6. Si dos niños/as en la familia están tomando el mismo medicamento, cada niño/a debe tener su propia botella/contenedor etiquetado.
7. Si las instrucciones de dosificación son diferentes a lo que dice la etiqueta (con receta o sin receta), la medicación debe ir acompañada con las instrucciones de un proveedor médico.
8. El personal del programa/centro le dará a su niño/a el medicamento, en la dosis correcta, a la hora, solo para el periodo de tiempo especificado.
9. Medicamentos de tiempo largo (por ejemplo epi-pens, crema tópica para el eczema, inhaladores, etc.) serán revisadas (padres/maestros) cada tres meses para asegurarse de que no hayan ocurrido cambios.
10. Medicamentos que vienen en múltiplos (como viales para nebulizadores) deben tener una etiqueta de la farmacia igual como la etiqueta de la caja. Si no se va a llevar en la caja, pregúntele a su farmacéutico por etiquetas para que pueda llevarlo a la escuela.
11. Si intentamos hablar 2 veces con la familia y no tenemos éxito, los medicamentos que no fueron utilizados serán descartados 2 semanas después de que el niño/a deje el programa.

¿PORQUE ES IMPORTANTE QUE YO HAGA ESTO?
Seguir las directrices asegura que a su hijo/a se le dará la medicación en condiciones seguras.

181.1  (03/14)
MEDICATION AUTHORIZATION

Completion of this form meets the requirements of HFS 45.06(6)(a) 1., HFS 46.07(6)(b) 1. a. & HFS 53.44(6)(c) 1. a. Wis. Adm. Codes.

Instructions: Complete this form before any medication (prescription or over-the-counter) is administered.

Forward yellow copy immediately to PNP after parent/guardian signature.

Separate authorizations are required for each medication!

<table>
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<tr>
<th>Prog.</th>
<th>Child Name:</th>
<th>DOB:</th>
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Health Care Provider Recommendation attached (✓): or Date on prescription label:

*not required for OTC topical emollients/barriers (i.e. Vaseline, chapstick)*

<table>
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<tr>
<th>MEDICATION</th>
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<tr>
<td>Name of Medication Specificaly as on label</td>
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*note below the location the medication/ointment/cream is to be applied to skin

Administering Medication – Special Instructions and/or possible side effects.

1.

2.

I hereby authorize administration of the above medication to my child by staff of the program above.

SIGNATURE – Parent or Guardian | Date Signed

TO BE COMPLETED BY CENTER PERSONNEL each time a dose of medicine is given. Keep this record confidential in the Yellow Health Action Binder. Log the dates and times medication was administered in the center medical log. Complete bottom line and place white copy in child’s file when medication is no longer required/authorized.

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<tr>
<th>Date Given</th>
<th>Time Given</th>
<th>Person Giving Medication &amp; any comments</th>
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(continue on other side if necessary)

White – Child File/Site | Yellow – PNP/Master File | 182 (08/09)

Mods (circle): used up/date ___ returned to family/date ___ disposed of/date ___
MEDICATION ADMINISTRATION: CONTROLLED SUBSTANCES

A controlled substance is defined by the US Drug Enforcement Administration (DEA) as a substance that has been recognized under the Controlled Substances Act (CSA) as having potential for abuse that may lead to physical or psychological dependence. The effective use of controlled substances by children in Head Start has increased over the past several years.

We ask parents to administer medication at home whenever possible. If a controlled substance must be administered by program staff, the following procedures must be adhered to:

****Documentation of Controlled Substances is required on the top portion of the Medication Authorization Form and Controlled Substance Log.

Receipt of Medication
1. Contact nurse to confirm medication is a controlled substance. Obtain information about medication purpose and side effects. Use the following website to determine if medication is a controlled substance.
   http://www.deadiversion.usdoj.gov/schedules/index.html
2. Health Team member will complete Health Action Plan (Medication greater than 10 days) and provide staff education
3. Complete the Medication Authorization Sheet with the parent. Review the directions on the medicine or the written instruction of the health care professional to ensure the Medication Authorization Sheet accurately reflects the dosing instructions.
4. Turn in the yellow copy of Medication Authorization Sheet to program nurse. Keep the (current) Medication Authorization Sheet in the Health Action Binder
5. Site director must be informed within 24 hours of receipt of controlled substance medication.
6. Parent and two staff members must count the number of pills/capsules provided by the parent. Log the amount of medication upon receipt on the Controlled Substance Log form. Each staff member must date-and initial where indicated.
7. Attach Controlled Substance Log to Medication Authorization form
8. Medication must be locked at all times.
9. Medication delivery devices must be labeled with the child’s name and stored close to the medication box

Administration of Scheduled Medication
1. Administration of controlled substances can only be done by the following
   a. Site director
   b. Teacher
   c. Individual staff members trained by the health team
      i. Substitute and float staff are not allowed to administer scheduled controlled substances
2. Administer medications by checking the 5 R’s. Ensure the **Right Medication** is given to the **Right Child** using the **Right Amount** at the **Right Time** given by the **Right Route**.

3. Administration of controlled substance must be done by two staff members.
   a. Staff obtain prescribed amount of medication
   b. Count remaining amount of medication and document amount on controlled substance log
   c. ***Note if discrepancy is found. If discrepancy is found notify the Health Manager immediately
   d. Two staff members initial controlled substance log

4. Observe child taking medication

5. Monitor for side effects

**Administration of as needed medication**
1. Administration of as needed controlled substances can be done by the following
   a. Site director
   b. Teacher
   c. Individual staff members trained by the health team
      i. Substitute and float staff are allowed to administer as needed (rescue) controlled substances

2. Administer medications by checking the 5 R’s. Ensure the **Right Medication** is given to the **Right Child** using the **Right Amount** at the **Right Time** given by the **Right Route**.

3. Administration of controlled substance must be done by two staff members.
   a. Staff obtain prescribed amount of medication
   b. Count remaining amount of medication and document amount on controlled substance log
   c. ***Note if discrepancy is present. If discrepancy is found notify Site Director and Health Manager immediately
   d. Two staff members initial controlled substance log

4. Observe child taking medication

5. If administration of emergency as needed medication is given (Lorazepam) – send medication or empty container to hospital

6. If as needed medications are not used, medication must be visually inspected weekly and documented on controlled substance log by two staff members
   a. Weekly inspection schedule to be determined by classroom staff

**Accountability of Controlled Substance**
1. Controlled Substance must be brought to and picked up from DCPC site by child’s parent/guardian. Medication cannot be sent to school with a child or accepted on the bus route by a staff member

2. Documentation of daily medications must be done even if a child is absent or administration is not done by program staff (medication given at home)
3. If medication transfer takes place (school to home due to school absence) transfer must be accounted for on controlled substance log and signed by two staff members.

4. If child is not able to take daily medication at school (medication dropped or refused). Call parent and make a note on the controlled substance log.

DOCUMENTATION: Controlled Substance Log (PNP/RN will provide), Parental Consent & Waiver for Administration of Medication.
Parental Consent and Waiver
For Administration of Medication

I, _______________________ [parent or guardian] hereby give my permission to Dane County Parent Council, Inc. ("DCPC") to administer the medication(s) listed on Appendix A to my child, ____________________________________ [name and date of birth], attending ___________________________________________ [name of site and location] while in attendance at such program.

I understand that it is my responsibility to provide to DCPC the medication(s) to be administered. I further understand that it is my responsibility to immediately notify DCPC of any change in my child’s medication(s) which are to be administered by DCPC.

I understand that I can, at any time, revoke my consent, by notifying DCPC, in writing, not to administer any or all medication to my child.

I understand and agree that DCPC will only administer medications which are properly prescribed for my child and in their original prescription bottle or packaging, and that such administration will be in accordance with the written directions provided by the prescribing physician or other health care provider. I understand that such medication(s) will only be administered by qualified individuals who have been assigned such responsibility.

I further understand and agree to hold DCPC, its employees, agents, and insurers harmless from any and all claims relating to or arising out of the administration to or use of such medication(s) by my child. I understand and agree that this waiver of liability only extends to acts deemed to be negligent and does not constitute a waiver of liability for intentional or reckless acts.

Parent or Guardian’s Signature ________________________________       Date: ___________
**MEDICAL LOGS**

To meet state licensing requirements (DCF 251.07 (6)(f)) a written record is to be kept of the following:

1. Accidents or illnesses that occur while a child is in the care of the Agency.
2. Medications administered to any child.
3. Unusual marks, bruises, burns, etc. observed on a child, which occurred while not in the care of the Agency.

Each program will receive a bound book with pages, consecutively numbered and lined, in which to record all the above. It is the responsibility of all program staff to see that this log is accurately, promptly and neatly maintained. **The log is admissible in court as evidence.**

**Use the Medical Log to record the following:**

1. Any abnormal markings observed on the child received outside the class, while not in the custody of the Agency. “Each child, upon arrival, shall be observed by a staff person for symptoms of illness. Any evidence of unusual bruises, contusions, lacerations, and burns shall be noted . . . and reported immediately to the person in charge of the center.”
   
   a. Suspicion of abuse or neglect of a child must be reported to CPS and recorded on the Suspected Abuse and Neglect Report Form – not in the medical log book (See also Child Abuse/Neglect Policy).

2. Serious and minor accidents requiring any kind of first aid or medical treatment or any type of bump or scrape that may leave a mark on a child.

3. Any illness or accident to a child, received while in the care of this Agency. (Include how the accident occurred, what the wound looked like, and first aid administered and by whom).

4. Any prescriptive or non-prescriptive medication administered to a child. – See Medication Policy + Procedure

5. Any other pertinent and/or unusual occurrences that may have any significant effect upon the health or safety of any child or staff person.

6. Employee injury – call human resources dept. to fill out Employee Injury/Illness Report form within 24 hours of injury. If injury was inflicted by a child, the incident must also be recorded in the center’s Medical Log.

**How entries will be made in the Medical Log**

1. Pages and lines shall not be skipped. Entries shall be written from edge to edge of the page. Pages may never be ripped out of the book!

2. Entries shall be recorded in chronological order on a daily basis.

3. Entries shall be in blue or black ink, dated, and signed by the person making the entry. No entry may be "whited out". To correct an error, draw a line through the error and initial.

4. Pages are numbered and MUST NEVER BE REMOVED FROM THE BOUND BOOK.

5. All Logbooks are to be turned in at the end of each program year.

6. Entries shall include the child’s first and last name. **Only one child name per entry.** – If
two children are injured, each child must be listed in a separate entry.

7. In the entry, state how the parent was notified and how you attended to the child.

NOTE: See the Child Abuse Policy for further documentation of these observations on the Child Monitoring Sheet. Recording medications given or any accidents that happen in the Medical Log is done in addition to and not a substitute for, completion of the Medication Authorization Sheet and the Accident Report Form.

NOTE: THIS LOGBOOK IS CONFIDENTIAL and is to be kept locked up at all times. It is admissible in court as evidence. Entries should be kept current, accurate and neat. All logbooks will be reviewed/initialed at least two times per year by the site director or Ed. & Compliance Manager.

The agency nurses and/or health manager, the Education & Compliance Manager will also review log books when visiting or observing in programs.

**Other Medical Log Reminders**

- Any accident resulting in the death or serious injury requiring professional medical treatment of a child while in the care of the center must be reported to the site director and Ed. & Compliance Manager, who will report the accident to licensing within 24 hours.
- For any injury to the head or mouth, call the parent/guardian immediately.
- Medications, which are not in use and are not picked up by the parents, should be discarded in a manner which will not make them accessible to children.
- Remember to wash all injuries when the skin is broken and to document that the site was cleaned with soap and water. (See Blood Borne Pathogen Control Plan)
- Bites also need to be washed with soap and water regardless of whether the skin was broken because germs are involved. (See Human Bite Procedure)
- Medical/Injury logs must be reviewed every 6 months by the site director or Ed. & Compliance Manager in order to determine that all possible preventive measures are being taken. There is to be written documentation in the logbook that reviews have taken place. Corrections/issues are to be discussed with staff. It is appropriate to note the changes or errors in the log.
- The Program nurse and/or Health Nutrition Manager may also review the log book when visiting or observing in programs.
POLICY ON ANIMALS IN THE CLASSROOM – (updated 2009)
Pets in the classroom offer many benefits to the development of nurturing, responsibility and understanding of nature in children.Pets offer calming, therapeutic opportunities for children and can add much to the classroom environment. Nevertheless, animals can pose serious health risks. Any pet or animal present at the facility, indoors or outdoors, shall be in good health, show no evidence of carrying any disease, be fully immunized, and be maintained on a flea, tick, and worm control program. Teachers need to evaluate their class of children and determine if and what type of pet may be beneficial to their children based on the guidelines below:

1. The specific Parent Advisory Committee (PAC) must approve, in advance of the pet’s arrival, the type of pet and the duration of time to be spent in the classroom. Utilize DCPC Parent Voting Form.
   
   All parents of children using that classroom space at any time during the day must be made aware of the presence of pets/animals in the classroom. (WI CC Licensing 251.07(7))

2. The Teacher must clarify with all parents that no child has any fears or allergies toward the type of animal they wish to be the classroom pet.

3. The Site Director must ensure no child or staff has allergies to the pet, or increased asthma symptoms, due to the pet and/or its bedding.

4. The classroom pet may not be larger than a tame rabbit. Dogs and cats are specifically prohibited from DCPC programs as classroom pets.

5. The classroom Teacher must gain permission to have the pet from the landlord of building in which the DCPC classroom is located (if applicable).

6. The classroom staff are responsible to keep the animal's environment clean and odor free.
   - See Pet Living Quarters.

7. Programs will adhere to the State Licensing Code, which states:
   
   a. Pets suspected of being ill or infested with ectoparasites (external lice, fleas, and ticks) or endoparasites (internal worms) shall be removed from the Center.
   
   b. In the event that an animal bites a child, a veterinarian shall be contacted by the Teacher to determine a course of action in the diagnosis of possible rabies in the animal. Procedures for emergency care of the child shall follow. Parents shall be notified of all actions.

   c. Reptiles, amphibians, turtles, ferrets, skunks, psittacine birds, exotic or wild animals, poisonous animals, and baby poultry are prohibited in order to prevent salmonella, rabies, and poisoning.

   d. Animal pens and surrounding areas will be kept clean.
8. All contact between animals and children shall be supervised by the caregiver who is close enough to remove the child immediately if the animal shows signs of distress or the child shows signs of treating the animal inappropriately.

9. Visiting pets must be kept on a leash or in a cage and have updated shot record. If there is a bite from the visiting pet, the owner will have to provide a shot record. Notify parents in accordance with child accident procedures.

GENERAL GUIDELINES in the classroom

1. Children and adults must wash hands immediately after contact with animals, animal food/products, or the pet’s environment.

2. Children should not be allowed to kiss pets or put their hands or other objects into their mouths after handling animals.

3. A discussion of Animal Safety, Care, and Handling must be presented to every child in the class (i.e.: not to provoke or startle animals or touch them when they are near food, etc.).

4. Properly clean and disinfect all areas where animals have been present.

5. Disposable gloves should be used when cleaning fish aquariums, and aquarium water should not be disposed in sinks used for food preparation/drinking water, or the sink must be thoroughly disinfected before the next use.

PET LIVING QUARTERS

When animals are kept in the program, the following conditions shall be met:

1. The living quarters of animals shall be enclosed and kept clean of waste to reduce the risk of human contact with this waste.

2. Animal cages shall be of an approved type and shall be kept clean and sanitary. Aquariums shall be cleaned 1-2 times a month and as needed.

3. Animal litter boxes shall not be located in areas accessible to children.

4. Animal litter shall be removed immediately from children’s areas and discarded as required by local health authorities.

5. Animal food supplies shall be kept out of reach of children.

6. Live animals and fowl shall be prohibited from food preparation, food storage and eating areas.

DOCUMENTATION: PARENT VOTING FORM
Dane County Parent Council, Inc.
Head Start

PARENT VOTING FORM

The purpose of this form is to insure that all interested PAC/HSPC members have a chance to make their views known. This will help ensure that their HSPC Representative or PAC is acting on their behalf.

PERSON CONTACTING PARENTS: ____________________________

ITEM/ISSUE: ____________________________________________________________________________

_____________________________________________________________________________________

Program ____________________________ Date: ____________________________

HSPC Representative: ____________________________

<table>
<thead>
<tr>
<th>NAME</th>
<th>YES</th>
<th>NO</th>
<th>REASON/COMMENTS/IDEAS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

253 (08/13)
HEALTH SCREENING REQUIREMENTS FOR PRESCHOOL HEADSTART

Over the next several pages, each required health screening is defined along with specific DCPC required forms. These health screenings include:

- Physical Exam
- Hearing
- Immunization
- Growth (height/weight)
- Vision
- Dental Exam

Part 1 of 6 – PHYSICAL EXAM

Complete health and developmental screening is required of all children enrolled in the Head Start program. Teachers and Family Outreach Workers share the responsibility for assisting families to complete these health and developmental screenings. Current regulations require that all developmental, sensory, and behavioral screenings are completed with 45 calendar days of program entry.

Physical Exams

Head Start Performance Standards require that each child entering the program be up to date on a schedule of preventive health care as determined by a health professional. This means that each child must have a comprehensive physical exam ANNUALLY which meets the requirements of the EPSDT (Health check) program. Families are encouraged to establish an ongoing relationship with an appropriate, accessible medical care provider and to obtain regular preventive care from this provider.

Physical exam dates and results must be verified before program entry. If staff are unable to verify that a child has had a complete “well-child” exam within the previous 11 months, a physical exam appointment MUST BE MADE IMMEDIATELY as part of the enrollment process. If an immediate exam cannot be obtained from the child’s primary provider, staff must contact the program’s nurse to schedule an exam as part of the enrollment process. A copy of the physical exam is requested by the Program Facilitator after receiving an ISR from the FOW with the date of the well child, name of clinic, and the doctor.
# Physical Examination

**Sex:** M F

**Date of Birth:** __________

### Height

1. Vision: Both ________
   - R. Eye ________
   - L. Eye ________

2. Hearing (audiometry) ________
   - Normal ________
   - Abnormal ________

3. Immunization History:
   - DPT #1 ________ #2 ________ #3 ________ #4 ________ #5 ________
   - POLIO #1 ________ #2 ________ #3 ________ #4 ________
   - HIB #1 ________ #2 ________ #3 ________ #4 ________
   - PCV #1 ________ #2 ________ #3 ________ #4 ________
   - HEP B #1 ________ #2 ________ #3 ________
   - MMR #1 ________ #2 ________
   - VARICELLA ________
   - If had the disease (Date/Yr) ________

### Allergies

5. Does the child have a milk allergy? N Y substitute: ________

### Medication(s)

6. Medicaid policy requires lead testing at around 12mo & 24mo (or once between 3-5yrs if no previous test is documented). Date of most recent blood lead test: (mm/dd/yy) ________ result ________

## Examination - To Be Done By Physician or Nurse Practitioner

### Cooperate, Appearance, Posture, Gait

<table>
<thead>
<tr>
<th>WNL</th>
<th>ABNL</th>
<th>Describe Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Speech

Eyes

Ears, Canals & TM

Nose, Mouth, Pharynx, Teeth

Neck

Lungs

Heart (if murmurs**)

Abdomen

Genitalia

Bones, Joints, Muscles

Neurological

Other

**Is dental prophylaxis needed? □ Yes □ No** If yes, please provide prescription: __________

### Problem/Needs

2. Treatment Plan

<table>
<thead>
<tr>
<th>Follow – Up Arranged</th>
<th>A. Physical Activity</th>
<th>B. Diet</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Unrestricted □ Restricted</td>
<td>□ Unrestricted □ Restricted</td>
</tr>
</tbody>
</table>

**Explain:** __________

### Certification

3. I certify that I have examined the above child on this date and that he/she is able to participate in child care activities.

**MD/PA or HealthCheck Provider**

**Signature**

**Printed Name**

**Date of Examination**

---

Please Print Address of Clinic and Telephone Number Clearly

Dane County Parent Council, Inc., operating Project Head Start, is a non-profit corporation and does not discriminate in the administration of its programs.

**White – Child’s Master File**

**Yellow – Teacher**

106 (3/10)
HEALTH SCREENING REQUIREMENTS FOR PRESCHOOL HEAD START

Part 2 of 6 - IMMUNIZATIONS

Complete health and developmental screening is required of all children enrolled in the Head Start program. Teachers and Family Outreach Workers share the responsibility for assisting families to complete these health and developmental screenings. Current regulations require that all developmental, sensory, and behavioral screenings are completed with 45 calendar days of program entry.

Immunization Record

The Day Care Immunization form (232) must be completed including dates of shots and parent/guardian signature, or 232 is to be signed by the parent and have a copy of the WIR record attached.

If the parent/guardian has no record and the record cannot be obtained from the WI Immunization Registry, it will be necessary for staff to get consent form(s) from the parent for any/all clinics at which the child received shots. If up-to-date records cannot be obtained, the child may need to start the vaccination series over.

Minimum requirements for ENTRY into Head Start are:

- 4 doses of DTP (diphtheria-tetanus-pertussis)
- 3 doses of OPV (oral polio)
- 1 dose of MMR (measles, mumps, rubella) – must be after 1st birthday
- 3 Hep B
- 3-4 doses of PCV
- 1-3 doses of HIB (depending on child’s age when received, check with PNP/RN or health manager if unsure); 1 dose must be after 12 months of age
- 1 dose of Varicella (unless parent verifies child has had the chicken pox disease-be sure to indicate this on the form!)

Ask the parent for the immunization record. After recording it on the immunization form, check to see if the child has received the minimum number of doses required for entry. If shots are required, review the bottom boxes of the form with the parent. Parent must initial the applicable space.

Provide the family with the local immunization clinic schedule and try to develop a plan to obtain what is needed. Children must have documentation of immunizations on file within 30 calendar days to maintain their enrollment. If assistance is needed to give immunization information, contact the PNP/RN or Health Nutrition Manager.

Complete immunizations are REQUIRED for attendance in school and childcare. Please explain to parents this requirement and emphasize the importance of immunizations to parents/guardians.
**DEPARTMENT OF HEALTH SERVICES**  
**Division of Public Health**  
F-44152 (Rev. 06/05)  

**DAY CARE IMMUNIZATION RECORD**  
State law requires all children in day care centers to present evidence of immunization against certain diseases within 30 school days (6 calendar weeks) of admission to the day care center. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child’s day care provider or your local health department.

**PERSONAL DATA**  
**PLEASE PRINT**  

<table>
<thead>
<tr>
<th>Child’s Name (Last, First, Middle Initial)</th>
<th>Date of Birth (Month/Day/Year)</th>
<th>Area Code/Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)</td>
<td>Address (Street, Apartment number, City, State, Zip)</td>
<td></td>
</tr>
</tbody>
</table>

**IMMUNIZATION HISTORY**  
List the month, day and year the child received each of the following immunizations. Do not use a (0) or (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

<table>
<thead>
<tr>
<th>TYPE OF VACCINE</th>
<th>First Dose Month/Day/Year</th>
<th>Second Dose Month/Day/Year</th>
<th>Third Dose Month/Day/Year</th>
<th>Fourth Dose Month/Day/Year</th>
<th>Fifth Dose Month/Day/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria-Tetanus-Pertussis (DTP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hib (Haemophilus Influenzae Type B)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate Vaccine (PCV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles-Mumps-Rubella (MMR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Vaccine is required only if the child has not had chickenpox disease.

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

- [ ] Yes year _ (Vaccine is required)
- [ ] No or Unsure (Vaccine is required)

**REQUIREMENTS**  
The following are the minimum required immunizations for the child’s age/grade at entry. All children within the range must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day care must have their records updated with dates of additional required doses.

<table>
<thead>
<tr>
<th>AGE LEVELS</th>
<th>NUMBER OF DOSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 months to 15 months</td>
<td>2 DTP/DTaP/DT</td>
</tr>
<tr>
<td>16 months to 23 months</td>
<td>3 DTP/DTaP/DT</td>
</tr>
<tr>
<td>2 years to 4 years</td>
<td>4 DTP/DTaP/DT</td>
</tr>
<tr>
<td>Kindergarten entrance</td>
<td>4 DTP/DTaP/DT</td>
</tr>
</tbody>
</table>

1) If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

2) If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

3) MMR vaccine must have been received or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

4) Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

**COMPLIANCE DATA AND WAIVERS**  
If the child meets all requirements (sign at Step 5 and return this form to the day care center), or

If the child does not meet all requirements (check the appropriate box below, sign and return this form to day care center).

- [ ] Although the child has not received all required doses of vaccine for his/her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child within one year and to notify the day care center in writing as each dose is received.

**NOTE:** Failure to stay on schedule or report immunizations to the day care center may result in court action against the parents and a fine of up to $25.00 per day of violation.

- [ ] For health reasons this child should not receive the following immunizations _________ (List in Step 2 any immunizations already received)

  ____________________________________________________________________________

  Physician’s Signature Required

- [ ] For religious reasons this child should not be immunized. (List in Step 2 any immunizations already received)

- [ ] For personal conviction reasons this child should not be immunized. (List in Step 2 any immunizations already received)

**SIGNATURE**

To the best of my knowledge this form is complete and accurate.

_________________________  __________________________  232 (05/10)

**White - Master**  
**Yellow - Teacher**
HEALTH SCREENING REQUIREMENTS FOR PRESCHOOL HEAD START

Part 3 of 6 - VISION

Complete health and developmental screening is required of all children enrolled in the Head Start program. Teachers and Family Outreach Workers share the responsibility for assisting families to complete these health and developmental screenings. Current regulations require that all developmental, sensory, and behavioral screenings are completed with 45 calendar days of program entry.

Vision Screening

Acuity must be checked in each eye separately (covering the other eye). Training will be provided for staff needing it. Specific screening instructions are below.

Supplies:
1. Single LEA Symbols Visual Acuity Test Kit
2. Child Response Card
4. Dixie Cups
5. Chair/Table

Step 1: Preparing the Children for Screening
- Practice symbols during class time before the screening date.

Step 2: Set up Screening Area
- Place the lamp stand on a table or chair and turn the lamp on.
- Select the disk card appropriate for the age of the child to be tested.
- Slide the disk card for the child’s age in the slot on the lamp.
- Use the measuring cord to position the chair so that the card is 5 feet from the child’s eyes.

Step 3: Screening Procedure
1. Have the child sit in the chair.
2. A child with corrective lenses must be wearing them for the screening.
3. Cover the left eye with an occluder (use a clean Dixie cup for an occluder). Instruct child to keep both eyes open. If necessary the screener should hold the occluder to prevent the child from “peeking around” the occluder. A separate occluder must be used for each child.
4. Turn the wheel until the first symbol is in the window. After the child gives his/her response, rotate the wheel clockwise to the next symbol.
5. A child may identify the symbol by stating the name or by pointing to the matching symbol on the Child Response Card.
6. If the child gets 2 or more symbols wrong, stop and test the other eye.
   i. The critical line for 3-year-olds is 20/50
   ii. The critical line for 4-to-5-year-olds is 20/40
7. Repeat steps 3-6 the right eye covered with an occluder.
8. The screen should establish a code word, such as “okay” or “fine” to be used to signal the chart attendant when the child incorrectly identifies a symbol. Avoid stating “wrong” or “no”. Responses to correctly identified symbols have another response such as repeating the child’s name for the symbol. The code word is reserved for incorrect responses.

Step 4: Interpreting Results
- Correctly identifying three out of four symbols on the child’s critical line is a Pass.
- Incorrectly identifying two out of the four symbols on the child’s critical line is a Fail.
- A child who is uncooperative, refuses to participate in the screening or is cognitively unable to complete the screening is termed “Can Not Test”

Step 4: Recording Results and Follow-up
- Record results on DCPC form #373
- Scan complete form #373 and email to the Child Specialist Database Specialist and send complete form #373 via DCPC mail to Red Arrow
- A child who fails his first screening is rescreened within 1 month.
- A child who fails his second screening is referred to his primary care provider or an eye care professional. Parents will be sent a letter, DCPC form 296, explaining the screening results. In addition to the letter, parents will also receive a Vision Examination Report form, DCPC form 296a. This form should be taken to referral appointment, completed by the health care professional and returned to the Health Manager.
- A child who is repeatedly screened with the results “Can Not Test” can either:
  1) Be rescreened monthly or
  2) Be referred to his primary care provider or an eye care professional. Parents will be sent a letter, DCPC form 296, explaining the screening results. In addition to the letter, parent will also receive a Vision Examination Report form. This form should be taken to referral appointment, completed by the health care professional and returned to the Health Manager.
  o If a child is unable to complete a second attempt at screening, referring him to an eye care professional is the best course of action.
- A child who exhibits any of the ABC signs of potential vision/eye problems is referred to his primary care provider or an eye care professional. Parents will be sent a letter, DCPC form #296, explaining the screening results. In addition to the letter, parent will also receive a Vision Examination Report form. This form should be taken to referral appointment, completed by the health care professional and returned to the Health Manager.
**ABC of Potential Vision/Eye Problems**

**Appearance**
- Crossed eye
- Regularly watering eyes
- Red-rimmed, encrusted or swollen eyes
- Drooping eyelid
- White pupil
- Possible eye injury

**Behavior sign**
- Body rigid when looking at distant objects
- Thrusting head forward or backward while looking at distant objects
- Tilting head to one side
- Peeking past the occluder during vision screening
- Squinting or frowning
- Excessive blinking
- Closing or covering one eye
- Holding objects very close to one or both eyes

**Complaint Sign**
- Headache, nausea or dizziness
- Blurred or double vision
- Burning, scratching or itchy eyes
- Sees blur when looking up after close work
- Unusual sensitivity to light
# Dane County Parent Council, Inc
## Head Start Vision Screening Report

<table>
<thead>
<tr>
<th>Child’s name:</th>
<th>DOB:</th>
<th>Program:</th>
</tr>
</thead>
</table>

If child has glasses, screening should be done with the glasses on the child. Glasses Rx: Y N  Wearing: Y N

### Screening Results:

<table>
<thead>
<tr>
<th>Screening Date</th>
<th>Right Eye</th>
<th>Left Eye</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Screening Date:</td>
<td>20/____</td>
<td>20/____</td>
</tr>
<tr>
<td>2nd Screening Date:</td>
<td>20/____</td>
<td>20/____</td>
</tr>
<tr>
<td>3rd Screening Date:</td>
<td>20/____</td>
<td>20/____</td>
</tr>
</tbody>
</table>

A rescreen is necessary if: 1) a 3-year-old child scores 20/60 or worse in either eye. 2) a 4-to-5-year-old child scores 20/50 or worse in either eye. 3) a child exhibits any of the ABC of potential vision/eye problems.

**Needs to be rescreened:**  
- Yes  
- No (If yes, rescreen should be completed in one month)

**Needs to be referred:**  
- Yes  
- No

### ABC of Potential Vision/Eye Problems:

#### Appearance:
- Crossed eye
- Regularly watering eyes
- Red-rimmed, encrusted or swollen eyes
- Drooping eyelid
- White pupil
- Possible eye injury

#### Behavior Sign:
- Body rigid when looking at distant objects
- Thrusting head forward or backward while looking at distant objects
- Tilting head to one side
- Peeking past the occluder during vision screening
- Squinting or frowning
- Excessive blinking
- Closing or covering one eye
- Holding objects very close to one or both eyes

#### Complaint Sign:
- Headache, nausea or dizziness
- Blurred or double vision
- Burning, scratching or itchy eyes
- Sore or blurry when looking up after close work
- Unusual sensitivity to light

#373 (05/15)
Dear Parent/Guardian:

What is the concern?
All children in Head Start have their vision screened. The purpose of this screening is to check for vision problems. The results of your child’s vision screening are not within an acceptable range. The results do not necessarily mean treatment or glasses are needed, but we recommend you take your child for a professional eye examination.

The screening results for your child are:

Date: ______________  Right eye 20/___  Left eye 20/___
Date: ______________  Right eye 20/___  Left eye 20/___

Could not see the line on the chart appropriate for age.
Repeatedly unable to screen
Other symptoms:

This is only a screening. It is not a complete eye examination.

What do I need to do?
Please have the eye doctor complete the enclosed Vision Examination Report Form at the time of the eye examination. The form should then be returned to Head Start.

If your child has no medical coverage available and the cost of this exam is a problem please talk with your Family Outreach Worker or teacher.

Why is it important for me to do this?
If problems exist and are not corrected, your child’s learning could be affected.

If you have any questions or want further information, please call Melinda Froehlich, the Health and Nutrition Manager, at the Head Start office: 275-6740.
VISION EXAMINATION REFERRAL

This child was screened for visual acuity with a LEA Shapes chart and is referred for a professional examination because:

Screening Results: DATE: ___________ Right eye: 20/____ Left eye: 20/____
DATE: ___________ Right eye: 20/____ Left eye: 20/____

_____ Could not see age-appropriate line
_____ Symptoms of visual difficulty:
_____ Repeatedly unable to screen

Visual Examination Report -- To be completed by Examiner

Date of exam: ________________ Visual Acuity: Both ______ Right _______ Left ________

Did you find a problem requiring treatment and/or observations?

_____ Yes _____ No

If yes, please indicate concern: ____________________________________________

Glasses needed? _____ Yes _____ No

Recommendations for classroom teacher: ______________________________________

Follow-up date: __________________________

Name of Examiner: __________________________________ Title of Examiner: __________________________

Address/Clinic:

Please return to: Health Manager
Dane County Parent Council – Head Start
2096 Red Arrow Trail
Madison, WI 53711

298a (03/15)
HEALTH SCREENING REQUIREMENTS FOR PRESCHOOL HEAD START

Part 4 of 6 - HEARING

Complete health and developmental screening is required of all children enrolled in the Head Start program. Teachers and Family Outreach Workers share the responsibility for assisting families to complete these health and developmental screenings. Current regulations require that all developmental, sensory, and behavioral screenings are completed with 45 calendar days of program entry.

Hearing Screening

A thorough hearing screening is scheduled for all enrolled Head Start children annually at one of the Hearing Clinics (i.e.: UW Communicative Disorders Department, Green County Public Health, or DCPC nurses). Audiometric testing is conducted at frequencies of 1000, 2000, and 4000 HZ. A child fails the screening if she/he fails to respond at the recommended level (20 db HZ) in either ear. Audiometric screening requires the children to wear earphones and respond to specific frequencies in each ear. Children will benefit from instruction and practice with this process in the classroom prior to testing. Hearing screening results will be recorded on form #315.

Children who fail the initial hearing screening should be retested within one month. At the second screening, if a child fails pure tone testing, a tympanogram and visual inspection will be completed as well. If a child fails pure tone testing and passes tympanograms, they will return to the UW Communicative Disorders Department for diagnostic testing. If a child fails pure tone testing and fails tympanograms, it will result in a parent notification and a physician referral form for follow-up care. FOW’s are to work with the family to ensure completion of follow-up work. The health manager generates the letters to the parent/guardian explaining the results of the screenings. These are distributed to parents through the teacher/FOW. In addition, the Hearing Clinic completes a Hearing Screening Report indicating problems identified. This form should be taken with the child to the medical provider and returned to 2096 Red Arrow by the medical provider after the child has been seen. (See form #315 Hearing Screening Report and form #314 Parent Letter).

Ensuring that children with chronic ear problems receive treatment to eliminate these problems and hopefully to prevent their re-occurrence is a critical responsibility of Head Start staff and parents.
HEARING SCREENING ROSTER

Center: ___________________________ Teacher: ___________________________ Date: ___________________________

Place “X” in first screening box if today is first screening. If this is the second screening, place date of first screening in “first screening box”.

<table>
<thead>
<tr>
<th></th>
<th>Last</th>
<th>First</th>
<th>First Screening</th>
<th>Absent</th>
<th>Pure-Tone Pass/Fail</th>
<th>Imittance Pass/Fail</th>
<th>OAE Present/Absent</th>
<th>Comments</th>
<th>Refer to MD</th>
<th>Pass</th>
<th>Retest</th>
<th>CNT</th>
</tr>
</thead>
</table>
Dear Parents/Guardian

Results
All Children at Head Start are checked at the University of Wisconsin Audiology Clinic to see if any of the children have problems with hearing.

The screening results for your child are:

<table>
<thead>
<tr>
<th>Date:</th>
<th>Pass</th>
<th>Fail</th>
<th>CNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What do I need to do?
Please make an appointment with a medical provider to evaluate the cause of this problem within 7-10 days.

It is very important that you take care of this as soon as possible. At the time of the appointment, your medical provider can explain the screening results. Please take the enclosed “Hearing Screening Report” with you to the medical provider and ask him/her to complete the form and return it to Head Start.

If your child has no medical coverage available and the cost of this exam is a problem, please talk with your child’s teacher or Family Outreach Worker.

Why is it important for me to do this?
Most hearing or middle ear problems can be corrected by prompt medical care, but the child must be seen by a doctor. Early treatment of ear problems can prevent more serious problems. Untreated problems may affect your child’s learning and behavior.

If you have any questions about this, please contact the Health Manager, or one of the nurses at Head Start at 275-6740.
**Hearing Screening Report**

**Initial Screening Date:** ____________

<table>
<thead>
<tr>
<th>TONE SCREENING at:</th>
<th>Right Ear</th>
<th>Left Ear</th>
<th>Sound field</th>
</tr>
</thead>
<tbody>
<tr>
<td>20/40 HL (1000 Hz, 2000 Hz, 4000 Hz)</td>
<td>Pass</td>
<td>Fail</td>
<td>CNT</td>
</tr>
</tbody>
</table>

**Repeat Screening Date:** ____________

<table>
<thead>
<tr>
<th>TONE SCREENING at:</th>
<th>Right Ear</th>
<th>Left Ear</th>
<th>Sound field</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000 Hz, 2000 Hz, 4000 Hz</td>
<td>Pass</td>
<td>Fail</td>
<td>CNT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TYPANOMGRAM</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>L</td>
<td>_______</td>
<td>_______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OAE(S)</th>
<th>Present</th>
<th>Absent</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>L</td>
<td>_______</td>
<td>_______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VISUAL INSPECTION</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right ear</td>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>Left ear</td>
<td>_______</td>
<td>_______</td>
</tr>
</tbody>
</table>

Results: Pass _______ Fail _______ Rescreen _______

Comment: ____________

**Physician Otological Exam Reply**

Dear Doctor, this child was screened by U.W. Audiology and failed the hearing screening as indicated below. This child is referred to you for a medical examination to evaluate the cause of the hearing screening failure. Please complete the following and return to the address or fax at the top of the page. Head Start is willing to assist the family with follow-up if you inform us of what is needed. Thank you.

<table>
<thead>
<tr>
<th>OTOSCOPIC EXAMINATION</th>
<th>Right Ear</th>
<th>Left Ear</th>
<th>Impacted Cerumen</th>
<th>Right Ear</th>
<th>Left Ear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal Examination</td>
<td>_______</td>
<td>_______</td>
<td>_______</td>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>Otitis Media</td>
<td>_______</td>
<td>_______</td>
<td>Retracted Eardrum:</td>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>Perforated Eardrum</td>
<td>_______</td>
<td>_______</td>
<td>Ventilating Tube-open:</td>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>Ventilating Tube-plugged</td>
<td>_______</td>
<td>_______</td>
<td>Other:</td>
<td>_______</td>
<td>_______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tympanometry at your office:</th>
<th>Pass</th>
<th>Fail</th>
<th>CNT</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Tone screening at your office:</th>
<th>Pass</th>
<th>Fail</th>
<th>CNT</th>
</tr>
</thead>
</table>

**Treatment prescribed:** ____________

**Follow-up at your clinic:** Yes _______ No _______ Date for follow-up visit: ____________

Comments: ____________

**Date of Examination:** ____________
**Physician’s Signature:** ____________
**Print Name:** ____________
**Clinic/Address:** ____________
**Phone:** ____________

White: MD return only
Yellow: Master File 315 (03/14)
Child’s Name: ___________________________ Child’s Date of Birth: ____________
(last name, first name)

Program: ___________________________ Date: _________ Tester: ____________
(last name)

Audiometry
Condition the child to respond to the beeps at 60 dB HL. Once the child is responding consistently,
lower the level to 20 dB HL and begin testing. Test at 20 dB HL at all frequencies; 2 responses are
needed for a pass. Enter a P for Pass or R for refer in each box.

<table>
<thead>
<tr>
<th>Ear</th>
<th>1000 Hz</th>
<th>2000 Hz</th>
<th>4000 Hz</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Did the child pass the audiometry screening? ............................ Yes   No   CNT

CNT reason: ________________________________

If no, choose Refer for retest in 6 weeks.
If yes, choose Pass.

Follow-up

- Refer for retest in 6 weeks .................................................. Yes   No
- Pass ................................................................. Yes   No
Head Start Middle Ear and Hearing Screening
SECOND VISIT

Child’s Name: ___________________________ Child’s Date of Birth: __________
(last name, first name)

Program: ___________________________ Date: _______ Tester: _______
(last name)

1. Audiometry
Condition the child at 60 dB HL at 2000 Hz. Once the child is responding consistently, lower the level to 20 dB HL and begin testing. Enter a P for Pass or R for Refer in each box.

<table>
<thead>
<tr>
<th>Ear</th>
<th>1000 Hz</th>
<th>2000 Hz</th>
<th>4000 Hz</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Did the child pass the audiometry screening? __________________________ Yes No CNT
If no or CNT, proceed to step 2. If yes, proceed to step 4 and choose Pass.

2. Acoustic Immittance Measures

GSI 38

<table>
<thead>
<tr>
<th>ECV</th>
<th>Peak cm²</th>
<th>daPa</th>
<th>Ear</th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td></td>
<td></td>
<td>Right Ear</td>
</tr>
<tr>
<td>*</td>
<td></td>
<td></td>
<td>Left Ear</td>
</tr>
</tbody>
</table>

- Is Peak cm²/Compliance ≥ 0.3 cm²/ml?
  Right Ear: Yes No
  Left Ear: Yes No

- If flat and no peak (NP), is ECV/Ear Volume > 1.0 (cm²/ml)?
  Right Ear: Yes No
  Left Ear: Yes No

Maico MI 26

<table>
<thead>
<tr>
<th>Ear Volume</th>
<th>Compliance</th>
<th>Pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td></td>
<td>Right Ear</td>
</tr>
</tbody>
</table>

3. Visual Inspection
Report any abnormalities in outer and middle ear appearance.
Right Ear: Normal or Other: __________________________ Left Ear: Normal or Other: __________________________

4. Follow-up
- For refer on tympanogram, visual inspection, or ololscopy:
  Refer to physician and retest: Yes No

- For second CNT audiometry or refer on audiometry but passed tympanogram, visual inspection, and otolscopy:
  Refer for diagnostic testing: Yes No

- Pass: Yes No

White Copy: Master File
Yellow Copy: UW
318 (05/14)
HEALTH SCREENING REQUIREMENTS FOR PRESCHOOL HEAD START

Part 5 of 6 - GROWTH

Complete health and developmental screening is required of all children enrolled in the Head Start program. Teachers and Family Outreach Workers share the responsibility for assisting families to complete these health and developmental screenings. Current regulations require that all developmental, sensory, and behavioral screenings are completed with 45 calendar days of program entry.

Growth (Height/Weight)

All enrolled children need an accurate measurement of their height and weight as part of the assessment of their growth and nutritional status. Children will be first measured within 45 days of program entry. All children will be measured a second time, in January of each year. Children with a BMI over the 95th percentile will be measured a third time in April.

Weight Procedure
1. Use a scale for measuring weights.
2. Have child remove shoes.
3. Have child remove outer garments (i.e. coat).
4. Read the weight to the nearest ounce and record the measurement.

Height Procedure
1. Use a stadiometer or a wall mounted tape measure for measuring heights.
2. Have child remove shoes.
3. Children will stand on the floor with heels together, back as straight as possible and with heels, buttocks and upper part of their back touching the wall with arms at their sides. The line of vision should be perpendicular to the wall. The head piece of the stadiometer or a block squared at right angles should be brought to the crown of the head.
4. Read stature to the nearest 1/4" and record.

Height/lengths and weights are ideally taken by the same person each time for consistency in measurement. Record results on DCPC form #372 (Height and Weight Measurements Results).

Scan complete form #372 -and email to the Child Specialist/Database Specialist and send complete form #372 via DCPC mail to Red Arrow.

The child’s height and weight are used to calculate their body mass index (BMI). The BMI has been shown to be a reliable indicator for determining if children are under weight, at a healthy weight or overweight. Children with a BMI over the 95th percentile or a BMI under the 5th percentile will be referred. Children under the 5th percentile will be referred to their primary care provider. A letter will be sent to the child’s parents. A letter will also be sent to the child’s primary care provider, notifying him/her of the child’s BMI. Children above the 95th percentile will be referred to The Wisconsin Nutrition Education Program. A letter will be sent home to the child’s parent.
DCPC is participating in I Am Moving, I am Learning (IMIL), which is a Head Start initiative designed to promote healthy eating habits and increase opportunities for physical activity in our preschool classrooms.
HEALTH SCREENING REQUIREMENTS FOR PRESCHOOL HEAD START

Part 6 of 6 – DENTAL EXAM

Complete health and developmental screening is required of all children enrolled in the Head Start program. Teachers and Family Outreach Workers share the responsibility for assisting families to complete these health and developmental screenings. Current regulations require that all developmental, sensory, and behavioral screenings are completed with 45 calendar days of program entry.

Dental Exams

Each child is required to have an oral examination completed by a dentist EACH PROGRAM YEAR. This must be completed as soon as possible to allow time for completing any treatment identified. Parents should also be encouraged to complete six-month dentals as well, as this is the best practice for children’s dental care.

DCPC has several resources for dental care available for our children. Children without insurance coverage may be eligible for services through ACCESS Health Care Center. Access appointments should be coordinated through the Program Specialist. Children whose medical home is ACCESS must go there for their dental care as well, unless there are visible significant cavities.

In addition, we are fortunate to have wonderful partnerships with area dentists, who host “Dental Days” events for DCPC Head Start children. **Head Start is responsible for transportation and attendance. Preschool children attending a Dental Days event MUST be transported by the assigned staff person. Parents can/should be encouraged to accompany the staff and child and/or meet the staff person there**
Dental Examination – Form #104

Child’s Name: ____________________________

Date of Birth: ___/___/____  PROGRAM ____________

TO BE FILLED OUT BY CLINIC

<table>
<thead>
<tr>
<th>(Most Recent) Dental Examination &amp; Cleaning</th>
<th>(Most Recent) Dental Follow-up Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: <em><strong>/</strong></em>/____</td>
<td>Date: <em><strong>/</strong></em>/____ &amp; <em><strong>/</strong></em>/____</td>
</tr>
<tr>
<td>Work Completed on this Date</td>
<td>Work Done on this Date</td>
</tr>
<tr>
<td>Cleanings</td>
<td>Fillings</td>
</tr>
<tr>
<td>X-Rays</td>
<td>Crowns</td>
</tr>
<tr>
<td>Topical Fluoride Treatment</td>
<td>Hospital</td>
</tr>
<tr>
<td>Other (Specify)</td>
<td>Other</td>
</tr>
</tbody>
</table>

Is follow-up work from this cleaning & exam needed? (Please circle) Yes No
Has patient completed all needed treatment at this exam? (Please circle) Yes No

If yes, has follow-up treatment been arranged? (Please circle) Yes No
If no, has follow-up treatment been arranged? (Please circle) Yes No

Number of appointments to complete needed work: 1 2 3 4
Date(s) of upcoming appointments scheduled: ___/___/____ ___/___/____

Has patient missed any cleaning appointments? # ______ (Please circle) Yes No

Has patient missed any follow-up appointments? # ______ (Please circle) Yes No

How can Head Start assist this family? ____________________________

METHOD OF PAYMENT: (Please Circle) Medical Assistance Private Insurance

*D Billing Head Start Purchase Order # __________________

Dentist Name: ____________________________
Address: ____________________________ Phone: _______________
Dentist Signature: ____________________________

White: Master File 104 (04/2010)
DENTAL EXAM FOLLOW UP INFORMATION SHEET — PARENTS COPY

Work that is needed at follow up appointments:
(Trabajo dental que se necesita en las citas de seguimiento)

Scheduled for (Fecha de la cita(s)): _____/_____/______ at ________:______ am / pm

(Please ✓ those that apply)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filling(s)</td>
<td>Back Tooth Extraction(s)</td>
</tr>
<tr>
<td>(Empastes(s))</td>
<td>(Extracción de muela)</td>
</tr>
<tr>
<td>Caps/Crown(s)</td>
<td>Front Tooth Extraction(s)</td>
</tr>
<tr>
<td>(Funda/Corona(s))</td>
<td>(Extracción de un diente frontal)</td>
</tr>
<tr>
<td>Sealants</td>
<td>Spacer</td>
</tr>
<tr>
<td>(Selladores)</td>
<td>(Implantes dentales)</td>
</tr>
<tr>
<td>X-Ray(s)</td>
<td>Other</td>
</tr>
<tr>
<td>(Rayos X)</td>
<td>(Otra)</td>
</tr>
<tr>
<td>Hospitalization</td>
<td></td>
</tr>
<tr>
<td>(Hospitalización)</td>
<td></td>
</tr>
</tbody>
</table>

If Hospitalization Is Needed:
(Hospitalización necesaria)

Pre-Op Physical:

An appointment will need to be made with your primary physician before dental surgery can be completed.
(Uma cita tendrá que ser hecho con su médico decabecera antes de cirugía dental puede ser completada.)

Scheduled for (Fecha de la cita(s)): _____/_____/______ at ________:______ am / pm

Dental Surgery:

Scheduled for (Fecha de la cita(s)): _____/_____/______ at ________:______ am / pm

Hospital: __________________________
HEALTH SCREENING REQUIREMENTS FOR EARLY HEAD START

Complete health and developmental screening is required of all children enrolled in the Early Head Start program. Family Advocates and Center-based Family Specialists are responsible for assisting families with completing these health and developmental screenings. Current regulations require that all developmental, sensory and behavioral screenings are completed within 45 calendar days of program entry.

Part 1 of 7-Physical Exam

Head Start Performance standards require that each child enrolling into Early Head Start is up to date on a schedule of preventive health care as determined by a health professional. EHS children must be seen for well child exams according to the EPSDT schedule (2 week, 2 month, 4 month, 6 month, 9 month, 12 month, 15 month, 18 month, 24 month, 30 month, and 36 month)

Documentation: DCPC must have documentation from the clinic of each well child exam for all EHS children. To be considered up to date, all EHS children must have documentation of their most recent well child exam on file within 45 days of enrollment.

Well child dates and results must be verified before program entry. If staff is unable to verify that a child had a complete well child exam within the previous months as listed on the EPSDT chart, then a well-child appointment must be made immediately as part of the enrollment process. If an immediate exam cannot be obtained from the child’s primary provider, staff must contact the program’s nurse to schedule an exam as part of the enrollment process.

EHS staff is to verify the date of the well child appointment with the parent and document date, clinic and name of provider for data entry. Families are encouraged to establish an ongoing relationship with an appropriate, accessible medical care provider and to obtain regular preventive care from this provider.

Follow Up

Head Start Performance standards state that a follow-up plan be in place for any condition identified in a well-child exam in order for treatment is begin and a pattern of ongoing care is established.

Any follow up will be noted in Child Plus. The PNP/RN will meet with EHS staff quarterly to discuss health and health follow-up.

DOCUMENTATION: PE I/T TRACKING FORM (509) AND AUTHORIZATION FOR REALEASE OF MEDICAL INFORMATION (325)
Physical Exam—Infant/Toddler

To be completed by medical personnel

Parent/Guardian Name: ___________________________ Program/FA: ________________
Child’s name: ___________________________ M _ F _ Date of Birth: ____________

Date of exam: ________________

Circle Well Child visit: 2 wk 2 mo 4 mo 6 mo 9 mo 12 mo 15 mo 18 mo 24 mo 30 mo 36 mo

Date of most recent blood lead test: ________________ (mm/dd/yy) result ________________

Medicaid policy requires lead testing at 12 mo & 24 mo (or once between 3-5yrs if no previous test is documented).

Vision:
- Physical exam of eyes: WNL / ABN
- Risk factors for vision loss: YES / NO
- Parental/medical concerns: YES / NO
- Further screening recommended: YES / NO

Hearing:
- Otoscopic exam: WNL / ABN
- Risk factors for hearing loss: YES / NO
- Parental/medical concerns: YES / NO
- Further screening recommended: YES / NO

<table>
<thead>
<tr>
<th>HEENT</th>
<th>WNL</th>
<th>ABN</th>
<th>Immunizations given today?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skinski</td>
<td></td>
<td></td>
<td>If yes, please list and attach immunization record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td>Immunizations catch-up plan needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C-V</td>
<td></td>
<td></td>
<td>Yes__ No ___</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M-S Genitals, Abdomen</td>
<td></td>
<td></td>
<td>Does the child have a milk allergy?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Nutrition</td>
<td></td>
<td></td>
<td>If yes, please list recommended substitute.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development</td>
<td></td>
<td></td>
<td>Other allergies?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Bowel Pattern</td>
<td></td>
<td></td>
<td>If yes, please list.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td>Current medications?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If yes, please list.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Problem/Needs | Treatment Plan | Follow-up needed? | YES | NO |
|--------------|----------------|-------------------|-----|----|

I certify that I have examined the above child on this date and that he/she is able to participate in child care activities.

Return to clinic in ________ months.

Examiner’s Signature

Clinic Stamp:

White: Master file-Red Arrow Yellow: FA Pink: Child Care 509 (08/10)
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
Verbal Communication and/or Copies of Records

1. Patient Information

Name – Last, First, MI                                      Date of Birth

Street Address

City State Zip Code

AUTHORIZES:  ☐ Release of information to:  or  ☐ Exchange of information with: (must select one or both)

Name of Health Care Provider, Clinic, Plan/Other

Address

City State Zip Code

DISCLOSURE OF MEDICAL RECORD COPIES

Information to be disclosed:                                Date of Service
☐ Physical Exams/History                                    ☐ Consultations
☐ Immunization/LEAD screens                                 ☐ Discharge Summary
☐ PT/SP/OT                                                    ☐ Labs - EKG/EEG/EMG
☐ Operation/Procedure Report                                ☐ Dental Exam/Treatment
☐ Mental Health/Psychology/Neuropsychology:

VERBAL COMMUNICATION
☐ Communication between those listed in Section 2 (includes any information unless limited below), or
☐ Limited communication (specified):

PURPOSE OF DISCLOSURE:
☐ Required for enrollment in group childcare
☐ Further medical care
☐ Coordination of health services
☐ Other: ____________________________

EXPIRATION DATE: This authorization will remain in effect until the following date(s) ________ or for one year from the date signed. Note: This authorization will apply to medical information generated during the extended time period.

RE-RELEASE: I understand the information used or disclosed based on this authorization may possibly be re-disclosed by the recipient and/or no longer protected by Federal Privacy standards.

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION
• Right to Receive Copy of this Authorization: I understand that if I agree to sign this authorization, I will receive a copy of it.
• Right to Inspect or Copy the Health Information to be Used or Disclosed: I understand that I have the right to inspect and copy the health information I have authorized to be used or disclosed per this authorization.
• Wisconsin Right to Privacy: Under Wisconsin law, you have the right to be free from unreasonable invasions of privacy. Wisconsin’s “Right of Privacy” statute protects individuals from using your name, portrait, or picture for advertising or trade purposes without first obtaining your written authorization.
• No Obligation to Sign: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for healthcare benefit on my decision to sign this authorization.
• Revocation: I have the right to revoke this authorization by notifying the Health Manager in writing of my desire to revoke it. However, I understand that any action already taken in reliance to this authorization, cannot be reversed and my revocation will not affect those actions.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes for the minor child listed above.

Print Name: ____________________________ Date: ____________

Signature: ____________________________ Authority to sign:  ☐ Parent  ☐ Guardian

White – Master File  Yellow – Parent/guardian  Pink – Program File  325 (04/14)
HEALTH SCREENING REQUIREMENTS FOR EARLY HEAD START

Part 2 of 7 - Immunizations

EHS children must receive immunizations according to the Health Check immunization schedule. All EHS children must have a full record of immunizations they have received within 30 days of enrollment. This information can be obtained from the Wisconsin Immunization Registry, from the clinic with well-child exam records, or having parents complete and sign the Day Care Immunization Record form.

If the parent/guardian has no record and the record cannot be obtained from the WI Immunization Registry, it will be necessary for staff to get consent form(s) from the parent for any/all clinics at which the child received shots. If up-to-date records cannot be obtained, the child may need to start the vaccination series over.

Ask the parent for the immunization record. After recording it on the immunization form, check to see if the child has received the number of doses required for entry. If shots are required, review the bottom boxes of the form with the parent. Parent must initial the applicable space. Provide the family with the local immunization clinic schedule and try to develop a plan to obtain what is needed.

DOCUMENTATION: IMMUNIZATION RECORD (232)
## Day Care Immunization Record

**Personal Data**

<table>
<thead>
<tr>
<th>Child's Name (Last, First, Middle Initial)</th>
<th>Date of Birth (Month/Day/Year)</th>
<th>Area Code/Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)</td>
<td>Address (Street, Apartment number, City, State, Zip)</td>
<td></td>
</tr>
</tbody>
</table>

**Immunization History**

List the Month, Day and Year the child received each of the following immunizations. **DO NOT USE A (1) OR (X) except to indicate whether the child has had chickenpox.** If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the record.

<table>
<thead>
<tr>
<th>Type of Vaccine</th>
<th>First Dose Month/Day/Year</th>
<th>Second Dose Month/Day/Year</th>
<th>Third Dose Month/Day/Year</th>
<th>Fourth Dose Month/Day/Year</th>
<th>Fifth Dose Month/Day/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hib (Haemophilus Influenzae Type B)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate Vaccine (PCV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles-Mumps-Rubella (MMR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (chickenpox) vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

- [ ] Yes, year (Vaccine is not required)
- [ ] No or Unsure (Vaccine is required)

**Requirements**

The following are the minimum required immunizations for the child’s age/grade at entry. All children within the range must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day care must have their records updated with dates of additional required doses.

<table>
<thead>
<tr>
<th>Age Levels</th>
<th>Number of Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 months through 15 months</td>
<td>2 DTP/DTaP/DT, 2 Polio, 2 Hib, 2 PCV, 2 Hep B</td>
</tr>
<tr>
<td>16 months through 23 months</td>
<td>3 DTP/DTaP/DT, 2 Polio, 3 Hib, 3 PCV, 2 Hep B</td>
</tr>
<tr>
<td>2 years through 4 years</td>
<td>4 DTP/DTaP/DT, 3 Polio, 3 Hib, 3 PCV, 3 Hep B, 1 MMR</td>
</tr>
</tbody>
</table>

If the child began the Hib series at 12-14 months of age: only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age. Note: a dose 4 days or less before the first birthday is also acceptable.

If the child began the PCV series at 12-23 months of age: only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required. MMR vaccine must have been received on or after the first birthday. Note: a dose 4 days or less before the first birthday is also acceptable.

Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th, or 5th) to be compliant. Note: a dose 4 days or less before the 4th birthday is also acceptable.

**Compliance Data and Waivers**

**If the child meets all requirements (sign at Step 5 and return this form to the day care center), OR**

- [ ] Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received, I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the day care center in writing as each dose is received.

**Note:** Failure to stay on schedule or report immunizations to the day care center may result in court action against the parents and a fine of up to $25.00 per day of violation.

- [ ] For health reasons this child should not receive the following immunizations: **(List in Step 2 any immunizations already received)**

  **Physician’s Signature Required**

- [ ] For religious reasons this child should not be immunized. (List in Step 2 any immunizations already received)

- [ ] For personal conviction reasons this child should not be immunized. (List in Step 2 any immunizations already received)

**Signature**

To the best of my knowledge this form is complete and accurate.

Signature: ________________________

White - Master, Yellow - Teacher, Date Signed: 232 (05/10)
HEALTH SCREENING REQUIREMENTS FOR EARLY HEAD START

Part 3 of 7 - Vision

Within 45 days of enrollment into EHS, a child’s visual status will be determined after review of child’s most recent well child exam in accordance with Health Check recommendations and the Vision Screening Checklist, including parent concerns. The Vision Screening Checklist must be filled out on an ongoing basis correlating to the ages on the checklist. For each well child exam one of the following statuses will be entered under hearing screening:

**Pass:** the physical exam shows correct functioning of the eyes, no risk factors for vision loss or concerns regarding vision were identified.

**Fail-refer:** the physician has referred the child to ophthalmology or another specialty based on their exam, past testing, or current vision concerns.

Children needing vision follow-up and treatment are assisted by DCPC staff to receive all needed follow-up.

**DOCUMENTATION:** DCPC Vision Screening Checklist for Birth to 36 months (294)
# DCPC Vision Screening Checklist for Birth to 36 months

**Child’s Name:** __________________________  **Initial Date:** __________________________

**Date of Birth:** __________________________  **Program:** __________________________

**Chronological Age:** __________________________  **Adjusted:** __________________________

Do you have any concerns about your child’s vision?  **Yes**  **No**  Please Describe:

## Birth to 7 weeks

<table>
<thead>
<tr>
<th>Question</th>
<th>Date of Completion</th>
<th>Question</th>
<th>Date of Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does child stare at surroundings when awake and alert? (Birth – 2 wks)</td>
<td></td>
<td>Does child visually respond to smiles and voices of others? (40 – 44 wks)</td>
<td></td>
</tr>
<tr>
<td>Does child momentarily hold gaze on bright light or objects? (Birth – 2 wks)</td>
<td></td>
<td>Does child show more visual inspection to details of objects and people (40 – 52 wks)</td>
<td></td>
</tr>
<tr>
<td>Does child blink at camera flash?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does child move eyes &amp; head together?</td>
<td>12 months to 18 months</td>
<td>Is child visually steering hand activity? (12 – 14 mths)</td>
<td></td>
</tr>
<tr>
<td>Does child’s eyes occasionally seem turned in? (Especially when awake for long periods of time)</td>
<td></td>
<td>Is child visually looking at simple pictures? (14 – 16 mths)</td>
<td></td>
</tr>
</tbody>
</table>

## 8 weeks to 6 months

<table>
<thead>
<tr>
<th>Question</th>
<th>Date of Completion</th>
<th>Question</th>
<th>Date of Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is child’s eyes beginning to move more widely with less head movement?</td>
<td></td>
<td>Has child now hold objects close to eyes to inspect it closer? (14 – 18 mths)</td>
<td></td>
</tr>
<tr>
<td>Is child beginning to follow moving objects or people? (8 – 12 wks)</td>
<td></td>
<td>Do child point to objects or people using simple words like “look or see”? (14 – 18 mths)</td>
<td></td>
</tr>
<tr>
<td>Is child watching parent’s face when being talked to or played with? (10 – 12 wks)</td>
<td></td>
<td>Does child look for and identify pictures in a book? (16 – 18 mths)</td>
<td></td>
</tr>
<tr>
<td>Is child beginning to watch own hands? (12 – 16 wks)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is child’s eyes moving in active looking of surroundings? (18 – 20 wks)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is child looking at hands, food, bottle when in a sitting position? (18 – 24 wks)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is child now looking at and watching distant objects? (20 – 28 wks)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## 7 months to 11 months

<table>
<thead>
<tr>
<th>Question</th>
<th>Date of Completion</th>
<th>Question</th>
<th>Date of Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does child’s eyes appear more mobile and move with little head movement (30 – 36 wks)</td>
<td></td>
<td>Does child occasionally visually inspect toys without needing to touch them? (18 – 24 mths)</td>
<td></td>
</tr>
<tr>
<td>Does child watch activities around him for longer periods of time? (30 – 36 wks)</td>
<td></td>
<td>Does child look at moving circular planes (e.g., wheels, fan) (24 – 28 mths)</td>
<td></td>
</tr>
<tr>
<td>Does child look for toys he/she drops? (32 – 38 wks)</td>
<td></td>
<td>Does child watch own hand while scribbling? (24 – 30 mths)</td>
<td></td>
</tr>
<tr>
<td>Does child visually inspect toys he/she is holding (38 – 42 wks)</td>
<td></td>
<td>Does child watch and imitate other children? (30 – 36 mths)</td>
<td></td>
</tr>
<tr>
<td>Does child creep after favorite toy or person when seen? (40 – 44 wks)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does child sweep eyes around room to see what’s happening? (44 – 48 wks)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Results and Recommendations:

- **Date:** __________________________  **Results or Recommendation:** __________________________

Rev. 09/23/2013
**Part 4 of 7-Hearing**

All children enrolled in the Early Head Start program will receive a minimum of one otoacoustic emission (OAE) hearing screen for early detection of hearing loss. Children will be screened between the ages of 9 and 36 months with a target screening age of 18 months. Children under the age of 6 months at enrollment that have not received a newborn hearing screen will receive an OAE hearing screening twice.

**PROCEDURE:**

1. Newborn hearing screening
   a. For a child enrolled before the age of 9 months, DCPC will obtain documentation that a newborn hearing screening was completed.
      i. The Family Advocate will obtain a Release of Medical Information for the child’s birth hospital and send an ISR to the Data Specialist.
      ii. The Data Specialist will request the records and enter a Newborn Hearing Screening event into Child Plus.
   b. If a child fails a newborn hearing screening, the PNP/RN will verify with the child’s primary care clinic that follow-up has occurred.
   c. If a newborn hearing screening has not been performed for a child under 9 months of age at time of enrollment the PNP/RN or UW audiologist will conduct an OAE screening on the child.

2. OAE screening
   a. Children will be screened once between the ages of 9 and 36 months.
      i. UW Speech and Hearing Clinic will perform OAE testing on all center-based EHS children (East Madison, Great Beginnings Sun Prairie, and Great Beginnings Arbor Hills).
      ii. UW Speech and Hearing Clinic will perform OAE testing on home-base EHS children at designated EHS events including Dental Night(s) and Hearing Screening Night.
      iii. DCPC PNP/RN will perform OAE testing on home-base EHS children who do not attend one of the designated EHS events.
   b. If a child does not pass the initial OAE screening, a second screening will be performed at least 6 to 8 weeks after the first screen.
   c. If a child does not pass a second OAE screening, he/she will be referred for further testing either to their primary care provider and/or a pediatric audiologist.

3. Hearing
   Within 45 days of enrollment into EHS, a child’s auditory status will be determined after review of child’s most recent well child exam in accordance with Health Check recommendations including parent concerns. For each well child exam one of the following statuses will be entered under hearing screening:
**Pass:** the otoscopic exam is within normal limits, no risk factors for hearing loss or concerns regarding hearing were identified.

**Fail-refer:** the physician has referred the child to ENT, audiology, or another specialty based on their exam, past testing, or current hearing concerns.

Children needing hearing follow-up and treatment are assisted by DCPC staff to receive all needed follow-up.

**DOCUMENTATION: Head Start Middle Ear and OAE Screening – 1st Visit (#319), Head Start Middle Ear and Hearing Screening – 2nd Visit (#320)**
Head Start Hearing Screening (0-3 years)  
FIRST VISIT

Child’s Name: ____________________________ Family Advocate/HS Site: ________________________  
(last name, first name)

Date: ___________ Tester: _______________ Child’s Date of Birth: ________________

1. Is there drainage from either ear? ......................................................... Yes  No  
   If no, proceed to step 2. If yes, reschedule screening.

2. Otoacoustic Emission (OAE) Measures

   Right ear OAEs........................................................................ Pass  Refer  CNT

   Left ear OAEs.......................................................................... Pass  Refer  CNT

   *If CNT, state reason here: _________________________________

3. Follow-up

   • Refer for retest in 6-8 weeks (did not pass or CNT OAE screen)..............Yes  No
   • Pass.........................................................................................Yes  No
Head Start Hearing Screening (0-3 years)
SECOND VISIT

Child’s Name: ________________________________ Family Advocate/HS Site: ________________________________
(Last name, first name)

Date: _________________ Tester: _________________ Child’s Date of Birth: _________________

1. Is there drainage from either ear? ................................................................. Yes No
   If no, proceed to step 2. If yes, refer to a physician and reschedule screening.

2. Otoacoustic Emission (OAE) Measures:
   On the date of the 1st screening, child (circle):
   - Passed / Referred in Right Ear
   - Passed / Referred in Left Ear
   - Could not be tested (noise, child refused, etc.)

   Right ear OAEs present ........................................ Pass Refer DNT CNT
   Left ear OAEs present ........................................ Pass Refer DNT CNT

3. Tympanometry **To be completed by UWSHC only

   Maico EZ Tymp

<table>
<thead>
<tr>
<th>Volume (ml)</th>
<th>Compliance (ml)</th>
<th>Pressure (daPa)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*</td>
<td>Right Ear</td>
</tr>
<tr>
<td></td>
<td>*</td>
<td>Left Ear</td>
</tr>
</tbody>
</table>

   - Right middle ear function .... Normal Abnormal DNT
   - Left middle ear function .... Normal Abnormal DNT

4. Follow-up
   - Refer to physician and retest (Absent OAEs & Abnormal Tymps or excessive wax) ______
   - Refer for diagnostic testing (Absent OAEs, Normal Tymps) ______
   - Pass (Pass OAEs for BOTH EARS) ______
Part 5 of 7-Growth

Height/weight data will be gathered for all enrolled EHS children at each well child visit. Growth chart plotting may be used to identify children who are not following an adequate growth curve. If growth chart indicates concern or if primary provider identifies concern, staff will work with family to implement interventions.

Part 6 of 7-Dental Exam

Best practice recommends each infant/toddler over age 12 months of age have an oral examination completed by a dentist each year. Wisconsin Health Check guidelines require annual dental exams beginning at age three.

Many EHS participants receive fluoride varnish at their well-baby exams. These topical fluoride treatments are recorded in the EHS dental data comments.

Children needing dental follow-up and treatment are assisted by DCPC staff to receive all needed follow-up.

DOCUMENTATION: DENTAL EXAMINATION (502)

Part 7 of 7-Pregnancy

Optimal prenatal growth and development is critical for healthy infants. Pregnant women enrolled in Early Head Start develop with their family advocate a pregnancy service plan that outlines the following service delivery: prenatal and postpartum health care, prenatal education and breastfeeding education.

Documentation of adequate prenatal care must be obtained for all expectant mothers enrolled in EHS. Documentation can either be full medical records or the Early Head Start Prenatal Exam form can be completed by the care provider. Documentation will be obtained for as many prenatal exams as possible. If there are concerns identified with the pregnancy, the PNP/RN will be notified and will work collaboratively with the FA to provide support and help coordinate any needed follow up care.
**EARLY HEAD START DENTAL EXAMINATION**

Child’s Name: __________________________

Date of Birth: __________/________/________

**DENTIST:**

**CHILD:**

**PROGRAM/FA:**

**TO BE FILLED OUT BY CLINIC**

<table>
<thead>
<tr>
<th>Dental Examination &amp; Cleaning</th>
<th>Dental Follow-up Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td>Date: __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
</tr>
</tbody>
</table>

**Work Completed on this Date ↓** (Please check)

<table>
<thead>
<tr>
<th>Cleaning</th>
<th>Fillings</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-Rays</td>
<td>Crowns</td>
</tr>
<tr>
<td>Topical Fluoride Treatment</td>
<td>Hospital</td>
</tr>
</tbody>
</table>

**Other (Specify) **

<table>
<thead>
<tr>
<th>Other</th>
<th>Other</th>
</tr>
</thead>
</table>

Is follow-up work from this cleaning & exam needed? (Please circle)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Is patient completed all needed treatment at this exam? (Please circle)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Has patient missed any cleaning appointments? (Please circle)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Concerns Addressed/Information Given:**

- Home Emphasis on Oral Hygiene
- Harmful Oral Habits
- Dietary Problems
- Needs Fluoride Supplement

**How can Early Head Start assist this family?**

**METHOD OF PAYMENT:** (Please Circle)

<table>
<thead>
<tr>
<th>Medical Assistance</th>
<th>Private Insurance</th>
</tr>
</thead>
</table>

**Date(s) of upcoming appointments scheduled:**

| ________ | ________ |

**Has patient missed any follow-up appointments?** (Please circle)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Dentist Name:** __________________________

**Address:** __________________________

**Phone:** __________________________

**Dentist Signature:** __________________________

* Billing Early Head Start Purchase Order # ________________
Physical / Immunization Requirements for Child Care Children (not in HS/EHS)

Infant/Toddler (0-2 yrs.)

Children under 2 years old are required to have a physical examination not more than 6 months prior to nor 3 months after admission to the childcare program. Children under 2 years old must also have additional physical exams at least every 6 months, preferably meeting the Health check requirements.

ALL children **must** have a current immunization record on file within 30 days of admission to the program. Immunizations must follow the schedule on the immunization record form. If immunizations are not current at the time of admission, at least one dose of each must be administered and immunization must be brought up-to-date within one year. Staff should help families locate their child’s record as *failure to provide a record within 30 days will prevent the child from attending the program.*

Note: please refer to the Early Head Start and 0-3 Child Care section for the specific required forms.

Preschool (2 years – school age)

Children at least 2 years old who are not school-aged must have a physical exam not more than 1 year prior to or later than 3 months after admission to the program. Additional physical exams are due based on EPSDT (Health check) criteria (e.g. annually for ages 3, 4, and 5 year olds).

Children must have a current immunization record on file within 30 days of admission to the program. Immunizations must follow the schedule on the immunization record form. If immunizations are not current at the time of admission, at least one dose of each must be administered and immunization must be brought up-to-date within one year (In addition, children will be excluded from kindergarten if immunizations are not up to date.)

Staff should help families locate their child’s record as *failure to provide a record within 30 days will prevent the child from attending the program*
NUTRITION SECTION
NUTRITION POLICY – (UPDATED 2011)

- **Applicable Head Start Performance Standards**
  - 1304.23(b)(1)(vi) “For 3-5 year olds in center based settings foods served must be high in nutrients and low in fat, sugar, and salt.”
  - 1304.23(b)(1)(iv) “Each infant and toddler in center-based settings must receive food appropriate to his or her nutritional needs, developmental readiness, and feeding skills.”
  - 1304.23(c)(2): “Food is not used as punishment or reward”; and
    : “Each child is encouraged, but not forced to eat or taste his/her food”

- **Applicable Child Care Licensing Rules**
  - “Enough food shall be prepared for each meal so that second portions of vegetables or fruit, bread and milk are available to children.”

- **American Dietetic Association Nutrition standards for child care programs**
  - In their position paper ADA recommends that menus follow the Recommended Dietary Allowances (RDAs) and the Dietary Reference Intakes (DRIs); that menus be consistent with the Dietary guidelines for Americans; that the addition of fat, sugar and sources of sodium should be minimized in food preparation and foodservice; that plenty of fresh fruits, fresh or frozen vegetables, and whole-grain products should be used and; that foods should be provided in quantities that balance energy and nutrients with the children’s small appetites.

- **Department of Agriculture has issued a report with concerns about the increase in obesity-linked diabetes in children.**
  - Obesity in children has emerged as a major health problem, particularly among African American girls, and Hispanic American and Native American children. The report recommends eating habits that contain lower percentages of fat, salt and sugars.

In accordance with the American Dietetic Association Nutrition standards for child care programs position paper and input/review from DCPC’s Consultant Registered Dietician:

All DCPC programs should achieve recommended standards for meeting children’s nutrition and nutrition education needs in a safe, sanitary, supportive environment that promotes healthy growth and development. Programs will ensure that children are routinely offered nutritious foods that keep them free from hunger, promote their proper growth, and reinforce choices and habits that prevent disease and support good health. (ADA 1999)

Menus will be consistent with the Dietary Guidelines for Americans:…Every child should be presented with meals and snacks that enable them to learn about and to practice dietary habits that allow them to eat a variety of nutritious foods, maintain healthy weight, choose plenty of fruit and vegetables and whole-grain products, avoid excessive fat and sodium, and use sugars only in moderation. Emphasis should be placed on use of unprocessed foods when available.
The addition of fat, sugar, and sources of sodium should be minimized in food preparation and foodservice. Adults often justify the addition of margarine, butter, salt, sugar, etc. during food preparation by pointing out that it enhances flavor, thereby increasing the likelihood that the children will eat their food. Children, however, have taste buds in their cheeks and all over the surface of their tongues. They are, therefore, much more sensitive to salty and sweet tastes than adults, so it is not necessary to add salt/sugar to season children’s food.

Nutrition education should be a component of each program…Every child should have opportunities to learn about food, food sources, nutrition, and the link between nutrition and health. Foodservice should be integrated with nutrition learning activities (see also: Nutrition Experience Activities)

DCPC is committed to continuing to provide all of the above guidance to both preschool and infant/toddler programs. Under all circumstances, DCPC staff will encourage breastfeeding mothers to continue breastfeeding when returning to work or school, and support the feeding of these children breast milk during their hours of care (see also Breastfeeding Policy later in this section). For infants transitioning to table foods, Infant teachers will stay in frequent, close communication with families about which foods have been introduced at home already before introducing these at the center. Infants and young toddlers will be fed on demand to the extent possible. Infants and toddlers who are sleeping at mealtime will not be awakened. Instead a plate of food will be saved and warmed up when the child awakens. Providing a snack only when a child sleeps through mealtime is not acceptable.

TRAINING
DCPC requires all NSPs to become ServSafe certified. Training can be accessed through the Health & Nutrition Manager.

MEALTIMES
Federal Performance Standards
Rationale: Food-related activities and leisurely mealtimes provide opportunities for the development of positive attitudes toward healthy foods; for decision-making, sharing, communicating with others; and for the development of muscle control and eye-hand coordination. Children also learn appropriate eating patterns and mealtime behavior when they observe adult behavior at family style meals. Children who are forced to eat, or for whom food is used to modify behavior, may develop unpleasant or undesirable food associations. This rationale serves performance standards 45 CFR 1304.23(c) (4).

All food prepared for meals, snacks, or treats must be prepared on the premises or in a licensed commercial site and delivered according to applicable food service requirements (DCF 251).

Staff should encourage positive experiences with food and eating. The staff are to be role-models, sitting at the table and eating with the children. Staff are to set good examples by eating the meals with the children and demonstrating a positive attitude toward all foods served. If staff eat a meal provided by any of the DCPC programs, they must eat it the food at the table with the children. This is a DPI regulation and it will be strictly enforced. If a staff member or child is on a special diet, this can be explained and used as a positive learning experience.
Children learn about food and nutrition from their teachers, either through direct instruction, in conversation, in guided practice, and especially through modeling! Staff are expected to encourage, but not force, children to taste the food offered, and not require children to eat all foods offered before any additional servings of any food are given. Because the most effective role models are people who are admired/identified with, it is essential that staff participate with the children in making mealtime a pleasant opportunity for learning about and practicing healthful eating habits.

Children who are hungry are sometimes prone to behavior issues. Staff are expected to quickly get children eating—when children are all seated, that table should begin.

Relaxing mealtimes provide children many opportunities to learn. As soon as developmentally appropriate, family-style meals are expected (meaning that children serve themselves from serving bowls, passing it to the next person). Conversation at the table between children and adults helps set an appropriate pace for the meal, while at the same time establishing a pleasant environment. (Staff should be sensitive to family customs that do not encourage children to participate in meal conversations.) Slow eaters are allowed sufficient time to finish their food; and children who become restless before the meal is over may be allowed to get up, clear their place, and are then directed to an alternate activity.

During mealtimes, adults encourage interesting table conversation across a variety of topics, not only subjects related to food and nutrition. Some methods for facilitating mealtime discussion include:

- Asking open-ended questions, modeling good listening skills, and encouraging turn-taking in conversation; and
- Encouraging children to compare, contrast, and classify food attributes, such as taste, texture, shape, size and color.

Understanding and accepting that a child may not eat the same amount every day, or be hungry at the same time every day, helps prevent feeding problems. If a child refuses a food, staff and parents are encouraged to offer such food again at a future time. Children may require a number of exposures to a new food before they will accept it. When introducing new foods, parents and staff should note that “pestering” a child is not an effective strategy.

“Clean-plate clubs,” “eating stars,” and other gimmicks are not appropriate ways to encourage children to eat. Staff will not require children to taste/eat one food before allowing additional servings of a preferred food. If staff have concerns about a child’s eating habits, please discuss these concerns with the program PNP/RN or Health Manager. If needed, PNP/RN or Health/Nutrition Manager may involve the Registered Dietician. A child’s mealtime food intake will not be restricted without the involvement of the PNP/RN and the child’s doctor.

In all cases, children are seated when eating and each child makes his or her food choices based on individual appetites and preferences from the menu offered.

Desserts: If special treats/desserts are brought, they are to be served at a mealtime. Staff should present this treat as a single-serving option with the meal. Cupcakes should be cut in half as these are otherwise considered a double-serving by CACFP standards. Treats must be purchased at a
store and have an ingredient list on the container.

**NOTE: any treats from home must be commercially prepared (purchased at store/bakery).** Parents are required to bring an ingredient list with the treats they bring in. No homemade foods can be served to children in DCPC programs. DCPC is responsible and liable for foods served to children, and we cannot control the sanitation/etc. of foods not prepared in our kitchens or purchased.

Families who want to share their favorite dishes will be able to do that during the potluck for the End-of-Year-Celebration (see Parent Engagement section for details). Parents are required to bring an ingredient list with the treats they bring in.

DCPC will provide basic foods for End of Year Celebration Events. Families may bring additional foods to share for these events if they so choose. However, under no circumstances will families be required to bring food to agency events.

**Nutrition Guidelines for Other DCPC Program Events**

As an agency, DCPC has made a commitment to enhance the overall wellbeing of program participants by offering a variety of health food choices at program events. Therefore, the agency will not purchase high sugar content foods to be served to children for any program event regardless of funding source. High sugar foods include but are not limited to candy, cakes, marshmallows, Jell-O, hot chocolate, pudding, and cookies. Any exception to this rule for children with special needs must be approved by the Registered Dietician and reviewed by one of the agency PNP/RN’s. If there is a question about whether or not a food is considered a high sugar product, the 0-5 Director or ASD will make the determination. For adult only events/meetings, healthier dessert options may be provided. Policy council will develop and approve a list of healthier dessert choices. Fresh fruit will be available in addition to dessert at all Policy Council meetings.
A. FOOD DURING ACTIVITIES AND SPECIAL DAYS

A basic, mandated, goal of our programs is to promote good nutrition and dental health for children. In general, the children we serve have significant amounts of high-fat/low-nutrition meals and snacks (i.e.: fast foods, soda, cake, candy, chips, etc.). Therefore, our challenge is to help children and families make alternate choices for treats and special events. Staff and programs are expected to lead by their example by building on more nutritional activities and treats (i.e.: ants-on-a-log, cheese/crackers, fruit, etc.).

If parents request to bring treats for a birthday or other special day, staff must inform them that homemade cakes/cupcakes/etc. are not allowed, as there is always a risk of the foods being mis-prepared and children/staff becoming ill. Options, (besides buying store-bought, poor nutrition foods) could include:

1. Encouraging the parent to come prepare the snack on site with the children or;
2. Encouraging the parent to provide other, more nutritious, store-purchased snacks. Parents are often very receptive to finding ways to limit their child’s sugar/salt intake when staff explain why this is important and give alternative choices (see also Nutrition Experience Policy for ideas).

In all activities, staff are expected to model creativity and limit poor nutritional snacks for the children. For example, if staff choose to bring a treat to celebrate a special day, he/she may not bring candies/cake/etc. (neither homemade or purchased). Instead - fruits, crackers, cheeses, or even stickers are more appropriate. Remember, food that is not prepared on site must have been commercially prepared.

Also, staff and other adults are not to eat outside of meal times or drink soda in the children's presence on the buses or in the room. Coffee or other hot beverages should always be in a covered mug, to prevent injury if it spills. Failure to comply with these expectations is grounds for disciplinary action.

It is the classroom teacher’s responsibility to ensure compliance with this within his/her own room.

Activities: Staff should not be using food items in art projects or for play. Staff are expected to remember two critical points:

First: Not all the children you serve have more than enough food to eat at home, so it may be disturbing or confusing to a child to see food used to paint/glue/play/etc. when he/she is hungry.

Second: If the children’s projects were sent home (or hung in the center) they could attract cockroaches, mice or other vermin.

Staff are expected to fully think about the goal or intention of the activity. In most, if not all, cases the goal can be accomplished without the use of food.
Other activities (math, science, etc.): The occasional use of food or edible food items for counting, stringing, sorting activities may be OK. This should be items such as Cheerios or macaroni for stringing, but should not be candy or sugary-sweet items. Again, staff are expected to keep in mind the above-discussed points, especially to determine if other non-food items can be used instead.

**Gum:** There are several potential hazards with gum and it should not be offered or used in the classroom/bus. Many young children do not have the motor control to chew gum and do other activities without choking on or swallowing the gum. Gum also has a tendency to end up in hair, carpeting or other furnishings. Lastly, some children’s dental repairs can be damaged by gum chewing. Even if it is brought as a special treat, gum should never be offered without parent permission and children should be expected to sit at the table or group while chewing (not move around the room or in active songs/etc.).

**B. FOOD AND BEHAVIOR MANAGEMENT**

Under no circumstances may food or food items (i.e.: gum, candy, snacks, etc.) be used as a reward or punishment for behavior compliance. The performance standards and state licensing rules clearly define this. (If edible reward/food is given as a “reward” to some for compliance/behavior and not given to others, the food being given was in fact also being used as a punishment for those others)

**C. OTHER CONSIDERATIONS**

Staff should be alert to any problems that can occur and be prepared to deal with these:

- Some foods are not religiously/culturally appropriate and should not be served to those children
- Be well aware of allergies of children, and ensure these items are not served to the child
- Occasionally there are some food items that can be easily contaminated and either not served or maintained at appropriate temperatures (raw fish, meat, mayonnaise dressing) – staff should ensure children are not served these foods some individuals may not have the money or resources to bring food and feel badly – staff must ensure parents understand they are not required to bring food for birthdays/special events or the End-of-Year-Celebration.
**FEEDING THE BREASTFED BABY IN DCPC PROGRAMS**

(Updated May 2015)

Breast milk is the best food for babies. It is the only food a baby needs during the first 4-6 months of life, and it continues to be an important source of nutrients for the first year. Breast milk contains the right balance of nutrients to meet the baby’s needs and changes over time. Breast milk is easy to digest and contains natural substances that help protect babies from infection and food allergies. Babies fed breast milk tend to have fewer illnesses.

**Supporting Breastfeeding Mothers**

Encourage breastfeeding mothers to continue breastfeeding when returning to work or school. Babies in child care who are breastfed may be:

- Breastfed by their mothers during visits to the center
- Bottle-fed their mothers’ expressed breast milk by the caregiver, and/or
- Bottle-fed the type of infant formula prescribed by the baby’s doctor while in care
  (caregivers should feed formula only if the mother requests its use with her baby)

To encourage expectant mothers to breastfeed and support currently breastfeeding mothers, each DCPC infant toddler center should have a cozy area for breastfeeding mothers and their infants. This area may include:

- A comfortable chair or rocking chair
- Place to wash her hands
- Pillow to support her baby on her lap while nursing
- Nursing stool or stepstool for her feet so she doesn’t have to strain her back while nursing
- Glass of water to help her to get enough fluid for nursing

**Information/resources on breastfeeding**

- Encourage her to get the baby used to being fed her expressed breast milk by another person before the baby starts in child care.
- Discuss with her the baby’s usual feeding schedule and whether she wants you to time the baby’s last feeding so that the baby is hungry and ready to breastfeed when she arrives. Ask her to call if she is planning to miss a feeding or is going to be late.
- Encourage her to provide a back-up supply of frozen or refrigerated expressed breast milk in case the baby needs to eat more often than usual or her visit to feed is delayed.
- Support and reassure her efforts to nurse as long as she is able and/or interested.
- If you have a mom who is interested in support or has questions about nursing, encourage them to communicate with their doctor – and ask if she is interested in talking with the program’s PNP/RN for additional guidance.
Use of Breast milk for Babies over 12 Months of Age

Some parents may request that DCPC continue feeding their babies breast milk after 12 months of age. Continue to serve babies their mother’s milk as long as the mother is able and wishes to provide it. Mothers who wish to continue providing breast milk for their child older than 12 months of age can do so WITHOUT having to submit a medical statement. Breast milk is an allowable substitute for cow’s milk in the DPI meal pattern for children.

GUIDELINES ON STORING, HANDLING, AND FEEDING BREASTMILK

By following safe preparation and storage techniques, nursing mothers and caretakers of breastfed infants can maintain the high quality of expressed breast milk and the health of the baby (Guidelines provided from resources through the CDC and American Academy of Pediatrics).

Handling of Breast Milk before Arriving at the Center

1. All breast milk should be brought to the child care center with the child’s full name and date.
   a. Each breast milk container should include the following dates:
      i. Date pumped
      ii. Date thawed if previously frozen
2. Breast milk is stored in the refrigerator or freezer right after they express it
3. Bottles are filled with the amount of breast milk the baby usually drinks at one feeding
4. Bottles of refrigerated or frozen breast milk are brought to the facility in a cooler with an ice pack to keep the milk at a cold temperature

Breast Milk Storage and Usage

1. Refrigerated (never frozen breast milk)
   a. Must be discarded after 48 hours
2. Frozen Breast Milk
   a. Frozen milk that is thawed should be used within 24 hours
3. Freshly Expressed (never refrigerated)
   a. Can be kept at room temperature for 6-8 hours

Handling and Storing Breast Milk at the Center

Breast milk from a mother is designed specially to meet the needs of her baby. Always make sure every bottle, bag, breast milk container is clearly labeled with the child’s name.

1. Refrigerate bottles immediately when they arrive and until ready to use, unless freshly pumped (freshly pumped milk can stay at room temperature for 6 to 8 hours)
2. Ensure the breast milk is stored in a refrigerator kept at 40 degrees Fahrenheit or under
3. Refrigerator must contain a small storage container labeled with the child’s name for each child that has breast milk stored in the classroom
4. If a parent wants to keep 1 bag of frozen expressed milk to have for back-up on site, contact the health team for additional guidance on how to store at the site
   a. Store milk toward the back of the freezer, where temperature is most constant
      i. Freezer compartment of a refrigerator-Can be stored for 2 weeks
      ii. Freezer compartment of refrigerator with separate doors-3 months
      iii. Chest or upright deep freezer-6 months
5. Use bottles of breast milk only for the baby for whom they are intended. In the event a child has mistakenly been given another child’s bottle of expressed breast milk, contact the health manager or PNP/RNs and direct the parent to consult their health care provider.

Preparing and Using Stored Breast Milk for Feeding

Breast milk may appear thinner, paler or even bluish in color compared to formula. There may be a thickened layer of cream at the top of the milk. Frozen breast milk may have layers of different colors and different appearances. This is normal.

1. **Safely Thawing Breast Milk**
   a. Check dates on all frozen breast milk to facilitate using the oldest first
   b. Thaw only as much frozen milk as you think a baby will need for a feeding
   c. Do not thaw frozen breast milk at room temperature, or by heating (not stove or microwave). The hot liquid can seriously burn babies. Also, heating damages special substances in the breast milk that protect babies’ health
   d. As time permits, thaw frozen breast milk by transferring it to the refrigerator for thawing
   e. May run under cold water
   f. Never re-freeze breast milk once it has been thawed

2. **Preparing/Feeding Breast Milk**
   a. Wash hands before handling breast milk
   b. Apply gloves when preparing breast milk bottle
   c. Check dates on all stored breast milk to facilitate using the oldest first
   d. Put desired amount of milk into bottle/sippy cup
   e. Warm only as much breast milk as you think a baby will need for a feeding
   f. Get milk to desired temperature by using a bottle warmer or putting bottle in bowl with warm water
   g. Swirl the bottle of breast milk before feeding, (breast milk separates into 2 layers when stored)
   h. Follow baby’s lead in the amount of breast milk to feed. Feed him/her until no longer hungry
   i. Breast milk should be discarded if it has been out of the refrigerator for more than 1 hour
      i. Once heated, breast milk cannot return to the refrigerator to use at a later time. Whatever portion has not been consumed within an hour should be discarded
NUTRITION/FOOD EXPERIENCE GUIDELINES

Once each week, Head Start Teacher Assistants are required to plan a nutrition experience. While it is interesting and fun to use sugary food experiences, the expectation is that these experiences will be nutritious (see also Nutrition Policy). Most importantly, we are responsible for teaching children nutrition concepts. These experiences can be done utilizing foods off the regular week’s menu or planning an activity emphasizing nutrition. Three basic concepts to emphasize throughout the year:

1. Nutrition, and nutritious foods, is what helps the body grow and get/stay strong.
2. Food is made up of different nutrients needed for growth and development.
3. There is not “good” food or “bad” food.
   Choose other adjectives, such as: "sometimes foods vs. always foods/growing foods," etc.

General Guidelines:

- Every week, the TA is to plan a nutrition experience for the children. These experiences should be planned using foods from the cycle menu or as an activity focusing on nutrition concepts (without food – i.e.: Chef Combo). TEACHERS ARE TO ENSURE THIS ACTIVITY HAPPENS.
- TA’s will complete the Nutrition Experience Log – filling in all six steps. Completed logs are to be kept on file until the end of the program year.
- When preparing food: wash hands and clean foods before preparation. Model this for children, and have children wash their hands.
- Allow children to do as much as possible including clean up.
- Use the nutrition experiences to cover all areas of development - cognitive, language, fine motor, self-help, social and cultural learning.
- Carry the nutrition concept/objective into activities throughout the day.
- Nutrition education activities should be offered at appropriate developmental levels, actively engage/involv children, and teach lifetime skills for problem solving and making decisions and taking responsibility.

Examples of exciting nutrition education activities include teaching children food safety and good nutrition (like making their own tossed salad in a baggie); learning about size, smell, shape, color, and growth; visits to the local grocery store to see the produce or to a farm to see the animals and crops, or to the bakery or a cheese factory; section fruits/count the parts and discuss the concepts of ‘whole’ and ‘part’; learn about size by lining up fruits from smallest to largest; make geometric shapes out of frozen dough and bake for snack.; etc.
NUTRITION EXPERIENCE LOG

(TA’s complete weekly for each nutrition experience – not just food activities)

Program: ____________________________________________________________

Date of Experience: _____________________________________________

Reviewed / Approved by Teacher (date/initials): ______________________

1. Activity/Experience and purpose:

1. How will you integrate content/concepts through this nutrition experience in the following areas:

   Vocabulary (examples: stir, mix, beat, bitter, sour, etc.)

   Literacy-

   Math-

   Science-

3. Materials Needed:


5. Follow-up reflection: (Did the children gain an understanding of the purpose? How well did they participate, enjoy and learn from the activity? Changes needed to make the activity even more successful?)

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DCPC Nutritional Services Monitoring – (Updated 2014)

DCPC programs have multiple systems for monitoring the nutritional component:

1. Kitchen Inspections:
   - Food Services Manager (FSM) will complete a pre-operational kitchen inspection prior to beginning services in Aug/Sept annually for 9 month programs closed during the summer months. Problems identified must be rectified before programs being serving foods.
   - All programs participating in the CACFP program will have at least 3 monitoring visits annually. These will be completed by a combination of Food Services Manager, Health/Nutrition Manager, and RD utilizing the NUTRITION SITE REVIEW form.
   - Plans of corrections will be completed by the NSP and site director. These plans of correction are to be posted in the kitchen until the next inspection can verify all areas of non-compliance are completed.
   - Site directors, who supervise NSPs, are responsible for ongoing monitoring of day-to-day operations to ensure compliance with all performance standards, DPI, and licensing requirements.

2. Integration of Nutrition component with other components:
   Child Development staff will ensure nutrition information, including food safety and nutrition experiences, etc. are incorporated into ongoing lesson planning and curriculum at sites, in accordance with lesson planning policies.

3. WI Child Care Licensing:
   All DCPC programs are monitored by WI CC Licensing, which includes meal service, kitchen safety, and sanitation, etc. (see also Licensing regulation).

4. City of Madison Accreditation:
   DCPC programs which are city-accredited have regular visits by the City Office of Community Services accreditors who monitor food service, mealtime routines, etc.

5. Food Production Records:
   NSPs are to complete weekly food production records, indicating the type and quantity of foods served, and the amount of leftovers. NSPs are to maintain updated menus weekly, and submit these with the food production records. These are submitted to the Health/Nutrition Manager weekly. Health/Nutrition Manager reviews these for completion and for input on which foods are popular and well-eaten with children, and which foods need to be re-evaluated during the annual menu committee review process.

   In addition, Health/Nutrition Manager reviews production records of centers where foods are prepared by public school personnel to ensure meals meet state and federal requirements.

6. Menu Committee:
   Annually, the menu committee will review feedback from NSPs, parents, teachers, site directors, RD, PNP/RNs, Food Services Manager, and documentation from production records and other sources in planning the following year’s menu.
FOOD SERVICE POLICY – (Updated 2014)

Provision of Food for the Cycle Menu

1. Each site will follow a standard 8 week cycle of menus.
2. In most cases, items will be purchased centrally for distribution to almost all sites.
3. Necessary items will be delivered by the Transportation Specialist according to an established schedule.
   - Please check deliveries in quickly. Food Services should provide communication on missing items and substitutions on a pink sheet which will be included with the food. Contact Food Services Manager (FSM) the same day you receive the food with any missing or incorrect items that are not noted on the pink sheet. Fax the invoice back to the FSM noting any issues. Follow up with a call to be sure the fax was received.
4. Supply requests for staple foods/supplies are to be submitted through fax on the “Supply Order Form”.
   - Supply requests are due by the end of the day on Thursdays and items will be sent on the following Thursday. If partial orders are sent with Tuesday food deliveries, this will be noted on a copy of the request enclosed with the delivery.
5. Variations on the cycle menu may be provided for field trips or other changes in the usual site.
   A. The Teacher should request a field trip menu on the Field Trip Request Form at least 2 weeks in advance. After supervisory and Transportation Manager approval, these will be forwarded to the Food Services Manager for approval and action. The Nutrition Services Provider should verify variations/distribution prior to the trip.
   B. Changes needed in menus due to site emergencies or temporary situations should be requested through the site director to the Food Services Manager. These requests should be in writing and in advance whenever possible.
   C. If substitute items are sent (for the regular cycle menu, for FFN, for special requests etc.) that affects the entire agency, the FSM will send an email to the site director(s). If the substitution involves only a specific site, the FSM will send a pink sheet with the food relaying any pertinent information.

Phone calls are for “emergencies” only. Please do not wait until the day foods/supplies are needed, since it would be unlikely that the FSM would be able to accommodate requests on the same day as the food is being prepared.
Provision of Nutrition Experiences

1. Each program will provide nutrition experiences for the children on a regular schedule and within the policy guidelines.

2. **Nutrition experiences should be based on the Cycle Menu.** Nutrition Experience Logs detailing the instructions and nature of the food/nutrition experience will be completed for each experience.

Provision of Special Foods for Children

1. For medical, nutritional, religious, and personal reasons (allergies, anemia, food restrictions, weight concerns, etc.), the Agency may alter the menu for a specific child. Parents may request the specific alterations for the child, with the involvement of the program Nurse and/or Health Manager. The Agency will make modifications and supply alternative foods as needed. See specifics in Food Allergies/Menu Accommodation policy earlier in the Health section.

Provision of Food and Paper Products

1. A supply of paper products will be provided as requested for the FFN’s.

2. A supply of coffee/tea/paper products will be provided for All Staff meetings. Upon approval by a director, other foods and paper products will be provided for other staff trainings.

3. Special foods requested for events must be approved by the health manager.

4. Emergency use paper products will be provided to sites upon the request of the site director.
FOOD SERVICE SUPPLIES AND EQUIPMENT PROCEDURES

Inventory

1. Each kitchen site will be supplied with basic and standard consumable supplies and equipment. Based on specific site needs and cooking responsibilities, items may be added or deleted from the standard supply.

2. As part of the program closeout process, the Nutrition Services Provider will inventory all kitchen supplies at the close of each program year and send a copy of the list to the Food Services Manager. The inventory will be updated to include any items added or removed during the program year.

3. Any inventory item that is lost, stolen or missing must be reported by the site director who will notify the Food Services Manager.

Provision of Consumable Supplies

1. A standard consumable supply list is provided to each site. Nutrition Services Providers will use this form to request consumable supplies from the Food Services Manager.

2. Necessary items will be delivered by the Transportation Specialist according to an established schedule.

Supply requests are due by the end of the day on Thursdays and items will be sent on the following Thursday. If partial orders are sent with Tuesday food deliveries, this will be noted on a copy of the request enclosed with the delivery.

Phone calls are for “emergencies” only. Please do not wait until the day foods/supplies are needed, since it would be unlikely that the FSM would be able to accommodate requests on the same day as the food is being prepared.

Provision of Miscellaneous Consumable Items

1. Requests for items listed on the Standard Kitchen Inventory Supply Form should be made on the Supply Request Order form and signed by the Site Director.
NUTRITION PROGRAM SITE REVIEW GUIDANCE

DCPC’s nutrition program is funded through the United States Department of Agriculture, Child Care and Adult Food Program (CACFP). The Wisconsin Department of Public Instruction (DPI) administers the nutrition program for the USDA, CACFP. Dane County Parent Council contracts with DPI for our nutrition program. This contract/agreement gives direction for the management of the program, food purchases, operating expenses, daily menus, and compliance rules.

Therefore, a written review of the DCPC’s nutrition sites will be made to assess compliance with CACFP regulations and Head Start performance standards in nutrition. These reviews will be performed three to six times a year. A pre-opening inspection will be performed before any reopened site may operate within the CACFP (i.e.: those sites that have re-opened after summer, or have moved).

The documentation of areas not in compliance found on the review will include a deadline for completion. It is the site’s supervisor responsibility for ensuring these requirements are in compliance. All written documentation and summaries must be posted on site and on file at the DCPC’s administrative office.

The following Review Guidance will provide details and areas for assessment and the level of compliance needed for Head Start and preschool programs (ages 3-5) and any I/T sites participating in the CACFP program.
NUTRITION SITE REVIEW

Name of Sponsoring Organization: Dane County Parent Council, Inc.  Agreement No. 13-6813

Date of Review ___________  Meal Service Observed _________________ Visit #  1   2    3

Arrival Time ___________  Departure Time _________________  Announced: ___  Unannounced: ___

Facility Name ________________________________________________________________________

Person interviewed at site: ________________________  Site Supervisor: ________________________

Note: Records of Daily Attendance, Enrollment, Household Size/Income statements, Invoices/Receipts for purchases for foods/services are maintained at the administrative office: Red Arrow Trail

Meal Service

For the meal observed, record the foods served and the quantity prepared or delivered for children ages 1 through 5 years in DCPC centers.

<table>
<thead>
<tr>
<th>Component</th>
<th>Foods Used</th>
<th>Quantity Prepared/Delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk – Whole/2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milk – Skim/1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meat/Meat Alternate</td>
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<td></td>
</tr>
<tr>
<td>Fruit and/or Vegetable</td>
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<td></td>
</tr>
<tr>
<td>Grain/Bread</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Food</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A meal/snack served to infant(s) was observed during this on-site review: ☐ Yes  ☐ No

If ‘Yes’, do the items and quantities observed meet the CACFP infant meal pattern requirements?

☐ Yes  ☐ No  ☐ N/A  If “No,” explain

All required components of the infant meal pattern are provided to the infant and at least one component is supplied by the center for claimed meals?

☐ Yes  ☐ No  ☐ N/A  If “No,” explain

Are Infant meal records completed correctly for infant meals and snacks claimed for reimbursement?

☐ Yes  ☐ No  ☐ N/A  If “No,” explain

Individual age-specific production records are maintained by the teacher for infant meals?

☐ Yes  ☐ No  ☐ N/A  If “No,” explain
A signed medical statement is on file for infants who are not receiving the required USDA infant meal pattern for meals claimed (i.e., are receiving cow’s milk instead of formula or table food in lieu of iron fortified cereal).

☐ Yes  ☐ No  ☐ N/A  If “No,” explain

The Infant Meal Notification Letter was sent to the households of all enrolled infants and is kept on file.

☐ Yes  ☐ No  ☐ N/A  If “No,” explain

List the type of iron-fortified infant formula the center provides: ____________________________

Number of meals served to enrolled participants:

<table>
<thead>
<tr>
<th>Age under 12 months</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 1 to 3 years</td>
<td></td>
</tr>
<tr>
<td>Ages 3 to 6 years</td>
<td></td>
</tr>
<tr>
<td><strong>Total meals served to enrolled participants</strong></td>
<td></td>
</tr>
</tbody>
</table>

Number of meals served to program staff:

|                     |

Do program adults or any people other than enrolled children eat the center meals?  ☐ Yes  ☐ No

If yes, where is the number of meals served to program adults and/or others recorded?

☐ Production Records ☐ Daily Meal Participation Record ☐ Other (Specify): ______________

Was all food sent for (circle: observed  most recent) meal prepared and served?  ☐ Yes  ☐ No

Was the quantity of food prepared sufficient for the number of persons served?

☐ Yes  ☐ No  If “No,” explain

Were participants properly offered all required components in accordance with the appropriate meal service method requirements (family-style dining, pre-plated, or cafeteria)?  ☐ Yes  ☐ No

If “No”, explain:

Is the physical count of all children participating in the meal service documented on the daily meal count sheet either during meal service or immediately following?  ☐ Yes  ☐ No

A signed medical statement is on file for children who are not receiving the required USDA meal pattern for meals claimed due to allergies or other special dietary needs.

☐ Yes  ☐ No  ☐ N/A  If “No,” explain

The proper type(s) of milk is served given the ages of the children present.  ☐ Yes  ☐ No

If “No” describe the technical assistance provided.

(List type(s) of milk provided) **1-2 year olds:** __________  **Over 2 years:** __________

The requirement to have water available throughout the day, including at meal times, has been properly implemented. If “No” describe the technical assistance provided.  ☐ Yes  ☐ No
List the meal counts for the same meal type observed or, if no meal is observed, closest meal to the time on the day of the review for each of the 5 preceding serving days. Also list the number of children who are in attendance according to the child care’s sign in/out attendance records. **Meal Type: ____________**

<table>
<thead>
<tr>
<th>Date</th>
<th># of Meals Counted and Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Room</strong></td>
<td>Cts</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

**Total:**

Do the meal counts for the prior 5 days appear reasonable when compared to the current day’s meal count?  □ Yes   □ No   If No obtain and record an explanation:

Do the meal counts for the prior five days appear reasonable when compared to enrollment and attendance records for the corresponding days?  □ Yes   □ No   If no, obtain and record an explanation:

Comments/questions re: overstocked foods/non-food items (if none, please indicate ‘none’):
### REVIEW GUIDANCE

ALL STATEMENTS ARE TO BE ANSWERED BY **YES** or **NO** with checkmark

*N/A only if the age group is not relevant*

Please initial each corresponding answer under Yes or No | Yes | No | Comments
---|---|---|---

## I. STORAGE AREAS – FOODS

All perishable foods are stored/maintained at these temperatures:

<table>
<thead>
<tr>
<th>Refrigerator</th>
<th>40 degrees or less</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freezer</td>
<td>0 degrees or less</td>
</tr>
</tbody>
</table>

Thermometers are inside each refrigerator or freezer

Foods are stored in NSF approved containers with tightly fitting lids. *NSF= metal, glass, food-grade plastic*

<table>
<thead>
<tr>
<th>Dry</th>
<th>Fridge</th>
</tr>
</thead>
</table>

All open, reusable food is labeled, dated, and properly stored in reusable containers

<table>
<thead>
<tr>
<th>Dry</th>
<th>Fridge</th>
</tr>
</thead>
</table>

## II. STORAGE AREAS – NON-FOOD SUPPLIES

In the kitchen all cleaning supplies and other poisonous materials are stored in locked compartments or stored out of reach of children

All foods are separated from cleaning supplies/other poisonous materials, dishes, utensils, and paper supplies

All supplies and cleaning bottles have identifying labels

Kitchen storage is clean and organized

Kitchen walls are clean/no chipping paint

Kitchen counters are clean and organized

Sinks and counters kitchen/classroom de-limed

Dishwasher clean and de-limed

Stove top and oven clean

Refrigerator clean in kitchen

Freezer clean & defrosted

Refrigerator(s) clean in classroom

Food is stored at least 6” off the floor

Storage areas are secure from theft

## III. FOOD PREPARATION, HANDLING AND SERVING

All raw fruits and vegetables are washed before use

Frozen meals are thawed in the refrigerator *(no other foods may be stored under meats)*. Quick thawing done under running cold water in plastic bag for immediate preparation

Each serving bowl or plate on the table is provided a spoon or other utensil for the serving of food

Each serving bowl or plate is covered before serving is to begin

More than enough food (10 to 20%) is provided to each table for seconds
### Please initial each corresponding answer under Yes or No

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extra foods from the kitchen are taken to classroom and offered</td>
<td></td>
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</tr>
<tr>
<td>All leftover foods from classrooms and from kitchen areas are disposed in the trash.</td>
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<td></td>
</tr>
<tr>
<td>Leftover foods may not be sent home with any children or adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No food may be kept longer than 2 hours once it’s been prepared in the kitchen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No food may be kept longer than 2 hours after serving in the classroom</td>
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<tr>
<td>Family style food service is used. Staff will not serve milk or juice or foods for children. (Unless child with special needs requires assistance)</td>
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<tr>
<td>Cold and hot foods are maintained and served at appropriate temperatures (NSP to check food temps before serving): 40 degrees or below for cold foods 135 degrees or above for hot foods</td>
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<tr>
<td><strong>Vended Meals or meals delivered from central kitchens:</strong> foods received at proper temps (≤ 40°F and/or ≥135°F)</td>
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<tr>
<td>Children clear their place settings</td>
<td></td>
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<tr>
<td>A container is used on each table for dirty silverware</td>
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<tr>
<td>Food handling procedures meet all sanitation requirements</td>
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### IV. CLEANING AND CARE OF EQUIPMENT

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<tr>
<td>A cleaning schedule is posted and current documentation shown</td>
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<tr>
<td>A sanitizing solution is available &amp; used appropriately</td>
<td></td>
<td></td>
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<tr>
<td>Can openers are clean and sanitized</td>
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<tr>
<td>Dishwashing &amp; sanitizing is done by an approved method:  Hand washing with three step method &amp; air drying  or  Mechanical with proper chemicals and drying method</td>
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<tr>
<td>Tables and other eating surfaces are washed and sanitized before and after each meal (2-step process required)</td>
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<tr>
<td>Tables and all other food contact surfaces are to be air dried after sanitizing</td>
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<tr>
<td>Cracked or chipped dishes and utensils are not used</td>
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<tr>
<td>Garbage cans are covered with lids and are lined with liners</td>
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<tr>
<td>Garbage cans are clean inside and outside</td>
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<tr>
<td>Garbage is removed daily</td>
<td></td>
<td></td>
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<tr>
<td>Carts are cleaned and sanitized daily</td>
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<tr>
<td>Equipment in kitchen must be provided by DCPC (no donations)</td>
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### V. PERSONNEL SANITATION

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<tbody>
<tr>
<td>Clean clothing is worn and closed-toe shoes are worn</td>
<td></td>
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<tr>
<td>A hairnet to cover hair is worn in the kitchen and while serving food in the classrooms</td>
<td></td>
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</tbody>
</table>
There is no use of tobacco or chewing gum in the kitchen.

<table>
<thead>
<tr>
<th>Please initial each corresponding answer under Yes or No</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hands are washed before touching foods, before work, after handling non-food items, after using the restroom, and after coughing, sneezing, or blowing the nose</td>
<td></td>
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<tr>
<td>Poly gloves are used when handling ready-to-eat foods such as breads, fruits and/or raw veggies.</td>
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</table>

**VI. PAPER WORK AND RECORD KEEPING**

Menus are planned by: circle DCPC Menu Comm w/ RD or School District or: ___________

DCPC purchased food: CN labeled products are purchased or comparable info from manufacturer are obtained & kept on file

**Vended Meals:** The vendor provides a daily record of the amounts of food delivered as well as serving size information for site staff to use that assures sufficient quantities are available to offer at least the minimum serving size requirement.

**Vended Meals:** The vendor provides copies of CN label information or manufacturers’ comparable information used for commercially purchased combination food items.

Current and dated menus are posted in the kitchen with any substitutes noted – if substitutions are made, these changed menus must be sent to main office at end of week.

Current and dated menus are posted in each classroom with any substitutions noted

Menus are planned by Head Start parents/R.D./Community persons per the Head Start Performance Standards or by the providing school district which meet CACFP requirements for each meal type.

Meal count records are recorded immediately following the meal by each classroom teacher & sent weekly to admin office

The meal-serving schedule is posted in the kitchen

The meal serving time is posted in each classroom

The ...And Justice for all poster is posted in an area accessible to parents.

All staff received CACFP civil rights training within the last year.

Parental notification flier is posted

Children with special nutritional needs have their first name, classroom’s name and their need posted in the kitchen for substitute cooks to follow

Medical statements are on file for those children who do not receive meals that are in full compliance with the USDA meal pattern due to allergies or other special dietary needs (originals in master file/2096)

A daily production record of the quantity of food prepared for each meal is maintained by the NSP & turned into HNM
The meal documentation corresponds to the meal observed

<table>
<thead>
<tr>
<th>Is WIC information made available to parents? (Enrollment Manager)</th>
<th>If not, why?</th>
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Please initial each corresponding answer under Yes or No

### VII. MEAL TIMES

<table>
<thead>
<tr>
<th>Children eat meal at scheduled time: meal served at scheduled time/children ate meal at scheduled time</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Adults sit and eat with the children, modeling table manners &amp; tasting new foods. Adults will eat child-sized portions</td>
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<tr>
<td>Child sized furniture and eating utensils are used by the children</td>
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<tr>
<td>No paper/plastic goods are used, except with the Program Supervisor’s Approval</td>
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<tr>
<td>Food is presented in a friendly and non-forceful manner. Food is not used in rewarding or punishing manner</td>
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<tr>
<td>Children are encouraged <em>but not forced</em> by staff to try all foods.</td>
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<tr>
<td>Time is provided for children and adults to wash hands &amp; face before &amp; after the meal</td>
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<tr>
<td>Time is provided for tooth brushing at least once a day</td>
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### VIII. BREASTFEEDING/FORMULA PREPARATION (I/T ONLY)

<table>
<thead>
<tr>
<th>Staff wash hands before and after formula/breastmilk preparation</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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<tr>
<td>Breastmilk is stored at proper refrigerator temps (40 degrees or below)</td>
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<tr>
<td>Each container of breastmilk is labeled with child’s name and dated</td>
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<tr>
<td>Once feeding begins, formula/breastmilk to be discarded within 1 hour (freshly expressed breast milk may remain at room temp for up to 8 hours)</td>
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<tr>
<td>Staff are holding infants while bottle feeding. Bottles may not be propped.</td>
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<tr>
<td>Breastmilk is warmed by a bottle warmer or warm running water only</td>
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<tr>
<td>Formula must be used by expiration date (found on package)</td>
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### IX. MISCELLANEOUS

<table>
<thead>
<tr>
<th>No animals are allowed in the food preparation or storage areas</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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<tr>
<td>The kitchen is not used as a traffic way or meeting room while food is being prepared</td>
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<tr>
<td>A fire extinguisher is readily available and currently dated in the kitchen area</td>
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<tr>
<td>Did key staff attend annual training on CACFP requirements?</td>
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<td>Was effective action achieved for all problem(s) notes during the last review</td>
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<tr>
<td>Is the corrective action page from the last review posted in the kitchen?</td>
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CORRECTIVE ACTION REQUIRED:

- Reviewer to note problems found and corrective action needed prior to leaving site, noting date corrective action to be completed.
- Health & Nutrition Manager will e-mail copy to site - NSP/CA to KEEP POSTED IN KITCHEN.
- SUPERVISOR will ensure completion and initial, keep posted.
- DCPC Representative and/or FSM to verify completion at next scheduled visit, and then submit form to Health & Nutrition Manager.

<table>
<thead>
<tr>
<th>Problems Found</th>
<th>Corrective Action To Be Taken</th>
<th>Date Due</th>
<th>Supervisor Verified complete</th>
<th>FSM/DCPC representative verified complete</th>
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Signature of DCPC’s representative and/or FSM  Date: ________________________

Signature of Site Representative  Date: ________________________

Signature of Site Supervisor  Date: ________________________

Cc: FSM, NSP, Site Supervisor, Ed. Compliance Manager  Original: Health & Nutrition Manager
**Food Service Cleaning Schedule**

(To Be Filled Out Daily)

Site: _________________________________

(Must be posted in the kitchen)

### Month:

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |

### Floors: Daily sweeping and mopping in eating/prep areas, also as needed.

### Refrigerator(s): Clean inside and wipe down outside weekly, also as needed.

### Freezer(s): Clean inside and wipe down outside weekly, also as needed.

### Stove/oven: Wipe spills daily. Clean burner rings and inserts weekly. Clean oven bi-weekly. Also clean as needed.

### Dishwasher: Wipe outside weekly. De-lime monthly. Clean removable spray wands weekly. Also clean as needed.

A. Check for correct temp weekly.

B. Check for correct pH weekly. (sanitizer only)

### Cupboards/shelving: Arrange & organize weekly. Wipe shelves bi-weekly. Also clean as needed.

### Garbage Recycle Container: Clean inside and outside daily.

### Small appliances: Clean after each use.

### Can opener:

Commercial – clean in dishwasher daily.
Hand-opener – wipe after each use. Sanitize and air dry (do not wash in dishwasher).

### Mop: Rinse in bleach solution and air dry daily.

### Carts: Clean and sanitize daily. Also clean as needed.
CACFP DOCUMENTATION REQUIREMENTS

To fulfill the contract obligations with the Department of Public Instruction, from whom the Agency is reimbursed for food used in the program, each site must keep records on the number of children and adults who are provided meals each day.

Documentation

1. Attendance/Meal Count Sheets
   A. The Teacher will record at each meal, the number of adults and enrolled children that are served meals at the site.
      a. Non-program staff includes state licenser, DPI representatives or other individuals not affiliated with DCPC.
      b. Enrolled children DOES NOT include siblings. Siblings over 12 years of age are considered program adults.
   B. The Attendance/Meal Count Sheet form shall be posted in the classroom.
   C. The Teacher is responsible for submitting this form on the last working day of each week to the main office.

2. Food Delivery
   A. The Nutrition Services Provider will receive an invoice form with the delivery of food.
   B. The invoice will include all of the food for the upcoming week; the amounts; and the day in which the individual items must be used. There are two columns; one is checked off by the Food Services Manager to show an individual foodstuff has been packed, the other to show that an individual foodstuff has been received.
   C. It is the NSP’s responsibility to check off that all food has been received, sign the form, and submit it to the site director after each food delivery.
   D. NSP will immediately contact the Food Services Manager if needed foods are not received.

3. Production Sheets
   A. Daily, dated menus for each approved meal service, including substitutions made, must be posted in each classroom and the kitchen. This requirement also applies to sites that receive their meals through the school district.
   B. Production sheets indicating the exact quantity of food prepared must be completed daily. Infant teachers will complete their own production sheets, to be submitted to the main office weekly. All other production sheets will be completed accurately by the NSP/CA at the site and submitted to the office at the end of each week. (Production sheets from vendor contracts (i.e.: SP, DF, MR) will be periodically reviewed.)
   C. Daily, dated production records for each meal which show the total quantity of each food item used in the preparation of the meal. For infants 0-12 months, record the type and amount of food served to each child. For children 1 yr. and older, the quantities should not be listed in terms of individual serving sizes. All quantities should be expressed in terms of can size, weight, or volume. Production records should be a reflection of the
amount of food that is prepared and available for the children to eat at each meal which must, at a minimum, meet the CACFP required amounts for the number of children and adults served. Also write the number of children and the number of adults to be served on the production records.

D. When meals are purchased from a school, the vendor must maintain full and accurate records that the agency will need to meet this responsibility, including daily production records listing the total amount of food prepared, and daily delivery records listing the amounts of food supplied.

E. Production records will be submitted each week – with the center copy of the updated menu indicating all changes/substitutions made.

**DOCUMENTATION: MEAL COUNT/ATTENDANCE SHEET, PRODUCTION RECORDS**

**Note:** All NSP’s will prepare/make available to enrolled children all foods sent from the central office at each assigned meal. All preparation is according to the weekly menu and daily recipes.

**NO EXTRA FOODS CAN BE STORED FOR USE FOR ANOTHER DAY OR SENT HOME WITH PARENTS/STAFF. IT MUST BE DISCARDED.** Failure to do so could result in a disciplinary action up to termination.
MENTAL HEALTH SECTION
MENTAL HEALTH IN DCPC PROGRAMS

DCPC embraces a vision of mental wellness. Staff communication with families draws upon the family’s knowledge of their child’s development, and respects their parenting strengths, values, culture, and childrearing approach. Relevant information shared in the FPA process, and drawn from the child’s records, is incorporated into discussions. Communication about a child’s social/emotional development can sometimes be difficult because issues related to mental health are sensitive ones. When staff take time to establish rapport and to build trusting relationships with families, the families may learn to feel more comfortable discussing issues related to mental health (Perf Stand 1304.24a).

Federal Performance Standard:

Guidance: Staff have many opportunities to exchange information with parents on child development and growth. In formal and informal settings, information on the following topics can be presented.

- **The typical development of young children** - Information provided to parents helps them understand some behaviors that they may view as problematic, such as attention seeking and saying “no”, as part of a temporary phase that plays a positive role in the child’s development.

- **The development of individual children** - When parents and staff understand and respect each child’s particular abilities and temperament, undue pressure on both parents and children can be avoided. For example, some children develop motor skills faster than their peers, while others are able to control strong feelings at an earlier age than most. Training and information can help parents and staff recognize when each child is ready to achieve a particular skill or needs special help.

- **Supporting parenting in the first few months following birth** - This period may be a time of stress, as parents adjust to new roles and cope with challenges such as limited sleep. Enlisting a family member or finding someone who can assist new parents with the care of their new baby and with other household responsibilities can ease this transition. Facilitating these relationships is a goal of the Family Advocate position.

- **Recognizing and understanding behavior that is an expression of their child’s response to a stressful situation** - It is helpful to understand that sudden changes in a child’s behavior may be the child’s response to a stressful situation.

- **Ways to assist parents in helping children deal with separation issues** - To help the child during separation, encourage parents to spend time in the facility with their child; bring tangible reminders of home and family, such as a favorite toy or photos; assist the child to play out themes of separation and reunion; and reassure the child about his or her parents’ return. Parents, too, may experience anxiety over separation from their children. Staff will help parents with such separation anxiety by validating their feelings, and by encouraging parent participation in the program.

- **Attachment issues** - To facilitate secure relationships and attachments to adult caregivers, DCPC programs provide consistent care from a small number of adults.
Guidance: Staff and parents share positive approaches they employ to respond to a child’s behavior. Staff responses to parent inquiries provide an opportunity to explore and to model alternative approaches and techniques.

The behaviors that adults demonstrate are those which will be internalized and emulated by children. All DCPC program staff will discuss with parents the fact that parenting, while most often a fulfilling experience, also can be difficult and stressful, and that a parent’s response to stress, just like responses to other behaviors, will be imitated by children. Training and information about age-appropriate behaviors and varying individual temperaments helps parents and staff both to determine appropriate responses and to model those behaviors. For such reasons, the following should be kept in mind: (see also Positive Guidance Policy in Child Development section)

- **Developmental Changes**-
  Healthy social and emotional development depends on how children view themselves, as well as the extent to which they feel valued by others. When adults have realistic expectations about a child’s behavior, they respond with a variety of interventions that set constructive limits and help children to achieve self-discipline. Providing children opportunities to succeed lays the foundation for healthy development.

- **Environment**-
  Day-to-day warmth and responsiveness from staff and parents influences a child’s ability to recognize and to act upon his or her feelings. A comfortable, safe, interactive environment increases a child’s sense of competence and control.

- **Positive techniques of guidance**-
  Undesirable behaviors, while a normal part of growing up, should be discouraged or redirected. The following strategies reflect best practices for responding to inappropriate behaviors
  - anticipation of and elimination of potential problems
  - redirecting a child away from a conflict or negative event to a more positive activity
  - offering the child choices among activities that are acceptable
  - helping a child learn about the logical or natural consequences of their actions
  - encouraging respect for the feelings and rights of others

Positive techniques are more effective than competition, comparison, or criticism. Rather than attempting to “stop” a child’s negative behavior, positive techniques help him or her to find and practice skills that will help now and in the future. It is for that reason the Head Start/Early Head Start staff work with parents to help them understand the negative effects of corporal punishment on self-esteem, and to find alternatives in the home. (See also Positive Guidance Policy in Child Development section)

There are many differences in opinion about parenting, and there is no single “best way” to parent. It is important, however, that children receive consistent messages that are respectful of the child and of family values, customs, and traditions.
Head Start Mental Health Model
Dane County Parent Council, Inc.

Updated 2015

Finding a healthy balance between too much and too little aggressive behavior is the most difficult task of growing up!

Beginning in 2011, DCPC began the process of program wide implementation of the CSEFEL Pyramid Model. Three sites were chosen as official demonstration sites and received ongoing training and coaching support. Our goal is to continue to expand the number of participating sites each year. As we increase the internal capacity of our program staff to support children’s social emotional development, we look forward to utilizing the skills of our mental health consultants in new and innovative ways.

Mental Health Consultants

DCPC’s mental health consultants are a team of professionals in child psychology, infant/child mental health, child/family counseling, and sensory integration and regulation. The general large group observations will be done yearly by one of these consultants in all Head Start programs. Additional observations will be done as needed. The purpose of these general group observations is to identify children who may need additional referrals for mental health support (not just behavioral), and give general impressions as to which programs have groups of children who may need special support. Parents are notified of the date in advance and encouraged to stop in and talk with the consultant at that time if they have questions about their child’s development. Consultants will write up observation summaries and review these with the teacher either the same day, or at a mutually agreed upon time. These summaries will also be given to the Family Engagement/Mental Health Manager to review and then forward to the Education Programming Manager and Education Compliance Manager and supervisors. Program supervisors will review this summary with the teacher within 1 week of receipt to clarify suggestions and ensure appropriate follow through.

Upon specific consent from a family, the mental health consultant(s) may observe and provide consultation with staff and/or parents for a particular child.

The mental health consultants will also conduct ongoing social skills groups to support the social emotional development of children who may benefit from this additional support.

Consultants are also available to present to Family Nights upon request, through the Family Engagement/Mental Health Manager.

The mental health consultants will serve as external coaches for our implementation of the Pyramid model. As external coaches, they will provide ongoing support to internal coaches and teaching staff in implementing positive social emotional support strategies.

Sensory Integration Support from Occupational Therapists

Occupational therapists are available to assist in determining strategies for children with concerns related to sensory regulation. Teachers or mental health consultants may request
specific consultation for individual children with parent permission. The OT’s will provide group teacher training in sensory regulation issues as requested.

**Positive Behavior Support Team (PBST)**

The PBST was created in an effort to assist Head Start teachers and parents in developing specific behavior support plans for children with challenging behaviors, recognizing that they know these children better than outside consultants. The team is composed of the Education Programming Manager, Education Compliance Manager, Disabilities Specialist, Family Engagement/Mental Health Manager, and Mental Health Consultants. The Health team is available on a consultative basis to rule out any health related issues and to prevent duplication of work/services between the Health and Mental Health departments. The broad representation ensures multiple needs of a child are being considered in developing behavior plans. This team also works to identify classrooms that are in need of greater support and coaching from the Educational Services department to ensure that the needs of all children are met.

**Pyramid Model Leadership Team**

The Pyramid Model Leadership Team guides our agency’s implementation of Pyramid Model practices. The team consists of the 0-5 Director, Family Engagement/Mental Health Manager, Education Programming Manager, Education Compliance Specialist, mental health consultants, internal coaches, and teaching staff representatives. The team meets monthly to plan trainings, support ongoing coaching, and analyze program level data. The goal of Pyramid Model implementation is to support school readiness by building social emotional skills and decreasing the incidence of challenging behaviors which may impede a child’s ability to learn new skills.
PLANNING PROCEDURES FOR CHILDREN WITH CHALLENGING BEHAVIORS

As early childhood professionals we are aware it takes children time to adjust to a new situation. These procedures should be followed for a child who consistently displays inappropriate behavior, after an adjustment period.

In response to the increasing number of children with challenging behaviors, DCPC has created a Positive Behavior Support Team for Head Start programs. This team is available to support teaching teams in successfully finding strategies to work with these children. DCPC also contracts with Mental Health Consultants, who are available for guidance for those children with suspected mental health needs. In all cases, parents/guardians will be invited and encouraged to be actively involved in developing plans to successfully meet the needs of the child.

**Classroom staff will consult with parents immediately when child health or developmental problems are suspected or identified. (Performance Standard) 1304.20 (e) (1) Parents know their children and their family, and thus interpret a child’s behavior within the context of their own family and culture. In order to accurately assess a child’s health and development, parents share their observations and concerns with all appropriate individuals; and, in turn, parents are informed about observations made by others regarding their child. Parents are involved in all decisions and follow-ups for further evaluation and intervention. It is useful for parents and staff to meet frequently to share observations and concerns, and to jointly make plans for further evaluation and intervention. Such consultations and observations should be documented. (Guidance to Performance Standard) 1304.20 (e) (1)

When developing a Response to Challenging Behavior plan, staff and Mental Health Consultants consider the following motivations/explanations for children’s behavior

| Sensory input (the child is gaining sensory regulation by his behavior) |
| Expression of self (the child is announcing his/her individuality and independence). |
| Attention (the child may be seeking positive or negative attention from peers or adults). |
| Expression and/or regulation of emotions (the child is conveying frustration, anger, happiness, fear, etc). |
| Escape or avoidance (the child may want to avoid an activity, interaction with a person(s), or any unpleasant situation). |
| Justice or revenge (the child may be attempting to get back at an individual or group) |
| Acceptance and affiliation (the child may be seeking to impress another or feel included in a group). |
| Power and control (the child wants to be in charge or dominate his/her environment). |
| Access to items, activities or rewards (the child gets items, privileges by misbehaving). |
| Effects of trauma (difficulty regulating emotions, exhibit regressive/aggressive behavior, act withdrawn, exhibit anxiety, act out in social situations, e.g. |
| Other – |

This is not an exhaustive list of motivations and explanations for behavior and staff are encouraged to think critically about their care. We know that some children can display challenging behaviors due to changes in the home environment, hunger, tiredness, etc. and want to build supports that effectively address the needs of the individual child.
Each classroom team has many skills and resources, and knows the children in their care! Therefore, each team is responsible for first identifying, acknowledging, seeking information, problem solving, implementing a plan and evaluating the results of the plan with regards to working with children who display challenging behavior.

In accordance with the 2005 Licensing Regulations, children will not be physically restrained. Children in imminent danger to themselves or others may be held briefly to stop the immediate danger, (see also DCPC Child Guidance Policy). Additionally, all DCPC staff members will refrain from using seclusion as a means of managing children’s behavior. Should a child’s behavior be consistently at the level of posing serious risk of harm to themselves or others, a behavior plan will be developed in consultation with a Mental Health Consultant and Childcare Licensing that may allow for the use of a separate space outside of the classroom for the purposes of calming. Any staff members that will be a part of implementing this plan will be fully trained by the Mental Health Consultant to ensure full compliance with Childcare Licensing Regulations and DCPC policies. Failure to comply with any aspect of this plan will result in disciplinary action up to and including termination of employment.
Mental Health Procedure

If a classroom teacher has a concern regarding a child in his/her classroom and believes a referral should be made to the Mental Health Consultants, the following should occur:

- Teacher will contact the CDS or Coach assigned to his/her site to discuss the concern
- CDS or Coach will provide the teacher with the following forms:
  - Authorization for Social Emotional Consultation (#401)
  - Social Emotional Consultation Request (#403)
  - Behavior Incident Report (BIR)
- The teacher will talk with the parent about his/her concerns and ask them to sign the Authorization for Social Emotional Consultation
- If the parent does not consent, the teacher will work with the CDS, or Coach and the FE/MH Manager to consider strategies for supporting the child in the classroom
- If the parent provides consent, the teacher will complete the first two pages of Social Emotional Consultation Request and submit it, along with the signed authorization, to the CDS or Coach assigned to their site. Additionally, if a teacher believes that a behavior support plan will be necessary, they will also complete 1 week of BIR forms and submit them to the CDS or Coach as well.
- Upon receiving the completed teacher packet, the CDS/Coach will take the following steps:
  - Review the submitted materials
  - Complete an observation of the child and offer any ideas and suggestions to help support the child
  - Complete page 3 of the consultation request and submit all documents to the FE/MH Manager

Upon receiving the completed packet, the FE/MH Manger will scan and upload the documentation into ChildPlus and will send an email to all appropriate members of the Positive Behavior Support Team (PBST) and the CDS/Coach assigned to the site.
Infant Toddler Health & Development Coordination – Updated 2013

Center Based Programming Coordination
Changes in our community of staff and program models have led us to take a closer look at our mental health consultation services, health consultation services, and disability services to find an improved way to support children, families, and staff.

ITHAD group: PNP/RNs, 0-5 Director, Education Programming Manager, Mental Health Consultants, and Disability Specialist

These young children are often complicated with multiple overlapping issues that involve several disciplines. While we are developing this process, it will not always be clear who should take the lead. We may not always agree. It will be very important to ensure we are frequently and consistently communicating with each other. If suggested guidance is given from one team member that is different or in conflict with another’s view, we will promptly contact each other to discuss and resolve and jointly determine next steps.

When a teacher has a concern about a child in her/his care:
1. Teacher should discuss observations and concerns with Site Director to look at interactions and environments. SD will review/start process of referral form, as needed. The consultant may also request that staff initiate the ITHAD referral process based upon her observations/conversations with staff. However, teachers should not wait for a mental health observation to discuss concerns regarding an individual child.

2. Teacher should complete the referral packet including parent permission and send to the 0-5 Director. The referral forms should be sent electronically in order to expedite the process.

3. 0-5 Director will e-mail the referral form to the ITHAD team and Site Director. Staff who have information regarding this child should reply to the group. Site Director input is mandatory before the referral process continues.

4. Based on this information, the 0-5 Director will determine the next steps. The team will discuss the progress of ITHAD referrals at monthly team meetings.

OTHER POINTS:
Summaries of the mental health consultant’s general observations will be shared with the Site Director. The mental health consultant will e-mail the tracking spreadsheet with updates from general observations to the ITHAD team. The team should respond to the group with any additional information regarding concerns discussed in the general observations.

PNP/RN will take the lead in coordinating next steps for children with significant health conditions which impact their social-emotional development.

Disabilities Specialist will be involved immediately in planning next steps for children with suspected or diagnosed disabilities. If staff/parents/consultants feel a referral to Birth to Three is indicated, the Disabilities Specialist and 0-5 Director should be contacted via e-mail and an
ITHAD referral packet completed. The DS/0-5 Director may seek the input of additional consultants. Staff will gather input regarding parent concerns and explain the Birth to Three referral process to parents. The team will gather needed data to best support the process within 14 days. Teachers will provide parents with ongoing communication and support regarding the referral status. Parents always reserve the right to initiate a referral to B-3.

For children with clear social/emotional concerns, Mental Health Consultant will take the lead in defining next steps.

If MHC or team decides a specific OT consultation is indicated, the 0-5 Director will contact the OT consultant.

CSES will print applicable emails to have filed in master file. Referral forms and summary reports (as needed) will be routed thru Children’s Services Specialist to have recorded in ITHAD spread sheet and then filed in child’s master file.

**DOCUMENTATION: INFANT/TODDLER HEALTH AND DEVELOPMENT CONSULTATION REQUEST (FORM 403)**
ITHAD Case Management Guidelines
The team will develop a plan which will include:

1. Recommendations to the teacher based on consultation with other team members. If multiple consultants are involved with an individual child, recommendations will be consolidated into one report before sharing with teachers. Consultants will try to avoid giving specific advice/recommendations before the joint report is developed.

2. Follow up dates and the person responsible.

3. Discussion with parents of suggested strategies. We will work hard to include parents in our interventions.

4. All children will active consent will be reviewed at monthly team meetings.

5. Determining if the plan is working or needs modification.

6. Assisting in transitions between I/T classrooms and between I/T and 3-5 classrooms.
Infant/Toddler Health & Development Consultation Request

DATE:  

PROGRAM:  

PERSON MAKING REQUEST:  

CHILD:  

DOB:  

Enrolled Since:  

Address:  

Home Phone:  

Parent/caregiver:  

Relationship:  

Contact #:  

Parent/caregiver:  

Relationship:  

Contact #:  

EHS:  

Advocate:  

Program PNP/RN:  

FORM #401  

CONSENT required for Soc/Emot Consult or Sensory Consult.  Is this attached?  

MEDICAL/HEALTH CONCERNS (including medications)/CURRENT HEALTH/DEVELOPMENT HISTORY  

Date(s) of Creative Curriculum:  

Areas of strengths  

Areas of concerns  

Possible ‘distant triggers’ for child’s behavior:  summarize family history & current situation:  

OTHER INDIVIDUALS/SERVICES INVOLVED WITH THIS CHILD:  

IFSP for  

Date of Release for Communicating w/ B-3  

Medical  

Date of Release for Clinic/Dr  

Mental Health therapy w/  

Date of Release for MH Provider/Clinic  

Description of the Concerns  

Intensity, frequency, and duration of concerns  

Possible Triggers  

WHAT YOU THINK MIGHT BE FACTORS CONTRIBUTING TO THE CONCERN:  


child name: _______________________________

WHEN DID YOU FIRST NOTICE THE CONCERN? ________________________________________________________________
____________________________________________________________________________________________________________
________________________________________________________________________
___________________________________________________________________________________________________________

CLASSROOM or INDIVIDUAL STRATEGIES:

<table>
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<th>That have worked (at least some times):</th>
<th>That haven’t worked yet:</th>
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FAMILY DISCUSSIONS DATES & SUMMARY OF INFO SHARED: ______________________ ________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

FAMILY RESPONSE /CONCERNS: ______________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

WHAT STAFF WANT FOR SUPPORT: ______________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Program staff, send this form to your program supervisor who will complete below & forward to 0-5 Director

Program Supervisor notes based on observations
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Site Director (required) ______________________ Date ______________________
Policy on Swaddling

Reference: State of Wisconsin group child care regulation 251.09 (1) (f)
Swaddling of infants is permitted, if requested by the parent. Swaddling is an age-old practice of wrapping infants snugly in swaddling clothes, blankets, or similar cloth so that movement of the limbs is tightly restricted.
If the child pulls the blanket out during nap time the provider must ensure that that blanket is kept away from the child’s mouth and nose.

Head Start Performance Standards: 1304.53(b) (3)
1304.21(c) (1) (1) Grantee and delegate agencies, in collaboration with the parents must implement a curriculum that: (i) supports each child’s individual pattern of development and learning.
1304.21(a)(3)(i)(E) Supporting and respecting the home language, culture, and family composition of each child in ways that support the child’s health and well-being

Swaddling to Support a Family’s Cultural Practices
In order for DCPC staff to provide care which supports a family’s cultural practices, parents may request that child care staff swaddle their infant during nap time up to the age at which the infant is able to turn herself over, but not longer than age four months. Parents must initiate and complete a Request for Swaddling form and demonstrate to the teacher how the infant is swaddled at home. Staff must be trained to swaddle by the PNP/RN before they can swaddle infants in child care. A copy of the Request for Swaddling form should be kept in the Health Action binder and the yellow copy sent to the PNP/RN. If an infant turns himself over, he must be unswaddled, and swaddling discontinued.

Swaddling as an Intervention
Swaddling may also be used as an intervention strategy to help awake infants soothe and regulate, particularly for infants under three months and those with underdeveloped regulation systems due to prematurity or infants with sensory differences. With careful consideration of the infant’s strengths and vulnerabilities, swaddling may be an effective and appropriate part of an individual child’s plan. It is important to assist infants in developing their own self-regulation capacities, and swaddling should be used as a last resort.

To determine if the use of swaddling as an intervention may be indicated for an individual infant, the teacher should complete the Infant/Toddler Health and Development Consultation Request form. Based on the information provided in the request and by the nurse and mental health consultant, the 0-5 Director will determine if an individual OT consult is indicated. If the OT consultant determines that swaddling would be an appropriate part of a child’s plan, individualized instructions will be outlined on the Request for Swaddling form. Staff must be trained to swaddle by the PNP/RN before they can swaddle infants in child care. Infants will be swaddled using the Kiddopotamus Swaddle Me wrap. The effectiveness of swaddling for these infants will be evaluated regularly and discussed by the team at monthly ITHAD meetings.
Dane County parent Council Parent, Inc.
Request for Swaddling Form

Child’s Name__________________________
Date of Birth____________________________
DCPC Program_____________________

I, __________________________________ , request Dane County parent Council, Inc. child care staff to swaddle my infant,____________________________ . I currently use swaddling to put my infant to sleep. I have demonstrated how I swaddle to DCPC staff. I understand that the medical community is uncertain about the potential health risks/benefits of swaddling. I will discuss the use of swaddling during sleep with my child’s health care provider. I understand that when my infant begins to turn him/herself over while sleeping or unswaddles him/herself, staff will no longer swaddle my child during nap time.

Parent Name______________________________________
Parent Signature___________________________________
Staff Signature_________________________________
Start Date __________________________________________
Date Swaddling to end_______________________________

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Request for Swaddling (Intervention)

I request DCPC to swaddle my infant,____________________________, as an intervention strategy to help my infant soothe and regulate while awake. Swaddling will be utilized according to the individualized instructions below. Staff will not swaddle my infant during sleep once he/she is older than four months.

Individualized Instructions from OT Plan:

Parent Name________________________________________   Staff Signature______________
Parent Signature_____________________________________
Date__________________________

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