HEALTH, SAFETY, AND NUTRITION

reach DANE

reach GREEN

Health, Safety, and Nutrition

Table of Contents

Introduction

Reach Dane 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 they are no longer contagious.
3. Parents are notified of communicable disease occurring in the classroom. The Public Health Department and WI Childcare 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 diseases.

Safety Section

Safety Policies

Classroom Safety Requirements

Reach Dane will ensure that all classroom sites are following state licensing requirements.

Teachers must complete a classroom Fire, Safety, and Health Checklist Form each month. The form must be posted at 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)

Home Safety Education

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

The Home Safety Checklist is in the parent handbook for the parent to review and go over.

Staff may take the Home Safety Checklist on the first home visit to discuss with parents and fill it out together if parents choose.

Home Visitation Teachers may complete the Home Safety Checklist together with parents, and record this on the HV Lesson Plan the week it is completed.

DOCUMENTATION: HOME SAFETY CHECKLIST 0-3 YEARS (#152)
HOME SAFETY CHECKLIST 3-5 YEARS (#153)

Reach Dane Policy on Sunscreen and Insect Repellent

(Updated June 2017)

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

Sunscreen

Babies *under* 6 months will avoid direct sun exposure. They should remain in the shade whenever possible. Wearing hats and using 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 the 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 sunscreen if they prefer. Reach Dane 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 waterproof.). *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, Reach Dane 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 and its strength. 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 Reach Dane 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 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, Reach Dane 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, Reach Dane will provide an approved insect-repellent.

Whether the bug spray is parent - or center-provided, **individual authorization forms #715 must be completed** for each child. Each authorization must list the full name of the bug spray product and strength. 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 out of the reach of children!

The following precautions will be taken:

1. The Reach Dane staff person should read and carefully follow all directions before applying the product. (Children may not apply insect repellents themselves)
2. **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)
3. 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.
4. Staff should apply repellent to children's exposed skin.
5. Do not use repellent on the hands of the children (so they don't rub eyes or mouth).
6. Staff should apply repellent to the adult's hands, and then apply to the child's face – taking care to avoid the eye and mouth areas.
7. Do not apply over cuts, wounds, or irritated skin. (Contact PNP/RN about children with eczema before needing to apply product)
8. Avoid using sprays in enclosed areas. Do not apply products near food, toothbrushes, etc.
9. Wash the exposed area immediately with soap and water if an allergic reaction is suspected.

Parent-provided repellent must contain 0- 30% DEET for Reach Dane 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.

DOCUMENTATION: PARENT/GUARDIAN AUTHORIZATION FOR SUNSCREEN/INSECT REPELLENT (#715)

Car Seat Training/Requirements

Staff who transport children by car seats will attend annual car seat training. Staff that should be trained include: family advocates, family outreach workers, health manager, FOW supervisors, EHS supervisors, and administrative services staff.

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 manufacturer or healthychildren.org for specific height and weight guidelines for each brand and model of car seat.

Age Group	Type of Seat	General Guidelines
Infants/ Toddlers	Rear-facing only seats and rear-facing convertible seats	All infants and toddlers should ride in a **Rear-Facing Car Seat** 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.
Toddlers/ Preschoolers	Convertible seats and forward-facing seats with harnesses	Any child who has outgrown the rear-facing weight or height limit for their convertible car seat should use a **Forward-Facing Car Seat** with a harness for as long as possible, up to the highest weight or height allowed by their car seat manufacturer.
School-Aged Children	Booster seats	All children whose weight or height is above the forward-facing limit for their car seat should use a **Belt-Positioning Booster Seat** 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.
Older Children	Seat belts	When children are old enough and large enough for the vehicle seat belt to fit them correctly, they should always use **Lap and Shoulder Seat Belts** for optimal protection. All children younger than 13 years should be restrained in the rear seats of vehicles for optimal protection.

WI State Law: (https://wisconsindot.gov/Pages/safety/education/child-safety/default.aspx)

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:
    a. 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)

   b. 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)
   c. 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
   a. If less than four years of age, the total penalty is $175.30
   b. 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 expiration. 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 health manager 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.

Emergency Procedures – Staff Responsibilities

(To be reviewed at monthly Site Meetings)

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 the 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 the building with the children and the lead teacher will check 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, emergency backpack, 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 June 2019)

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 Reach Dane 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 Reach Dane 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 for an outside line.

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. Online first aid training will be required for all new staff to complete within 6 months of hire. Training monies are available for staff who are also interested in First Aid certification.

Fire/Tornado/Severe Weather Plans

(Detailed Policies to 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 the location of every child.

Flood Plans

Few, if any, Reach Dane sites are in areas at risk for flood. However, each site may

find itself in this emergency situation. Because each Reach Dane 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 Reach Dane owned site, contact the site director or a member of management for assistance. If the site has a property owner, 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 attached in Child Plus, office staff will begin contacting families.

Lost or Missing Children

See full policy in the 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 get a hold of 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 Director of Business Operations and Career Pathways. The director 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 the 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 Index (AQI) that is "Unhealthy" or worse, treat the situation similarly to inclement weather and remain indoors. The site director and/or site staff will monitor if there is an "unhealthy" AQI.

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 the official agency policy.

Yellow Health Action 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, which need to be looked at further because they may be a potential source of danger to children and staff. In addition, the assigned PNP/RN may periodically review logs.

Each child's accident report will be reviewed by the program supervisor and Director of Business Operations and Career Pathways 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, do not panic. Ensure an adult stay with the children to keep them calm.
2. Stop the bus in a safe position/place
3. Prevent additional accidents and injury:
    a. Turn on hazard lights
    b. Set brakes
    c. Turn off ignition
    d. Set reflectors
    e. Evacuate if:
        i. There is a fire
        ii. It smells like gas
        iii. There is smoke
        iv. There is a danger of drowning
        v. 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
        i. Give clear and concise answers
        ii. Get name and badge number
    d. Write up all the 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 Director of Business Operations and Career Pathways and the Executive Director– who will then file a report with Childcare Licensing within 48 hours of the accident.

Head Injuries

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:

1. 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
2. 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
3. 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.

5-Minute Contact Person

Each Reach Dane site will establish a 5-minute contact person in case of emergencies. The current staffing structure is two staff open a center and two staff close a center. In the event one of those staff members calls in sick, they will notify their supervisor and/or Site Director, and then alert the 5-minute contact person to report to the site and/or be called in the event of an emergency.

Medical Emergency First Aid Plan (To Be Posted)

The following guidelines are for staff to follow in case of 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 the 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 always remain with the injured child. 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 Director of Business Operations and Career Pathways 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 the 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 the teeth or jaw.
    c. Take the child to the dentist immediately.
3. If tooth is fractured: Call the dentist for treatment guidance. Staff can do little about 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. <u>If it is not possible</u> 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. <u>Take the child to the dentist immediately. It is most important that the tooth be replanted within 30 minutes by the dentist.</u>
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 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 quickly check 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 the daily attendance (and tracking sheets), first aid kit, and emergency cards/Health Condition Alert forms on every drill/emergency.

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 conducted monthly.
4. **Home Based Programs**: Fire drills will be conducted first and third quarters at the clusters and second quarter in the child's home using the home safety checklist. The fire drill will be recorded on form #350 " FIRE and SAFETY DRILL Documentation for GROUP CHILDCARE CENTERS “the same day as the fire drill occurs. This should be posted in a clear view.
5. Smoke detectors are to be checked weekly and recorded on the safety checklist log sheet.
6. 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.
7. Children who need one-on-one attention should be listed on evacuation plans (with initials) and sought out by staff members during a drill.
8. 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 always kept on – be sure they are 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. Staff are to take the daily attendance and tracking sheets, first aid kit, and emergency cards (including Health Condition Alert forms) on every drill/emergency.

Shelter Selection: How to Determine the Best Spot

1. The lower the floor, the more desirable the protection. Basements are the safest shelter.

2. If there is no basement, the location should be 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 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. Do not 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 by 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 first aid kit.
    d. Stay put until an all-clear has been determined. **

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 your 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

(Note: 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:

First Aid Kit	
First Aid Book	1
Adhesive Tape Roll	1
Band Aids	30
Cold Pack	2
Gauze Roll	1
Gauze Pads 2” x 2”	5
Gauze Pads 4” x 4”	5
Scissors	1
Thermometer	1
Thermometer sheaths	25
Toilettes – water based	10
Gloves	2 sets

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:

DOCUMENTATION: FIRST AID/HEALTH SUPPLIES RE-ORDER FORM (#397c)

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

EMERGENCY BACKPACK SUPPLIES RE-ORDER FORM					
SITE / PROGRAM:			**TEACHER:**		
******CHECK OFF SUPPLIES NEEDED******					
	Preschool Contents	✓ if needed		**Infant/Toddler Contents**	✓ if needed
1.	Working Flashlight w/ batteries		1.	Working Flashlight w/ batteries	
2.	Weather Radio w/ batteries		2.	Weather Radio w/ batteries	
3.	Whistle		3.	Whistle	
4.	First Aid Kit (Band-Aids and Gauze)		4.	First Aid Kit (Band-Aids and Gauze)	
5.	Walkie Talkie w/ batteries		5.	Walkie Talkie w/ batteries	
6.	Paper Cups		6.	Paper Cups	
7.	Kleenex Tissue Packet		7.	Kleenex Tissue Packet	
8.	2-3 Pairs of Gloves		8.	2-3 Pairs of Gloves	
9.	Food Item		9.	Food Item	
10.	Note Pad and Pen		10.	Note Pad and Pen	
			11.	Wipes	
			12.	Disposable Diapers	
			13.	Changing Pad	
			14.	Ziploc Bags	
Please return to the Site Director. Thanks					

This emergency backpack containing all necessary supplies will be taken:

1. During fire drills
2. During any emergency evacuation

*Children should never carry an emergency backpack.

*During evacuations, children are to be wearing Reach Dane 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.

BLOOD / BODILY FLUID SPILL KIT SUPPLIES RE-ORDER FORM
(Form 414)

BLOOD / BODILY FLUID SPILL KIT SUPPLIES RE-ORDER FORM		
SITE / PROGRAM:	**TEACHER:**	
******CHECK OFF SUPPLIES NEEDED******		
	CONTENTS	✓ if needed
1.	Plastic Bucket	
2.	Permisorb Clean-Up Kit (incl. shovel / etc.)	
3.	Protective Gown/Mask	
4.	Goggles	
5.	Small Spray Bottle of Germicide	
6.	(2) Germicidal Moist Towelettes	
7.	Gloves	
8.	Tongs (for picking up broken glass)	
9.	Laundry Detergent Bottle (empty – for broken glass)	
10.	Exposure Incident Forms	
11.	Pink Laminated Directions	
12.	Supply Re-Order Form	
13.	Fluid Absorbent	
14.	(2) Red Bio-Hazard Bags**	
15.	Biohazard Sticker (for laundry detergent bottle)	
16.	Bleach	
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.

Bloodborne Pathogens Exposure Control Plan

(Updated 8/2009)

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

Purpose

The purpose of this exposure control plan is to:

1. Eliminate/minimize employee occupational exposure to blood or certain other body fluids.
2. Comply with the OSHA Blood borne Pathogens Standard, 29 CFR 1910.1030.

Exposure Determination

OSHA requires that the agency determines which employees could be exposed to body fluids containing blood in the course of their work. Reach Dane has determined that the following job classifications could be exposed to blood borne pathogens while fulfilling their job requirements:

Lead Teachers, Site Directors, Openers/Closers, Home Visitation Teachers, Family Advocates, Teacher Assistants, Childcare Teachers, Transportation Specialists and Administration Assistants.

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

Implementation Schedule and Methodology

1. **Compliance Methods**
    a. Standard precautions will always be observed 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 vomit 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 their hands and any other potentially contaminated skin immediately or as soon as feasible with soap and water. Employees must also wash their 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 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 ensure 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 is 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 Reach Dane 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 gowns 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 dustpan 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. Reach Dane shall make available the Hepatitis B vaccination series to all employees who have occupational exposure.
   b. Reach Dane 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.
   c. 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.
   d. 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.
   e. 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:

i. Made available at no cost to the employees.
ii. Made available to the employee at a reasonable time and place.
iii. Performed under the supervision of a licensed healthcare professional; and
iv. Provided according to the recommendations of the U.S. Public Health Service.

5. **Post Exposure Evaluation and Follow-up**
   a. Reach Dane 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:
      i. Documentation of the route of exposure, and the circumstances under which the exposure incident occurred.
      ii. Identification and documentation of the source individual.
      iii. 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.
      iv. When the source individual is already known to be infected with HCV, HBV or HIV, testing need not be repeated.
      v. 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:
      i. The exposed employee's blood shall be collected as soon as feasible for testing after consent is obtained.
      ii. The employee will be offered the option 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:

i. A copy of 29 CFR 1910.1030
ii. A written description of the exposed employee's duties as they relate to the exposure and circumstances under which exposure occurred.
iii. Written documentation of the route of exposure and circumstances under which exposure occurred.
iv. Results of the source individual's blood testing, if available; and
v. 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.
g. 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.
h. The healthcare professional's written opinion for post exposure follow-up shall be limited to the following information:
    i. A statement that the employee has been informed of the results of the evaluations; and
    ii. 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.
    iii. All other findings or diagnosis shall remain confidential and shall not be included in the final report.

6. **Information and Training**
    a. 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:
        i. A copy of the standard and an explanation of its contents.
        ii. A discussion of the epidemiology, symptoms, and hazards of blood borne diseases.
        iii. An explanation of the modes of transmission of blood borne pathogens.
        iv. The recognition of tasks that may involve exposure.
        v. An explanation of the use and limitations of methods to reduce exposure, for example, engineering controls, work practices and personal protective equipment (PPE).
        vi. Information on the types, use, location, removal, handling, decontamination, and disposal of PPEs.
        vii. An explanation of the basis of selection of PPEs.
        viii. Information of the Hepatitis B vaccination, including efficacy, safety, method of administration, benefits and that it will be offered free of charge.

ix. Information on the appropriate actions to take and people to contact in an emergency involving blood or other potentially infectious materials.
x. An explanation of the procedures to follow if an exposure incident occurs, including the method of reporting and medical follow-up.
xi. Information on the evaluation and follow-up required after an employee exposure incident.
xii. An explanation of the signs, labels, and color-coding systems.
xiii. An explanation of Reach Dane's Blood borne Pathogens Exposure Control Plan and a method of obtaining a copy.

b. 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.
c. 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
      i. 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.
      ii. 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.
      iii. Training Records
         1. The Human Resources Manager is responsible for maintaining the following training records. These records will be kept in the training files. The following information shall be documented.
            a. The dates of the training sessions
            b. An outline describing the material presented
            c. The names and qualifications of persons conducting the training
            d. The names and job titles of all persons attending the training

iv. Availability
    1. All employee records shall be made available to the employee in accordance with 29CFR 1910.20.
    2. 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.
v. Transfer of Records
    1. 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**
    a. The Executive Director and Human Resources Director are responsible for annually reviewing this program and its effectiveness and for updating this program as needed.

DOCUMENTATION: EXPOSURE INCIDENT INVESTIGATION FORM (#336)

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: 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, Reach Dane 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 childcare.

Guidelines to promote safe sleep

Sleep position

- Place infants up to twelve months of age 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 indicating 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; Reach Dane 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 the site supervisor or Director of Business Operations and Career Pathways if room temperature needs adjustment.
- Infants should not have hats on while they sleep. For programs licensed for 4-week-olds, physicians may order 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 Reach Dane. Sleep sacks will be provided for children less than 12 months of age.
- Swaddling can only be used in accordance with Reach Dane swaddling guidelines.
- Smoking will not be allowed in or near Reach Dane.

Supervision

- When infants are in their cribs, they will be always within sight and hearing of staff. Ensure the lighting is appropriate so that all staff can clearly see sleeping children.
- 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 an employee has not had additional training, Reach Dane 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 families to have 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 Reach Dane and a copy will be provided in the parent handbook. Information regarding safe sleep practices, safe sleep environments, reducing the risk of SIDS in childcare 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 Section

Health Policy

The overall goal of Reach Dane'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 childcare setting. Despite the best efforts of parents and childcare providers, children in childcare often get sick and it is important to have guidelines to know how to proceed.

Parent Education

Reach Dane will provide opportunities for parents to learn about preventative medical and oral health care, emergency first aid, environmental hazards, safety practices for the home, safe sleep, child's nutritional status, pregnancy and postpartum care, issues related to child mental health and social and emotional well-being, and appropriate vehicle and pedestrian safety.

Preventative medical and oral health care will be discussed with parents during the enrollment process and throughout the school year, using enrollment paperwork and reports from the health team as talking points. Staff will discuss enrolling in insurance, finding a primary clinic and scheduling physical and dental exams on home visits and through phone calls. Emergency first aid education is given in handout form and found in the parent handbook. Environmental hazards and safety practices for the home are discussed about using the home safety checklist – see Home Safety Education section. Staff will educate parents on safe sleep using SIDS brochures and handouts. Reach Dane agency nurses educate pregnant moms regarding this topic during pregnancy. The child's nutritional status is reviewed by staff using the nutrition assessment and nutrition history interview. Pregnancy and postpartum care education is ongoing throughout the pregnancy using the pregnancy services plan and the agency nurses also meet with parents.

Reach Dane has implemented the ACT Raising Safe Kids Parenting Curriculum to educate parents on information regarding mental health and social and emotional well-being. Vehicle and pedestrian safety are discussed at the start of the school year through our bus safety curriculum during phase-in/open house. Staff also educate parents regarding proper car seat installation and can work to schedule appointments with Safe Kids Dane County. Reach Dane works with Safe Kids to provide parent training as requested.

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 childcare 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 childcare settings.

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

You may encounter medical emergencies or urgent situations as a childcare 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 significantly dehydrated: sunken eyes, lethargic, not crying tears, not urinating.
- The child has a 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 directions.

Symptoms Requiring a Child to be Sent Home

Children in childcare 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 whether 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 childcare 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/he 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 childcare centers (found in the 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 tend 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 Reach Dane 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 in 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 if 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 if contamination has occurred. Any violation of these confidentiality provisions could result in criminal consequences, according to state law.

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

Reach Dane 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
Reach Dane recognizes that it 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.

Reach Dane Communicable Disease Policy and Exclusion Guidelines

(Updated 2023)

There are only 3 reasons to exclude an ill child from a childcare 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 childcare regulations identifies certain diseases that are reportable to LHD and give permission to childcare 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 childcare from WI Communicable Diseases Chart, May 2014:

1. Chicken pox (varicella)
2. Conjunctivitis (pink eye- bacterial or viral) – exclude with fever
3. COVID-19 (Coronavirus Disease) ** - DHS updating
4. 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
5. Hand, Foot, and Mouth Disease – exclude with fever
6. Hepatitis A**
7. Hepatitis B**
8. Herpes simplex (cold sores) – exclude until fever free, able to control drooling, blisters resolved
9. Impetigo
10. Influenza
11. Lice (pediculosis)
12. Measles (Rubeola) **
13. Meningitis **
14. Mumps**
15. Pertussis (whooping cough) **
16. Pinworms
17. Ringworm of the body (tinea corporis) and of the scalp (tinea capitis)
18. RSV (Respiratory syncytial virus)
19. Roseola (Exanthum subitum)
20. Rubella (German measles) **
21. Scabies
22. Shingles

23. Staphylococcal infections (including MRSA) ** - Exclude if wound drainage cannot be contained
24. Strep throat/Scarlet fever
25. 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.**
B. Communicable Disease Exposure Notices are stored on the Reach Dane Shared Drive in the Communicable Disease Exposure Notices folder and on the Reach Dane website on the staff intranet.
C. The length of time to exclude varies with each disease; check with PNP/RN, Health Manager or the WI Communicable Disease Chart, May 2014 to determine when child may return to childcare.
D. 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 childcare. **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 childcare 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 the last episode of diarrhea.
    a. Diarrhea is defined as more watery, less formed, more frequent stools not associated with a diet change or medication (looser/thinner than applesauce consistency)
        i. 3-5-year-olds: three or more large watery stools in 8 hours or one loose uncontrolled stool for which preschooler cannot make it to the bathroom in time.
        ii. Infants/toddlers: three or more large watery stools in a diaper or three large stools that cannot be contained in a snug fitting diaper.
    b. A child with diarrhea may remain in childcare if he/she has no other symptoms and has a letter from a health care provider stating the child should not be

excluded from childcare (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 childcare 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, rash, 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. old's). 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. COVID-19 – see section below
B. Herpes Zoster (Shingles) – Child may remain in childcare if rash is covered by clothing or bandage until rash has crusted. If rash cannot be covered, consult health care provider.
C. Lice – Head Lice does not require immediate exclusion. Children found to have head lice may stay until the 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.
    a. 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.
D. Mouth sores – Exclude when inflammation of oral membranes without control of oral secretions is present. Children with "cold sores" need not be excluded.
E. 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.

F. 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.
G. 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 the end of day if area is covered with a bandage. If cannot be covered, contact the nurse. Child may return when anti-fungal treatment has been started.
H. 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 the 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.

COVID-19 Procedures

Prevention Strategies

Schools and childcare programs should implement the following strategies to help reduce the risk of COVID-19 and other respiratory illnesses. Layering prevention strategies can be especially helpful when respiratory viruses are causing a lot of illness in your community, you, or those around you have risk factors for severe illness, and you or those around you were recently exposed, are sick, or are recovering.

Immunizations

Stay up to date with the immunizations that are recommended for you. For most people that means getting a current flu and COVID-19 vaccine.

Immunizations help prepare your body to defend itself from viruses and severe illness. Some immunizations teach your immune system what the virus looks like so it can prepare to protect against it. Other immunizations directly provide you with antibodies to protect you from the virus. Getting vaccinated can reduce your chances of getting infected to some degree, but its main strength is preventing severe illness and death. More evidence suggest that the COVID-19 vaccine can also lower your chances of developing Long COVID.

Hygiene

Practice good hygiene by covering your coughs and sneezes, washing, or sanitizing your hands often, and cleaning frequently touched surfaces.

Covering your coughs and sneezes limits the spread of germs to protect others. Handwashing with soap removes germs from your hands, making them less likely to infect your respiratory system when you touch your eyes, nose, or mouth. If soap and water are not available, using a hand sanitizer with at least 60 percent alcohol can kill these germs. To remove germs and dirt from surfaces, use household cleaners that contain soap or detergent.

Steps for Cleaner Air
Take steps for cleaner air. This can mean bringing in fresh outside air, purifying indoor air, or gathering outdoors. Virus particles do not build up in the air outdoors as much as they do indoors.

Bring as much fresh air into the building as possible by opening doors and windows and/or using exhaust fans. If your home has a central heating, ventilation, and air conditioning system (HVAC, a system with air ducts that go throughout the home) that has a filter, set the fan to the "on" position instead of "auto" when you have visitors and use pleated filters. Change your filter every three months or according to the manufacturer's instructions. Use a portable high-efficiency particulate air (HEPA) cleaner. Move activities outdoors, where airflow is best.

Preventing Spread When You are Sick
Stay home and away from others (including people you live with who are not sick) if you have respiratory virus symptoms that are not better explained by another cause. These symptoms can include fever, chills, fatigue, cough, runny nose, and headache, among others. *See Exclusion Guidelines.

Masks
Wearing a mask can help lower the risk of respiratory virus transmission. When worn by a person with an infection, masks reduce the spread of the virus to others. Masks can also protect wearers from breathing in infectious particles from people around them. Different masks offer different levels of protection. Wearing the most protective one you can comfortably wear for extended periods of time that fits well (completely covering the nose and mouth) is the most effective option.

Face masks are not allowed on children under two years of age or on any child with a disability who cannot wear a mask, or cannot safely wear a mask, for reasons related to their disability.

1. Individuals under 2 years of age: not required
2. Individuals 2 years of age and older: not required except in special circumstances. When required, masks should be worn indoors, outdoors in crowded settings or during activities that involve sustained close contact with other people, and on Reach Dane transportation (busses, vans, etc.).
    a. Staff and children over 2 years of age may choose to wear a mask if they are more comfortable doing so, regardless of respiratory transmission levels.
3. Individuals are required to mask during a COVID-19 infection
4. Special circumstances that Reach Dane may require masking:
    a. When the COVID-19 level is high (see Madison & Dane County Public Health Respiratory Illness Dashboard https://publichealthmdc.com/coronavirus/dashboard).
5. Refer to Centers for Disease Control and Prevention (CDC) for guidance on masking: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/masks.html

Reach Dane will continue to follow local ordinances and Head Start regulations for mask usage.

Physical Distancing
Putting physical distance between yourself and others can help lower the risk of spreading a respiratory virus. There is no single number that defines a "safe" distance, since spread of viruses can depend on many factors.

Infectious droplets and particles build up closer to the person who is releasing them. The closer you are to someone who has a respiratory virus, the more likely you are to catch it.

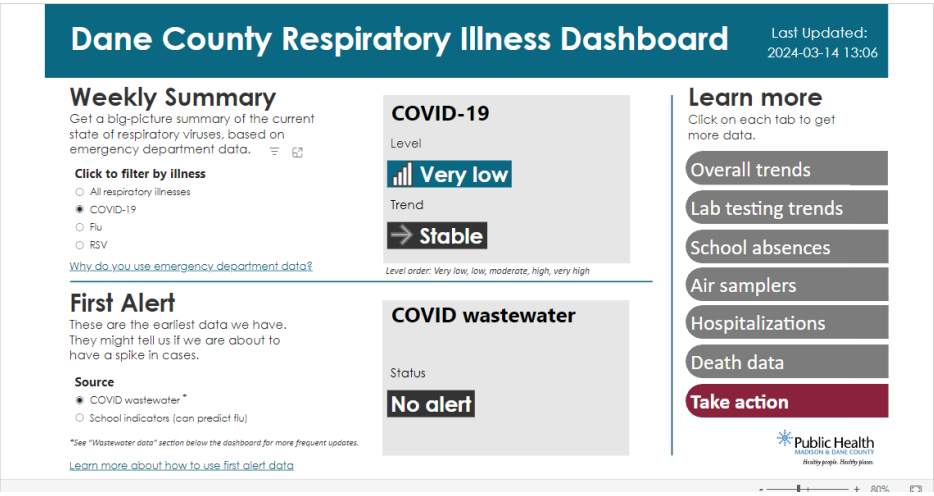
Testing
Testing for respiratory viruses can help you decide what to do next, like getting treatment to reduce your risk of severe illness and taking steps to lower your chances of spreading a virus to others. There are various types of tests for respiratory virus infections. Antigen tests ("self-tests" or "rapid tests") usually return results quickly (around 15 minutes). A healthcare provider normally conducts PCR tests. Although antigen tests are usually faster, they are not as good at detecting viruses as PCR tests. This means that you might get a negative result with an antigen test but be infected with the virus.

Tests can help you find out if you are currently infected with a certain respiratory virus. While testing does not change how likely you are to catch or spread respiratory viruses, or how severe your illness might be, it can provide useful information to help you make prevention or treatment choices.

Treatment
Seek health care right away for testing and/or treatment if you believe you may have a respiratory virus (if you feel sick or tested positive for one) and you have risk factors for severe illness. If you have flu or COVID-19, treatment may be an option to make your symptoms less severe and shorten the time you are sick. Treatment needs to be started within a few days of when your symptoms begin.

Respiratory Illness Dashboard
Dane County Respiratory Illness Dashboard is a tool to help Reach Dane decide what prevention steps to take based on the latest data.

Respiratory Illness Dashboard



Refer to Madison & Dane County Public Health website: https://publichealthmdc.com/coronavirus/dashboard. At high levels of community transmission, Reach Dane may implement additional safety measures.

Communication

Reach Dane will promote COVID mitigation strategies to staff and families via email, Child Plus, Class Dojo, and the agency website during pertinent times of the year (i.e., start of school, flu/cold season, etc.).

Policies will be reviewed at least annually. Any changes will be communicated to staff and families via emails, parent letters, and updating information on the agency website.

The program will post and notify families of any confirmed staff or child cases of COVID-19.

Visitors

All visitors that need to enter Reach Dane facilities should self-monitor for symptoms of COVID-19 and other respiratory illnesses. They must follow Public Health guidelines if they are ill or have been exposed to COVID-19. Visitors will also need to follow Head Start Guidelines and local ordinances for any COVID requirements (i.e., masking, vaccination, etc.). During Low and Medium COVID levels, there are no restrictions to visitors.

During High COVID Transmission:

- Reach Dane may require masking for all visitors.
- Reach Dane may restrict school age siblings from coming into the building.
- Reach Dane may restrict non-essential visitors and/or volunteers in the classroom.

Symptom Check

Continue to perform Daily Health Checks and follow COVID and normal exclusion guidelines as needed. Refer to the Reach Dane Blue Book for normal exclusion guidelines.

Transportation Procedures

Hand sanitizer will be available on the bus for students to use as they board the bus. Follow Head Start Guidelines and local ordinances for any COVID requirements (i.e., masking, vaccination, etc.).

During High COVID Transmission:

Disinfect high touch points (i.e., STAR seats buckles, windows, handrail) daily. Clean back of seats as students tend to touch these frequently and breathe onto that surface.

Home Visitation

- Confirm all home visits in advance (if possible) and ask the parent/guardian if anyone in the house has any COVID symptoms or has tested positive for COVID.
- If anyone in the household tests positive for COVID, ask how you can support the family while they are sick. In-person home visits will be stopped until the individual meets the criteria to return to normal activities – see exclusion guidelines.

During High COVID Transmission:

- Limit the amount of equipment brought into any home.
- Take only washable toys and be certain to put them in the dishwasher later for disinfecting. Avoid soft toys as these are more difficult to disinfect.

Exclusion Guidelines

Stay home and away from others if you have respiratory virus symptoms that are not better explained by another cause. These symptoms can include:

- Fever
- Chills
- Fatigue (tiredness)
- Cough
- Runny or Stuffy Nose
- Headache

Other symptoms may include but are not limited to:

- Chest Discomfort
- Decrease in Appetite
- Diarrhea
- Muscle or Body Aches
- New Loss of Taste or Smell
- Sneezing
- Sore Throat
- Vomiting
- Weakness
- Wheezing

You can go back to your normal activities when, for at least 24 hours, both are true:

1. Your symptoms are getting better overall, **and**
2. You have not had a fever (and are not using fever-reducing medication).

When you go back to your normal activities, take added precautions over the next 5 days, such as taking additional steps for cleaner air, hygiene, masks, physical distancing, and/or testing when you will be around other people indoors.

If you develop a fever or start to feel worse after you have gone back to normal activities, stay home and away from others again until, for at least 24 hours, both are true:

1. Your symptoms are improving overall, **and**
2. You have not had a fever (and are not using fever-reducing medication).

Then take added precautions for the next 5 days.

Please reference the CDC website for examples of when to stay home and away from others: https://www.cdc.gov/respiratory-viruses/prevention/precautions-when-sick.html.

Positive COVID-19 Test - Reporting

1. If an enrolled child or employee tests positive for COVID-19 via laboratory testing through the medical system, the Department of Children and Families will be contacted. Reach Dane does not need to report at-home positive tests.
2. The program will post and notify families of any confirmed staff or child cases of COVID-19.
3. Reach Dane will report COVID-19 outbreaks to Public Health through the COVID-19 Facility Survey - https://survey.alchemer.com/s3/7318728/COVID-19-Facility-Survey. Reach Dane will also report the outbreak to the Department of Children and Families.
4. Reach Dane will discuss potential classroom closures based on current positive COVID numbers. Factors considered include the number of student and staff absences, safety practices, Public Health data and other community concerns.

Reach Dane Bed Bugs Policy – Center Based

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

Bed bugs are experts at hiding. Their slim flat bodies allow them to fit into the smallest of spaces and stay there for prolonged 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 belongings carrying bed bugs into a Reach Dane childcare or Head Start classroom.

Bed bug resources for staff, including bed bug information, parent handouts, can be found in the Communicable Disease Exposure Notices folder on the shared drive and on the Reach Dane website on the staff intranet.

Guidelines for Childcare 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.
- Various 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 (i.e.: 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 bugs should be removed from the 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 childcare center or school will not be excluded from childcare or school.
- Staff should notify a Reach Dane PNP/RN with concerns of possible bed bug bites on a child.
- Children living in a home with a known bed bug infestation:
    - Are not excluded from childcare or school

    - Car seats, diaper bags, backpacks and unnecessary personal effects cannot be brought into the Reach Dane facility.
    - Necessary personal effects (i.e., coats, hats, gloves, a change of clothing) will be stored in a plastic container while the child is at daycare.
    - 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) Bee Sting Allergies. A Generic Health Action Plan is used for all other health conditions requiring modification of care. The nurses or health manager will complete a Food Allergy/Intolerance plan.

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 in each classroom close to the medications and will be labeled as Health Action Plan Binder. In this binder, the Reach Dane 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 Reach Dane 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.

Policy for Children with Medical Procedures

Reach Dane must provide care for children with complex medical needs. When these children are enrolled, the health team must be consulted during enrollment to determine the start date for the child to ensure appropriate staffing is in place to provide safe care for the child. The Health and Nutrition Manager and/or the Nurse Consultants will determine the level of care necessary for each child. The health team will develop a general health plan for the child that will stipulate the level of care, in addition to specific medical procedures to be performed in the classroom.

Level of Cares are outlined as RN- Only Tasks vs RN Delegated Tasks.

1. **RN- Only Tasks**
   The following tasks can only be performed by Registered Nurses and may not be delegated to Special Needs Aids or other staff. Reach Dane must arrange for RNs to provide these tasks and Reach Dane Nurse Health Consultants are the only back-up that can be utilized should RNs not be available to provide cares. These cares include:
   - Administration of fluids, medications or TPN through Central Lines, PICCs and Ports
   - Intermittent Straight Urinary Catheterization
   - Tracheostomy cares
   - Children who are on ventilators
   - Children who are insulin-dependent diabetics: Nurses must be consulted prior to administration of insulin, glucagon, or any other intervention to maintain blood glucose

2. **RN Delegated Tasks**
   The Nurse Health Consultants may delegate the following tasks to trained staff. If a child is enrolled with the following medical needs, a Special Needs Aid should be available to the child to perform the following procedures. If a Special Needs Aid is not available to provide cares, then other Special Needs Aid, Site Directors, or Assistant Site Directors may provide back-up care. If the aforementioned are unavailable to provide cares, then the Health and Nutrition Manager or the Nurse Health Consultants will provide cares. The Nurse Health Consultants will check in once per week with classroom staff to answer questions and assist with care coordination, as necessary. These cares include:
   - G-tube cares including flushes, medication administration and feedings
   - Empty of indwelling urinary catheters, colostomy, ileostomy or urostomy bags.
   - Checking of blood sugars through capillary finger sticks
   - Utilizing assisted devices such as gait-belts, walkers or wheelchairs that require training of proper body mechanics
   - Oxygen Usage in the classroom

Reach Dane Food Allergies/Intolerances Policy Procedures

(Updated 7/2022)

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. Allergic reactions 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. Reach Dane 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.

If a staff member has a severe food allergy and is prescribed an epi-pen, he/she should contact the PNP/RN or Health/Nutrition Manager. The PNP/RN or Health/Nutrition Manager will work with the site to make a plan to reduce/eliminate the risk of exposure to the allergy.

1. **Food Allergy or Intolerance is identified from the Health Condition Alert form**
    a. If food allergy or intolerance is identified, the PNP/RN or Health/Nutrition Manager must be contacted immediately and talked with, please do not 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).
        i. 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.

ii. Parents will be asked to meet with staff prior to the child's start date to assist in the development of an individual plan.
iii. PNP/RN and/or Health/Nutrition Manager will send the plan to key staff listed below.

2. **PNP/RN will:**
    a. Contact parent to initiate and ensure completion of the Reach Dane food modification 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 SPECIAL DIETARY NEEDS TRACKING FORM and FOOD ALLERGY EMERGENCY PLAN.
    c. If a child has a disability requiring menu accommodations, the PNP/RN will send to the MD the SPECIAL DIETARY NEEDS TRACKING FORM and/or FOOD ALLERGY EMERGENCY PLAN to be completed and signed by licensed physician.
    d. PNP/RN will contact the classroom staff, NSP's, site director, and Food Service Manager to discuss the participants meal modifications.
    e. Schedule site staff training for EpiPen use (required for all classroom staff when an EpiPen is prescribed for a child).
    f. Twice a year, the PNP/RN will review the food modification plans in the yellow Health Action Binders.
3. **Dietitian will:**
    a. If needed, RD will clarify the food allergy implementation plan and develop a food allergy communication sheet.
    b. If needed, RD will develop an alternative menu identifying all foods child cannot eat and specifying appropriate substitutes using a master menu for that age group within the time frame of 24-48 hours.
    c. RD will do individualized NSP training as needed.
    d. The RD will approve the 8-week cycle menu at the completion of the menu committee meetings.
4. **Teacher will:**
    a. Be aware of food allergies and required substitutes. For children with severe allergic reactions, discuss with PNP/RN or Health/Nutrition Manager specific classroom accommodations and notifications needed.
    b. The teacher will develop a communication plan with NSP to ensure correct food is provided for each meal. As part of the communication plan, the teacher or teacher assistant will confirm the food substitutions on the Food Ingredient Check and Substitutions form with the food provided by initialing in the appropriate column. The form will be sent back to the NSP on the food cart.
    c. With parental permission, photograph the allergic child, and place the picture on the food modification plan from PNP/RN or Health Manager.
    d. Place the food modification plan in the designated location in the Yellow Health Action Binder.

e. Add the child's name, allergy info, and small photo to CLASS ALLERGY FORM
f. Ensure outside food is not brought into the classroom. Reach Dane does not allow parents to bring food in for celebrations, except for End-of-Year celebrations.
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 have 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 there is no ingredient list on the food product when it arrives, do not serve the food to the child.
    d. Each site will create an NSP Allergy Action Plan to address who will be responsible for reading the ingredient labels and serving the food/communication with staff in the classroom. The form must be posted in the classroom. The NSP Allergy Action Plan will be readdressed at each site meeting.
    e. The NSP will complete the Food Ingredient Check and Substitutions form. At time of food preparation, the NSP will fill out the form for each classroom listing the food to omit and what the substitution is. When sending the cart to the classroom, the NSP will have the form on the cart for classroom staff to complete and initial the second check. When the meal is finished, the form will be sent back to the kitchen for the NSP to keep the records. The form(s) will be submitted weekly to the Health Manager with the production records.
    f. Participate in classroom curriculum activities relating to food allergies.
    g. Have available a Reach Dane "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 a communication plan with the teacher to ensure correct food is provided for each meal.
6. **Food Manager will:**
    a. Purchase and distribute allergy free foods from the Allergy Order Form as requested.
    b. Work with NSPs to ensure each site maintains an "emergency allergy-free meal".

Breakfast/Snack	Lunch
Rice Chex Small jar applesauce	Rice Canned Chicken (with water only) Canned Green Beans

c. All allergy food sent to the site will have ingredient labels.

7. **Site Director will:**
    a. If a child with food allergies will be transferring to another program, the site director should communicate with the health team, new site director and/or classroom staff.
    b. If a child is starting new in a classroom, the site director will check Child Plus to see if any food plan is listed.
    c. The Site Director will orient all staff substitutes to site specific communication plans between the NSP and the individual program.
    d. Will ensure the NSP Allergy Action Plan will be posted in each classroom. At site meetings, the site director will go over the plan to ensure it is still accurate. If there is any staff turnover, the site director will ensure the new staff member is aware of the plan. If a new lead teacher or NSP starts, a new plan must be signed.
8. **Health Manager will:**
    a. If needed, 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.
    b. Enter data from the Food Allergy Implementation Plan into Child Plus.
    c. If needed, the Health Manager will support the PNP/RN review Food Allergy/Intolerance Action Plan in yellow Health Action Binders twice a year.
    d. Please contact the 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 mealtimes.

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

DOCUMENTATION: NSP ALLERGY ACTION PLAN (#518), INVENTORY CHECK AND SUBSTITIONS (#523)

Reach Dane Non-Food Allergies Procedures

(Updated 2022)

1. **Non-Food Allergy is identified from the Health Condition Alert form – EpiPen Prescribed**
    a. 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 do not leave a message. Be prepared to tell PNP/RN/Health Nutrition Manager the best way to reach the parent (including phone numbers).
        i. 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).
        ii. Staff must complete the Medication Authorization Form with parent/guardian and plan for receipt of EpiPen.
        iii. The site director must also be told of the allergies prior to the child's start date.
2. **Non-Food Allergy is identified – no EpiPen**
    a. Forward the Health Condition Alert form to the assigned PNP/RN.
    b. Add child to posted CLASS ALLERGY FORM.
    c. Ensure all involved staff are aware of the child's allergies and exposure action plan.
    d. The site director must also be told of the allergies prior to the child's start date.
3. **For non-food allergy requiring EpiPen, Teacher will:**
    a. Be aware of allergy and symptoms of exposure.
    b. Discuss with PNP/RN or health manager specific classroom accommodations and notifications needed for children with severe allergic reactions
    c. With parental permission, photograph the allergic child, and place the picture on the BEE STING ALLERGY plan or HEALTH ACTION plan from the PNP/RN
    d. Place the plan in the Yellow Health Action Binder.
    e. Add the child's name, allergy info, and small photo to Class Allergy Form
    f. 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.
    g. Be responsible when allergy inducing items are brought into classroom or the children are outside to ensure safety regarding the child's allergy.
    h. 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 BEE STING ALLERGY plan or HEALTH ACTION plan
    b. If a child has a history of <u>anaphylaxis</u>, 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 health plan to:

i. Teacher - responsible for ensuring that an epi-pen is available, if prescribed. Also, responsible for ensuring all staff are aware of the allergy and action plan.
ii. Parent
iii. Submit health plan to health manager for data entry
iv. Schedule site staff training for EpiPen use (required for all classroom staff when an EpiPen is prescribed for a child).

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 – do not overreact, 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 child who bit, was there blood-to-blood contact?
3. **Provide treatment** for bite:
    a. **If there is 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 involves 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.** Reach Dane will pay for this doctor's visit. Check the status of the bitten **child's tetanus immunization** (same as DTP). 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 a staff member 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 them how you handled the incident and wound. The victim's parents 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 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 first aid given (see above).

3. Teach parents and the 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.
    a. If there is no break in skin: The skin should be inspected and washed daily with soap and water.
    b. 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.
5. Please see the Mental Health section for further guidance on responding to biting.
6. If biting continues, consult PNP/RN/Health and Nutrition Manager to rule out underlying medical issues. Also contact the site director for support.

Procedure for Controlling the Spread of Infectious Disease

Prevention and control of infections in childcare 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 childcare.

"The best weapons against increased risk of infection in childcare are hand washing, surface sanitation, immunization …" Susan Aronson, MD, *Healthy Childcare 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. Reach Dane 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 always be followed 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 Reach Dane 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 people 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:**
    a. During contact with blood or body fluids which may contain blood (i.e.: vomit or feces)
    b. During diapering, or assisting a child with toileting
    c. 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 childcare setting, this means cleaning toys, surfaces, and diapering areas as scheduled (see Reach Dane Cleaning Sanitation, Disinfecting Checklist (#218) for more info.

Day-to-Day Sanitation and Disinfecting

WI Childcare 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. Reach Dane 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. Reach Dane has also approved a quaternary sanitizer for this purpose. (If using bleach for disinfecting, it must be prepared daily at ¼ cup to 1gallon 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

Water Table and Water Table Toys

In accordance with NAEYC accreditation standards of best-practice, and in an effort to minimize the spread of infections, water tables will be cleaned and sanitized daily.

1. After the end of each day's use, drain the table
2. Wash the inside of the table and playthings with a detergent soap and drain table again
3. 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

4. Drain the table and allow it to air dry overnight (do not wipe it dry). Air dry utensils. Refill the table in the morning.
5. Additional precautions:
    a. Have children wash their hands well with soap before and after using the table
    b. Do not allow bubble blowing in the water
    c. Do not allow children who have open wounds, rashes, band aids on their hands to use the table
    d. 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.

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 the table with a disposable towel. Toss. Spray with the disinfectant solution. Allow to air dry.

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.

Hand-washing and Personal Cleanliness

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

Reach Dane 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 Reach Dane 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.).

DOCUMENTATION: REACH DANE CLEANING, SANITATION, AND DISINFECTION CHECKLIST (#218)

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, chest/breast 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.
2. **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 it 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.
3. **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)
4. 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.
5. Outdoor spills: Cleaning bodily fluid spills from dirt or grass is difficult, but since there is still a potential for exposure there 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.
    a. 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 (e.g.: 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 biohazardous. 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 the Health Manager to dispose of the 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 the spread of both diarrhea and respiratory illnesses. The most important considerations for a successful hand-washing program are:

- A consistent approach
- A readily available supply of soap and water
- 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 of the spread of germs.
- Adults should wash their hands:
    - Upon arrival at the center
    - After either using the bathroom, 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
    - After arrival
    - Before beginning work responsibilities
    - After cleaning tables with sanitizing solutions
- Children shall wash their hands:
    - After toileting or diapering
    - Children's hands and faces will be washed before and after meals
    - After coughing or sneezing into hands
    - 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.)
    - After playing with animals
    - Before they help prepare food or snacks
    - 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 always be kept high and out of reach of children.

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 childcare 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. 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 Reach Dane 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 childcare 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 the table with a 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 the 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 the 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. Adults 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.

Toothbrushing 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 they are 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/Developmentally 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 generally 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).
5. 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

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). See also Blood Borne Pathogens Control Policy
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
    a. 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.
    b. Training will be provided to all staff annually on effective sanitation and hygiene practices.
6. Infection Control
    a. 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, the parents/guardian shall make this decision. 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

1. 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.

2. The Team shall discuss ways that the Program may help anticipate and meet the needs of the infected child.
3. 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.
4. Any consultation or notification outside of the Support Team must have the consent of the HIV-infected child's parent/guardian.
5. 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 people 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

1. Education
    a. All staff shall receive education on effective sanitation and hygiene practices.
    b. 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.
    c. Whenever possible, this training shall be made available to parents and volunteers.
2. Evaluation of staff infected with HIV
    a. No staff member shall be removed from their position solely because he/she is HIV infected.
    b. In the case of an HIV infected person with a secondary disease (such as TB) which presents recognized risk of transmission, the Support Team shall be consulted.
        i. 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.
        ii. 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.
        iii. Failure by the infected employee to follow the Support Team recommendations will result in a recommendation for dismissal.
    c. If there is no secondary infection which constitutes a medically recognized risk of transmission, no modification will be made. The Support Team shall periodically review the case.
    d. Confidentiality shall be observed throughout this process, defined as follows in Part C.
3. Confidentiality
    a. The people who know the identity of the staff member who is HIV infected will be the Support Team.
    b. The infected person may choose to notify other personnel for support purposes; however, this is not required.
    c. Any consultation or notification outside the Support Team must have the written consent of the HIV infected staff person.
    d. All persons shall treat all information related to a person's HIV infection confidentially.
        i. 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.

ii. All medical information and written documentation related to HIV infection shall be kept by the Agency representative (Human Resource Manager) in a locked file.
iii. To further protect confidentiality, names will not be used in documents except when essential.
iv. Any person who breaks confidentiality will be subject to dismissal according to the Agency Personnel Policies.

4. Testing
    a. 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.
5. Infection Control
    a. All employees and volunteers shall follow the Procedures for Controlling the Spread of Infectious Diseases for the handling of body fluids.
    b. 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 Reach Dane 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 on the day of injury and a copy of the form should be sent home with the child that day. If a child receives any head injury, the parent/guardian should be called immediately.

The form is submitted to the site director within 24 hours of the accident. The site director will review/sign the form and submit it to the Child Specialist/Data Specialist for scanning into Child Plus. 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, Director of Business Operations and Career Pathways, and Health/Nutrition Manager the day the accident occurs if the child requires any medical attention. If applicable, 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 Director of Business Operations and Career Pathways shall report the accident via email or phone call with supporting documentation to the licensing specialist within 24 hours.

DOCUMENTATION: CHILD'S ACCIDENT/INCIDENT REPORT (#206)

Medication in the Classroom

(Updated 2018)

We encourage parents to administer medication at home whenever possible. On the rare occasion that medication must be administered at school, the **Medication Authorization Form (#182)** must be completed. All medications, creams, ointments, etc. need a signed Authorization Sheet before Reach Dane 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 (#181.1)** 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 a copy of Medication Authorization Sheet to program nurse immediately.
4. Strictly adhering to the State Licensing and Federal HS Performance Standard rules listed below.
5. Keep the (current) Medication Authorization Sheet in the Yellow Health Action Binder
6. Keep all medications locked in specified medication box.
7. Before administering medications, check the medical logbook and Yellow Health Action Binder for the last dose given to reduce the risk of medication errors.
8. 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
9. Return all medicines to parents when the length of time to administer is ended.
10. Send the Medication Authorization Sheet to the health team to scan and enter into Child Plus.

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 the 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 the last 12 months and kept current.
e. All medications, prescription or non-prescription, must be recorded on both the medication authorization form and medical logbook. Documentation in the medical logbook 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 logbook.
    i. Note: Reach Dane staff will not administer any rectal medicines.

2. Before administering medications, staff must check the medical logbook and Yellow Health Action Binder for last dose given to reduce the risk of medication errors.
3. Staff must wash their hands before and after administering any medications.
4. <u>All</u> medication shall be labeled and stored under lock and key <u>including those required for staff and volunteers</u>. This is true for both prescription meds and OTC meds such as aspirin, cough drops, etc.
5. Medication requiring refrigeration shall be kept in the refrigerator in a separate locked, covered container clearly labeled "medication".
6. 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.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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.
12. 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 the 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.

13. EHS center-based staff are to review all medication authorizations with their PNP/RN.
14. Prior to administering any medications, staff must minimally review the medical logbook, Yellow Health Action Binder, and Five Rights. Staff with questions should contact their PNP/RN.
    a. Training for all other medications (salves, ear/eye drops, EpiPen's, 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.
    b. 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.
15. 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.
16. 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.
17. If a medication dose is missed or administered off schedule during the child's time in care, staff must notify the program nurse/Health Manager, parent/guardian, site director and Director of Business Operations and Career Pathways. The program nurse/Health Manager will follow up with the site staff regarding details of the incident. The site director or Director of Business Operations and Career Pathways will report the incident to Day Care Licensing. Medication errors will be treated like any other child incident with a full investigation and include Human Resources.
18. EHS FAs will review meds with parents/guardians of assigned children in Reach Dane childcare 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 Reach Dane'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 the 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.

EpiPen's for Bee Stings:
Staff will collaborate 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 coordination of this.

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. The 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 Reach Dane 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 a 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 Reach Dane 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 Reach Dane the medication(s) to be administered. I further understand that it is my responsibility to immediately notify Reach Dane of any change in my child's medication(s) which are to be administered by Reach Dane.

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

I understand and agree that Reach Dane 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 Reach Dane, 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) (dm)) 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 logbook (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 an 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 Part-Year Program Classroom 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's 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 Director of Business Operations and Career Pathways.

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 Director of Business Operations and Career Pathways, 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 Director of Business Operations and Career Pathways 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 logbook when visiting or observing the programs.
- If your Logbook needs repair or needs to be replaced, contact the Director of Business Operations and Career Pathways.

Policy on Animals in the Classroom

(Updated 2019)

Pets in the classroom offer many benefits to the development of nurturing, responsibility and understanding of nature and empathy in children. Pets offer calming, therapeutic opportunities for children and can add much to the classroom environment. Nevertheless, animals can pose serious health risks. For the health and safety of children enrolled, staff must follow the guidelines below when any animal is brought into the classroom.

Programs will adhere to the State Licensing Code 251.07 (7), which states:

1. Animals shall be maintained in good health and appropriately immunized against rabies. Rabies vaccinations shall be documented with a current certificate from a veterinarian. The Child and Family Programing Director will maintain those records.
2. Pets suspected of being ill or infested with external lice, fleas and ticks or internal worms should be removed from the center.
3. Reach Dane shall ensure that parents are aware of the presence of pets and animals in the center. If pets and animals are allowed to roam in areas of the center occupied by children, written acknowledgement from the parents shall be obtained. If pets are added after a child is enrolled, parents shall be notified in writing prior to the pets' addition to the center.
4. Reptiles, amphibians, turtles, ferrets, poisonous animals, psittacine birds, exotic and wild animals may not be accessible to children. The animal may not have any physical contact with the children, including the children reaching over or through a barrier to touch the animal.
5. All contact between pets or animals and children shall be under the close supervision of a childcare worker who is close enough to remove the child immediately if the pet or animal shows signs of distress or the child shows signs of treating the pet or animal inappropriately.
    a. In the event that an animal bites a child, the parent shall be notified, and a veterinarian shall be contacted by center personnel to determine a course of action in the diagnosis of possible rabies in the animal. Procedures for emergency care of children shall be followed. Parents shall be notified of any action taken by the veterinarian, as well as the name, address and telephone number of the veterinarian who was consulted.
6. If dogs or cats are allowed in areas of the center accessible to children, the certificate of insurance shall indicate the number and types of pets covered by the insurance.
    a. State Licensing Code 251.04(2)(g)2 states an indication that pets are included in the liability coverage if cats or dogs are permitted in areas of the center accessible to children during the hours of operation.

Requirements for All Animals on Reach Dane Premises

All animals subject to this policy must meet the following requirements:

1. All animals must be current on their rabies vaccine and wear their rabies vaccine tags.

2. All dogs must be licensed, as required under Wisconsin law, and wear their license tags.
3. Owners/handlers and trainers of any animals on Reach Dane premises are responsible for complying with applicable laws in connection with their animals.
4. Vaccination and health records must be provided upon request.
5. Animals under active treatment for any health conditions may not visit until one week after resolution of symptoms and completion of antibiotic treatment, and if requested, by Reach Dane, a letter of health from a licensed veterinarian.
6. Animals must be clean, well groomed, and free of parasites. Dogs should be bathed within 24 hours prior to the visit and free of ticks/fleas. If the same dog is visiting during the week, the dog must be bathed at least 2 times weekly. Cats should be groomed with an anti-allergen product within 24 hours prior to the visit.
7. At all times, animals must be under the control of the handler or trainer. Visiting dogs must be kept on a short leash (less than six feet and no retractable leads). Service animals and certified therapy dogs are not required to be on a leash. Animals must be well behaved, which includes but is not limited to no jumping, snarling, growling, yipping, whimpering, barking, or scratching. Animals must be housebroken and fully socialized. The handler must provide all care for the animal.
8. Animals should be toileted prior to entering Reach Dane buildings and waste properly disposed. The animal's handler or trainer should be prepared to immediately clean up any waste and dispose of feces, including sanitizing the area if applicable. If the handler has a disability and cannot physically clean up after their own service animal, the handler should inform staff so that a Reach Dane staff member can assist.

Classroom Pets

1. HSPC, Head Start Policy Council, HSAC, Health Services Advisory Committee, and/or staff will be notified when an animal is kept on site for more than a day. 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. If for religious reasons, a parent notifies the teacher or Site Director their child cannot be near or in the same space as a pet, specifically cats and/or dogs, special accommodations will be made for that child/family.
3. The Site Director must clarify with staff and the families that there are no medically documented 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 Reach Dane programs as classroom pets.
5. The classroom Teacher must gain permission to have the pet from the property owner of the building in which the Reach Dane classroom is located (if applicable).
6. The classroom staff are responsible for keeping the animal's environment clean and odor free.
    a. See Pet Living Quarters.

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

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, excluding water dishes, may not be placed in areas accessible to children.
6. Animals in classrooms shall be confined in cages while food is being prepared or served in the classroom.

Service Animals/Therapy Animals

Definitions:

Service animals: are defined as dogs, miniature horses, or other animals individually trained to work or perform tasks for people with disabilities, as defined by the Americans with Disabilities Act (ADA) and Wisconsin law. Service animals work or perform tasks directly related to a person's disability. Animals whose sole function is to provide comfort or emotional support do not qualify as service animals.

Therapy animals: are animals involved in Reach Dane sponsored programs and have been vetted and/or registered to participate in those programs.

Handlers: are the adults responsible for the animal while on Reach Dane premises.

Service Animals:

1. If an animal is not involved in a Reach Dane sponsored program, staff should first determine whether the animal is a service animal or personal pet. To determine if an animal is a service animal, staff may only ask the handler two questions: *Is this service animal required because of a disability? What work or task has this animal been trained to perform?*
2. If the animal does not meet the criteria for service animal, the handler should immediately remove the animal from the premises, unless it has been approved to visit under this policy.

3. A service animal is not required to wear a vest and the handler does not need to provide proof of certification that the animal is a service animal. If staff have any questions, they should contact the Health Manager or the Director of Business Operations and Career Pathways.
4. A service animal may accompany a child or visitor with a disability anywhere on Reach Dane premises, provided that no special precautions are required in those areas. The handler can be asked to remove the service animal from an area when emergency care needs to be provided to an individual.
5. While a service animal is on Reach Dane premises, staff should comply with the following requirements:
    a. Allow a service animal to accompany the handler at all times and everywhere on Reach Dane premises except when prohibited as identified above.
        i. Do not pet a service animal.
        ii. Do not feed a service animal.
        iii. Do not deliberately startle a service animal.
        iv. Do not separate or attempt to separate a handler from her or his service animal or without the handler's express permission.
6. Service animals in training are subject to the same guidelines set forth in the policy. In the event that the animal because disruptive (i.e., biting, barking, incontinence, or physical illness) during its training, the site director will be called to intervene and have the handler remove the animal from the premises.
7. A service animal trainer may be asked to produce a certification or other credential, issued by a school for training service animals, stating that the animal is being trained to be a service animal.

Therapy Animals:

Therapy animals must be accompanied by their handlers in classrooms at all times. The handler and dog must have completed a therapy dog training program. Handlers must provide Reach Dane with documentation indicating successful completion of the training program. All therapy animals must meet the requirements of the policy on animals in the classroom.

Teacher Monitoring for Potential Allergic Reactions

After the therapy animal leaves the room, teachers should be monitoring children for any potential allergy signs or symptoms. Teachers should ensure that children are washing their hands following exposure to the animal. Hand washing is one of the most important ways to remove allergens.

Signs and symptoms to look for are as follows: sneezing, coughing, itchy skin or rash, eye problems, nose problems, itchy ears, and irritability. If experiencing symptoms, ensure hands are washed, apply cool compress to eyes, follow asthma action plan (if applicable) and contact health team for further directions, if needed.

As part of the enrollment process, the health team will complete an Animal Allergy Plan for the Classroom if needed. Please reference that plan for any needed interventions.

If a child or staff member starts to have severe allergy symptoms while the animal is in the classroom, the animal must be removed from the room immediately and notify the health team.

Cleaning/Safety General Guidelines

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. If a staff member or enrolled child has significant signs/symptoms of an allergic reaction, the therapy animal will be prohibited from visiting the classroom.
5. Properly clean and disinfect all areas where animals have been present
    a. Rugs, cushions, pillows, blankets that come in contact with the animal must be vacuumed or washed twice a week or more frequently if needed.
    b. Classrooms must be vacuumed every other day when an animal has been in the room. The vacuum cleaner must be equipped with a "HEPA" filter.
    c. Dust weekly to keep pet dander to a minimum.
6. Disposable gloves should be used when cleaning fish aquariums, and aquarium water should not be disposed of in sinks used for food preparation/drinking water, or the sink must be thoroughly disinfected before the next use.

DOCUMENTATION: ANIMAL ALLERGY PLAN FOR THE CLASSROOM (#600)

Child Health Requirement for HS & EHS

Head Start Performance Standards state "A program, within 30 calendar days after the child first attends the program or, for the home-based program option, receives a home visit, must consult with parents to determine whether each child has ongoing sources of continuous, accessible health care – provided by a health care professional that maintains the child's ongoing health record and is not primarily a source of emergency or urgent care – and health insurance coverage."

If a child does not have such a source of ongoing care and health insurance coverage, Reach Dane must assist families in accessing a source of care and health insurance that will meet these criteria, as quickly as possible.

Family Outreach Workers will communicate with parents regarding ongoing sources of continuous, accessible health care and health insurance coverage at enrollment using the **Health and Developmental History Form (#312)**. Family Advocates will communicate with parents using the **Health and Developmental History Year 1/Year 2-3 (#171/172)** and for pregnant moms the **Applicant Enrollment Form (#703)**. The information will be entered into Child Plus for tracking.

Follow Up

Any follow up regarding helping families with accessing ongoing care and health insurance coverage will be noted in Child Plus. The health manager will meet with HS staff twice a year to discuss ongoing access and insurance and the PNP/RN will meet with EHS staff quarterly.

DOCUMENTATION: HEALTH AND DEVELOPMENTAL HISTORY FORM #312, HEALTH AND DEVELOPMENTAL HISTORY YEAR 1 #172, HEALTH AND DEVELOPMENT HISTORY YEAR 2/3 #171, APPLICANT ENROLLMENT FORM #703

Health Screening Requirements for Preschool Head Start

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

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

Part 1 of 6 – Physical Exam

Complete health and developmental screening are 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 Child Services Database Specialist after receiving an ISR from the FOW with the date of the well child, name of clinic, and the doctor.

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 to begin and a pattern of ongoing care is established.

Any follow-up will be noted in Child Plus. The health manager will meet with HS staff twice a year to discuss health and health follow-up, reports will be sent out monthly.

DOCUMENTATION: PHYISCAL EXAM FORM (#106)

Part 2 of 6 – Immunizations

Complete health and developmental screening are 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 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. Parents must sign 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.

DOCUMENTATION: DAY CARE IMMUNIZATION FORM (#232)

Part 3 of 6 – Vision

Complete health and developmental screening are 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. EyE Check LEA Symbols Test Kit
2. Child Response Card
3. Occluder glasses (horse or butterfly)
4. Chair/Table

Step 1: Preparing the Children for Screening

- Practice symbols during class time before the screening date.

Step 2: Set up Screening Area

- 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 or glasses that came with the kit). Instruct the 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. Glasses must be wiped with an alcohol wipe between each child.
4. Flip the book to each page for the child to identify the symbol. There are 4 pages for each eye (labeled in book).
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.
    a. The critical line for 3-year-olds is 20/50
    b. The critical line for 4-to-5-year-olds is 20/40
7. Repeat steps 3-6 with 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 in Child Plus
- 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, Reach Dane form #296, explaining the screening results. In addition to the letter, parents will also receive a Vision Examination Report form, Reach Dane 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 with the Plus Optix machine
    - 2) Be referred to his primary care provider or an eye care professional. Parents will be sent a letter, Reach Dane form #296, explaining the screening results. In addition to the letter, parents 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.
    - 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, Reach Dane form #296, explaining the screening results. In addition to the letter, parents 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.

DOCUMENATION:

VISION SCREENING REFERRAL – PARENT LETTER (#296), VISION SCREENING REFERRAL – PHYSICIAN LETTER (#296A)

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 of double vision
- Burning, scratching or itchy eyes
- Sees blur when looking up after close work
- Unusual sensitivity to light

Part 4 of 6 – Hearing

Complete health and developmental screening are 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 Reach Dane 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. The 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.

DOCUMENTATION: HEARING SCREENING ROSTER (#292),

PARENT LETTER/REFERRAL FORM (#314), HEARING SCREENING REPORT (#315), HEAD START HEARING SCREENING FIRST VISIT (#316), HEAD START HEARING SCREENING SECOND VISIT (#318)

Part 5 of 6 – Growth

Complete health and developmental screening are 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 the 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 the 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.

The same person ideally takes height/lengths and weights each time for consistency in measurement. Record results in Child Plus.

The child's height and weight are used to calculate their body mass index (BMI). BMI has been shown to be a reliable indicator for determining if children are underweight, 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.

Reach Dane 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.

Part 6 of 6 – Dental Exam

Complete health and developmental screening are 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.

Reach Dane 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 Child Services Database 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 Reach Dane 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.**

DOCUMENTATION: DENTAL EXAMINATION FORM (#104)

Health Screening Requirements for Early Head Start

Complete health and developmental screening are 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: Reach Dane 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 to 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: PHYSICAL EXAM I/T FORM (509) AND AUTHORIZATION FOR REALEASE OF MEDICAL INFORMATION (325)

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. Parents must sign 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)

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, including parent concerns.

For each well child exam one of the following statuses will be entered under vision 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.

Vision Screeners Based on Age:

The Vision Milestones form must be filled out on an ongoing basis correlating to the ages on the checklist. The milestones form will be completed from birth to 12 months of age. Staff can look up the "Eight Key Vision Development Milestones to Monitor from Birth to First Birthday" for additional support and information on the staff intranet.

Plus Optix vision screener will be completed once between 13 months to 3 years of age. Let parents know the vision screener does not replace an eye exam with an eye doctor.

For optimal screening results, screen in an environment with lower-level subdued lighting. Be sure to eliminate or block any sources of sunlight and/or incandescent light from reflecting on the subject's eyes.

1. Position yourself approximately 3 feet from the child.
2. Start screening and slowly rotate the device upward to meet both of the child's eyes. Adjust your distance from the child until both eyes are clear on the screen. The machine will warn you if you are too close or too far away. Position yourself with one foot in front of the other, slowly rock forward until you are in the capture range.
3. Keep the vision screener device steady until the capture process is underway.
4. The results screen will appear at the end of the screening process – pass or refer.
5. Results will be documented on the EHS Vision Screening Report.

**Plus Optix vision screeners have a better success rate at 18 months of age and older.

Follow Up:

Children who are a CNT because of crying or moving around and the vision screener cannot capture their pupils, staff will need to rescreen within 4 weeks. Children who are noted to refer on the vision screener, will be referred directly to their primary care physician for further evaluation.

Children needing vision follow-up and treatment are assisted by Reach Dane staff to receive all needed follow-up.

DOCUMENTATION: EARLY HEAD START VISION SCREENING REPORT (#376), REACH DANE VISION MILESTONES FOR BIRTH TO 12 MONTHS (#294)

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, Reach Dane 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-based EHS children at designated EHS events including Dental Night(s) and Hearing Screening Night.
    iii. Reach Dane PNP/RN will perform OAE testing on home-based 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
    a. 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:
        i. Pass: the otoscopic exam is within normal limits, no risk factors for hearing loss or concerns regarding hearing were identified.
        ii. 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 Reach Dane 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)

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 follows the American Academy of Pediatrics Bright Futures schedule for dental care.

Many EHS participants receive fluoride varnish at their well-baby exams. These topical fluoride treatments are recorded in Child Plus as an oral health screening.

Children needing dental follow-up and treatment are assisted by Reach Dane 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. A pregnancy service plan is developed between the family advocate and their enrolled pregnant mom 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.

Physical/Immunization Requirements for Childcare Children

(Not in HS/EHS) Infant/Toddler (0-2 years)

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 WI EPSDT (AAP Bright Futures) 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 Childcare section for the specific required forms.

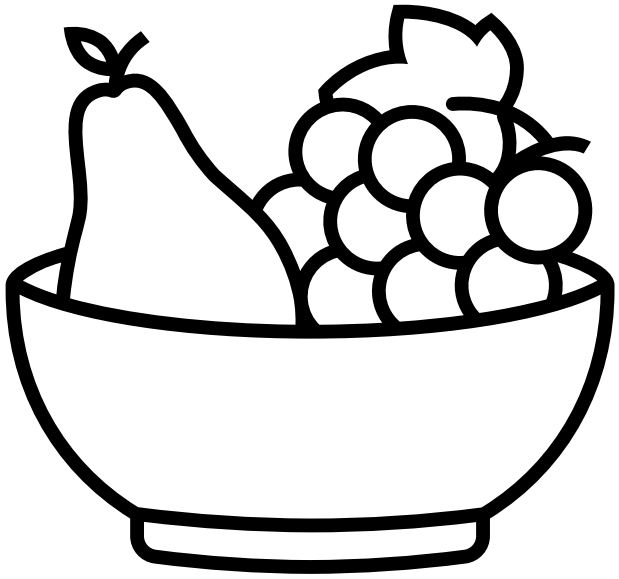
Preschool (2 years – school age)

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 (AAP Bright Futures) 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 2021)

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 Childcare Licensing Rules

- DCF 251.07 (5)(a)4 "The amounts indicated on the CACFP minimum meal requirements are used for determining amounts of food that must be prepared and are not considered "helpings". It is recommended that small portions of all food items be served and that seconds be available." If needed reference DCF 251.07 in Childcare Licensing Rules.

American Dietetic Association Nutrition standards for childcare 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 childcare programs** position paper and input/review from Reach Dane's Consultant Registered Dietician:

All Reach Dane 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.

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 the use of unprocessed foods when available.

The addition of fat, sugar, and sources of sodium should be minimized in food preparation and food service. 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 gain experience about food, food sources, nutrition, and the link between nutrition and health.

Reach Dane is committed to continuing to provide all the above guidance to both preschool and infant/toddler programs. Under all circumstances, Reach Dane 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.

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 the Reach Dane programs, they must eat 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 admired/identified with, it is essential that staff participate with the children in making mealtime a pleasant opportunity for learning about and practicing healthy eating habits.

Children who are hungry are sometimes prone to behavioral issues. Staff are expected to quickly get children to eat-when children are all seated, that table should begin.

Relaxing mealtimes provide children with many opportunities to gain experience. 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 proving a pleasant environment. (Staff should be sensitive to family customs that do not encourage children to take part 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 helping 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 food, staff and parents are encouraged to offer such food again at a future time. Children may require several 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.

Celebrations: No outside food is allowed to be brought into the classrooms for celebrations. Celebrations include, but are not limited to holidays, Halloween, Valentine's Day, birthdays, and star of the week. Families may bring food for End-of-Year Celebrations.

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 food they bring in.

Reach Dane will provide basic foods for End of Year Celebration Events. Families may bring other foods to share for these events if they choose. However, under no circumstances will families be required to bring food to agency events.

Nutrition Guidelines for Other Reach Dane Program Events

As an agency, Reach Dane 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 child's doctor and reviewed by one of the agency's PNP/RN's. If there is a question about whether a food is considered a high sugar product, the health manager or food service manager will make the determination.

Food in the Classroom Policy

(Updated 2021)

1. **Staff Beverages**

Staff and other adults are not to eat outside of mealtimes 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.

2. **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.

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 tends 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.).

3. **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)

Feeding the Breastfed Baby in Reach Dane 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 childcare 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 Reach Dane 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 does not 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 childcare.
- 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 if 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 added guidance.

Use of Breast milk for Babies over 12 Months of Age

Some parents may request that Reach Dane continue feeding their babies breast milk after 12 months of age. Continue to serve babies their mother's milk if 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 childcare 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
b. Freezer compartment of a refrigerator-Can be stored for 2 weeks
c. Freezer compartment of refrigerator with separate doors-3 months
d. 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 assorted 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

Head Start classroom staff may plan nutrition experiences throughout the school year. 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:

- **These experiences should be planned using foods from the cycle menu or as an activity focusing on nutrition concepts (without food).**
- When preparing food: wash hands and clean food before preparation. Model this for children, and have children wash their hands.
- Allow children to do as much as possible including cleaning up.
- Use 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/involve 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; etc.

Reach Dane Nutritional Services Monitoring

(Updated 2021)

Reach Dane 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 begin serving food.
   - 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 on-going 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 on-going lesson planning and curriculum at sites, in accordance with lesson planning policies.
3. **WI Childcare Licensing:**
   - All Reach Dane 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:**
   - Reach Dane 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. 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 public school personnel prepare foods 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

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. The Transportation Specialist will deliver necessary items according to an established schedule.
    a. Please check in deliveries quickly. Food Services will note any missing items and substitutions on the food invoice sheet. Contact Food Services Manager (FSM) the same day you receive the food with any food shortages.
4. Supply requests for staple foods/supplies are to be submitted through fax or email on the "Supply Order Form."
    a. Supply requests are due by the end of the day on Thursdays and items will be sent on the following Thursday.
5. Other Food Situations
    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. If any food service emergency arises, contact the Food Service Manager immediately. If needed, contact the Administrative Services Director.
6. Inventory
    a. 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.
    b. Nutrition Service Providers will follow all close-out procedures.

Please do not wait until the day food/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 Special Foods for Children

1. For medical, nutritional, religious, and personal reasons (allergies, anemia, food restrictions, weight concerns, etc.), food services will provide substitutions for that specific child. NSP's will use the Allergy Order Form to request all alternative foods. Parents will discuss all substitutions needed for the child, with the involvement of the program Nurse and/or Health Manager. **See specifics in Food Allergies/Menu Accommodation policy earlier in the health section.**
2. Special food requested for events must be approved by the health manager.

Nutrition Program Review Guidance

Reach Dane's nutrition program is funded through the United States Department of Agriculture, Childcare and Adult Food Program (CACFP). The Wisconsin Department of Public Instruction (DPI) administers the nutrition program for the USDA, CACFP. Reach Dane 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 Reach Dane'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's responsibility for ensuring these requirements are compliant. All written documentation and summaries must be posted on site and on file at the Reach Dane'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.

USDA Nondiscrimination Statement with Complain Filing Procedure

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**

U.S. Department of Agriculture

Office of the Assistant Secretary for Civil Rights

1400 Independence Avenue, SW

Washington, D.C. 20250-9410; or

2. **fax:**

(833) 256-1665 or (202) 690-7442; or

3. **email:**

program.intake@usda.gov

This institution is an equal opportunity provider.

DOCUMENTATION: NUTRITION SITE REVIEW, FOOD SERVICE CLEANING SCHEDULE (#517)

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 enrolled children that are served meals at the site.
    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.
    d. Electronic Storage of Meal Count Forms, policy as follows:
        i. Completed classroom meal count forms will be stored in the child plus data system. The child plus data system is the electronic storage and hardware system Reach Dane uses.
        ii. Enrollment, health, and fiscal departments will have authorized access and manage the data.
        iii. Child plus has secure logins and timed-out capabilities. The system also uses a two-step authentication process. Only those staff who have authorized access will have access.
        iv. Records are organized based on site, classroom, and child. Reports run from child plus can retrieve past data.

v. Reach Dane uses a cloud-based storage system with retrieval access through child plus.
vi. Each program/site and classroom have their own electronic device to use within their classroom and in their office.
vii. As an agency standard, the PDF version of all documents are stored in Child Plus.
viii. Reach Dane certifies that the records and data will be readily accessible at all times for review by government officials, paper copies will be printed on request, records will be retained for 3 years including the current year as specified by government officials, and a yearly review and evaluation of record and data retention systems will be done to ensure effectiveness.

2. **Food Delivery**
    a. The Nutrition Services Provider will receive an invoice form with the delivery of food.
    b. The invoice will include all the food for the upcoming week, the amounts, and the day on 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 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 food is 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., 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 reflect 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.
        i. Program Adults: an adult employee or volunteer who performs CACFP labor on the day the meal is eaten. This includes meal preparation, serving

meals, assisting during meal service, cleaning before and after meals, and performing administrative tasks related to the CACFP operation. The cost of meals served to program adults is an allowable CACFP expense, i.e., the food consumed by the adult can be paid for with CACFP funds.

ii. Non-program Adults: an adult who does not perform CACFP labor on the day the meal is eaten. This includes van drivers, maintenance employees, volunteers or parents not involved with meal preparation or meal service, administrative staff not performing CACFP labor and people in the community and visitors such as DPI or USDA officials. The cost of meals served to non-program adults is an unallowable CACFP expense, i.e., the food consumed by the adult cannot be paid with CACFP funds. Financial records must show other funds used to cover these costs (e.g., tuition or charging a fee).

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.

Policy on Swaddling

Reference: State of Wisconsin group childcare regulation 251.09 (1) (k) (L)

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: 1302.31(b) (1) (i) 1302.31(b) (1)

Teaching practices must: (i) Emphasize nurturing and responsive practices, interactions and environments that foster trust and emotional security.

Swaddling to Support a Family's Cultural Practices

In order for Reach Dane staff to provide care which supports a family's cultural practices, parents may request that childcare 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 or Health Manager before they can swaddle infants in childcare. A copy of the Request for Swaddling form should be kept in the health action binder and sent to the EHS Enrollment and Health Data Specialist. If an infant turns himself over, he must be un-swaddled, 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 Director of Business Operations and Career Pathways 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. 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.

Baby Carrier Policy

Why Use Baby Carriers?

When a baby is held close, caregivers can recognize early cues. Every time a baby is able to let us know that she is hungry, bored, or wet without having to cry, her trust in us is increased, her learning is enhanced, and our own confidence is reinforced. This cycle of positive interaction deepens the mutual attachment between caregiver and child. Carried babies cry less. According to one study infants who received supplemental carrying (not only in reaction to fussiness) cried and fussed 43% less overall. Babies who are held close are more able to regulate their own physiological functions (breathing, heart rate, temperature) and emotions in response to their caregiver. Babies who spend a significant amount of time in car seats and baby swings or other equipment can develop squaring of the cranium or spinal deformities. Properly carrying a baby allows for natural development of cranium, spine, and postural muscles.

Currently, Reach Dane has approved the Moby Wrap and Ergo Omni 360 for staff to use. Only approved carriers may be used in upright positioning. Teachers must have one of the mental health consultants train and observe use before being able to use a carrier. A list of teachers who have had the training will be maintained. **Parent consent and ITHAD request for training is required before use.** Members of the ITHAD team, site directors and coaches will be part of a team to continue to monitor and support appropriate use of carriers.

These general guidelines are followed at all times when using the Ergo carrier or Moby wrap:

- Attend to and check on baby often, especially those under 4 months of age. Regularly check that your child is comfortably and securely seated in the sling.
- Check for ripped seams, torn straps or fabric, and damaged hardware before each use. If found, stop using carrier.
- Always check to ensure that all knots, buckles, snaps, straps, and adjustments are secure.
- Never leave a baby in a sling carrier that is not being worn.
- Never use a sling carrier when balance or mobility is impaired because of exercise, drowsiness, or medical conditions.
- Never place more than one baby in the sling carrier.
- Never use/wear more than one carrier at a time.
- Never use a sling carrier while engaging in activities such as cooking and cleaning which involve a heat source or exposure to chemicals.
- Never wear a sling carrier while driving or being a passenger in a motor vehicle.
- Do not let baby sleep in the front outward position.
- Ensure that the baby is safely positioned in the sling carrier according to manufacturer's instructions for use. Baby should be positioned properly. Baby's knees should be higher than her bottom and legs spread so that her spine and hips are supported for healthy development.
- Always keep baby's face free from obstructions. Baby's airway should be clear. You should not have to move fabric to see her face. Her chin should not rest on her chest

but instead be tipped up. If the baby's chin is pressed tightly to baby's chest, this can restrict baby's airway. A newborn's airway is much like a straw; when the chin falls to the chest, the straw gets pinched, and the airway is restricted. Check to ensure you can slip your finger between baby's chin and chest to check for correct positioning. She should not be pressing her face into your chest. In this case you can gently move the baby's head, so his ear is against your chest instead.

- Baby should stay in an upright position. For young infants under 5 months, an upright tummy to tummy position with a snug carrier supporting baby is ideal. Make sure your baby's back is straight and supported. Baby's head and neck must be gently and completely supported, with chin off chest.
- Practice! Practice with a doll or teddy first. Understanding the instructions with your mind is just the first step; your body needs to understand them as well. Doing a few practice uses will help you build muscle memory. Start low to the ground. Most carries can be accomplished while sitting on the floor. As you build muscle memory and confidence, you can move up, next lifting your baby onto your body from a bed or chair. It is best to try a new carrier with your baby when you are both well rested and generally content.
- Be aware of how your movements affect the baby; avoid any bumping or jarring motions, protect baby's head and neck when bending down or leaning forward. Keep one hand on baby when bending over.
- Your balance may be adversely affected by your movement and that of the baby. If you do not feel comfortable, please do not proceed in wearing the Ergo or Moby.
- Follow general cleaning guidelines according to the manufacture directions. Spot clean as needed; launder immediately if there are accidents and then according to the directions from the manufacture on weekly/monthly washing.
- Do not use bleach.

Specific guidelines for the Ergo carrier:

- Be sure that all fasteners are secure
- Baby must weigh 7 lbs. minimum (3.2 kg) and be at least 20 inches tall (50.8 cm) for use with the Ergo Omni 360.
- Front carry-facing out must be over 5 months with head control
- Hip carry and back carry-must be over 6 months with good head control

For detailed instructions:

https://ergobaby.com/instructions

To view instructional videos: https://ergobaby.com/instructions#Omni360

Specific guidelines for the Moby Wrap:

- Only use this carrier for children between 8-35 lbs.
- Always make sure you have a nice deep seat and a tight top rail, but ensuring it is not too tight against your body

- Double knots are more secure, especially for slippery wraps. It is best, especially as a beginner, to make sure you have plenty of tail left and are not tying in the tips.
- Check your wrap frequently for signs of heavy wear.
- Make sure your wrap is pulled up high enough on your baby's back. Arms out is perfectly fine for older babies and toddlers, but the fabric should still be at least at arm pit level and there is an allowance room for head movement.

For detailed instructions:

https://mobywrap.com/pages/instructions

Use the following guidelines to assess when it is appropriate to discontinue using the Ergo or Moby for a particular child:

- If baby is in a carrier that supports healthy positioning
- You are continuing to assess for safety, and you are both comfortable
- You are reading the babies cues and supporting all aspects of their development providing a wide range of developmentally appropriate opportunities
- The baby hits the weight limit for that particular carrier.

Contact your coach or mental health consultant with questions or support in using carriers.

*Information gathered from a variety of sources, including Babywearing International, Baby Carrier Industry Alliance, All About Babywearing: Your Guide to Safe, Ergonomic Baby Carriers & Babywearing: Everything You Need to Know to Wear Your Baby Safely