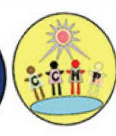
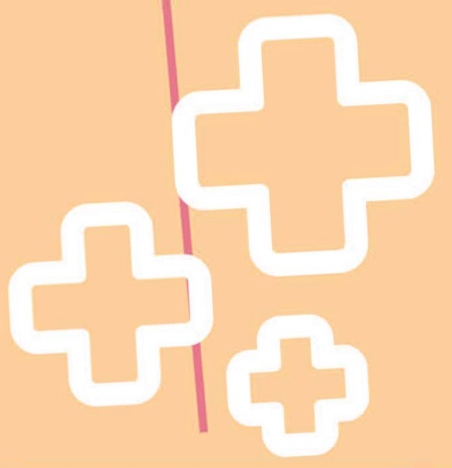
San Francisco Department of Public Health

Child Care Health Program



HEALTH & SAFETY MANUAL



Health and Safety Manual Policies and Procedures
San Francisco Child Care Health Program (CCHP)
Maternal, Child & Adolescent Health
San Francisco Department of Public Health
Revised 2024

The CCHP Team is grateful to the many individuals who shared their expertise and spent considerable time developing and reviewing this manual.

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GENERAL DISCLAIMER ABOUT INFORMATION ACCURACY

Although every effort has been made to provide accurate and complete information, CCHP makes no warranties, express or implied, to the accuracy of content in this manual.

CCHP assumes no liability or responsibility for any error in the information contained in this manual.

Visit or contact organization or provider's website to ensure accuracy, eligibility criteria and deadlines for updated information.

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A. INTRODUCTION

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CCHP PARTNERSHIP

The health professionals of the San Francisco Department of Public Health, Child Care Health Program (CCHP) have created this manual of resources and sample policies and procedures for Childcare Centers, Family Child Care Homes, and Family Resource Centers. This manual includes requirements and best practices for health and safety.

The goal of the CCHP program is to support childcare providers in providing the best quality childcare and ensuring that children, families, and staff remain healthy and safe. The following health professionals will be working together with you to support this goal.

Public Health Nurse Consultant

Public Health Nurse (PHN) Consultants will provide ongoing consultation to the childcare site. The PHN can visit the site and is also available by email or by phone. They can assist in the development of policies and procedures concerning health, disaster preparedness, safety, and nutrition. They can provide training and resources for staff and families.

The PHN will coordinate all the health screenings, provide vision screening for children ages 3-5, and case management/linkages to services for children who did not pass the vision and/or dental screenings. The PHN can assist with reviewing children's medical files to ensure adequacy of vaccinations and appropriate care plans for chronic health conditions. The PHN can also conduct a facility health and safety assessment to provide recommendations for improvement, if desired.

Registered Dental Hygienist

The Registered Dental Hygienist (RDH) provides dental screenings and fluoride varnish application for children ages 0-5, dental circle times with children, midday toothbrushing staff trainings, oral health consultation, and other oral health interventions for children, staff, and families.

Certified School Audiometrist

The Audiometrist provides hearing screenings for children ages 3-5, resources and linkages to audiological services, and case management for children who did not pass the hearing screening.

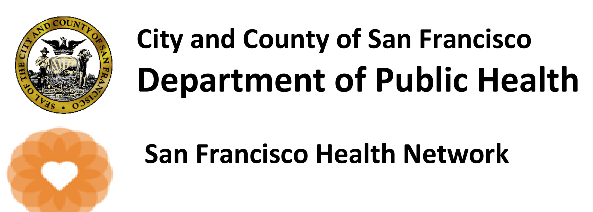
Health Workers

Health Workers work with assigned childcare centers in providing height, weight screening (BMI) percentile, and non-invasive carotenoid screening with a Veggie

Meter device. Health workers will provide parents/guardians a BMI nutrition report with fruit and veggie intake results after each screening. Health workers will also provide educational groups through nutritional and mindfulness circle time. Health workers may need to assist in CCHP dental, hearing, and vision screenings, including screening follow-ups and promoting the Healthy Apple program. Health workers will provide Spanish and Cantonese language services for monolingual families.

Health Program Coordinator

The CCHP Health Program Coordinator supports child care sites to develop policies and procedures regarding nutrition, physical activity, gardening, and healthy lifestyle for children. They encourage child care sites to participate in the Healthy Apple Program and can provide technical assistance in completing the Healthy Apple assessments and developing action plans, if desired.



Maternal, Child, and Adolescent Health
Child Care Health Program
333 Valencia St, 3rd Floor
San Francisco, CA 94103

Date: Child Care License #:

AGREEMENT BETWEEN SF CHILD CARE HEALTH PROGRAM (CCHP) AND CHILD CARE CENTERS, FAMILY CHILD CARE HOMES, AND FAMILY RESOURCE CENTERS

It is agreed by the SF Child Care Health Program and the administration of:

Name of Site:

That the site will support and commit to CCHP's efforts to promote children's health and well-being.

That CCHP and the site will collaborate to:

- Inform parent/guardians of CCHP services
- Gather signed health screening consent forms from parents/guardians **(*if applicable*)**
- Jointly work with families, CCHP staff, and community partners to address enrolled child's health issues or concerns.

That the site will take the opportunity to participate in activities to improve health, safety and nutrition for enrolled families.

That the site will collaborate with enrolled families, CCHP staff, and community partners with mutual respect and professionalism.

That the site's participation is entirely *voluntary*, and CCHP services are provided at no cost to the program.

That CCHP reserves the right to discontinue services to the site per criteria set by the funder and/or management.

That items or gifts provided to the site throughout the program by CCHP are distributed based on availability and are subject to change.

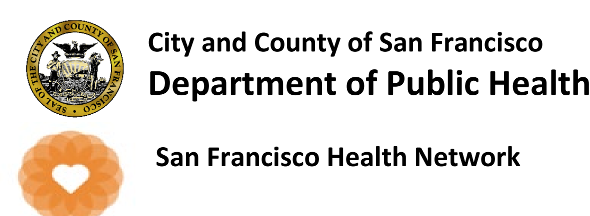
That all health information will be kept confidential and private by CCHP to the extent permitted by the law.

CCHP welcomes the opportunity to work with the site to ensure that all children ages birth to five years old have access to high quality, early child care and other support services.

____________________________ ________________________
Site Owner/Director/Staff's Printed Name Signature

____________________________ ________________________
CCHP Nurse Consultant's Printed Name Signature

Revised 7/31/24



City and County of San Francisco
Department of Public Health
San Francisco Health Network

Maternal, Child, and Adolescent Health
Child Care Health Program
333 Valencia St, 3rd Floor
San Francisco, CA 94103

Fecha: Número de licencia del Cuidado Infantil:

ACUERDO ENTRE CHILD CARE HEALTH PROGRAM DE SAN FRANCISCO (CCHP) Y LOS CENTROS DE CUIDADO INFANTIL, HOGARES DE CUIDADO INFANTIL FAMILIAR Y CENTROS DE RECURSOS FAMILIARES

Este es un acuerdo por el Child Care Health Program de San Francisco (CCHP) y la administración de:

Nombre del Cuidado Infantil:

Que el sitio de Cuidado Infantil apoyará y se comprometerá con los esfuerzos del Child Care Health Program (CCHP) para promover la salud y el bienestar de los niños.

Que el Child Care Health Program (CCHP) y el sitio de Cuidado Infantil colaborarán para:

- Informar a los padres/tutores sobre los servicios de CCHP
- Reúna los formularios de consentimientos de exámenes de salud firmados por los padres/tutores (si corresponde)
- Trabajar en conjunto con las familias, el personal de CCHP y los socios de la comunidad para abordar los problemas de salud de los niños inscritos en el Cuidado Infantil.

Que el sitio de Cuidado Infantil aprovechará la oportunidad de participar en actividades para mejorar la salud, seguridad y nutrición de las familias inscritas.

Que el sitio de Cuidado Infantil colaborará con las familias inscritas, el personal de CCHP y los socios comunitarios con respeto mutuo y profesionalismo.

Que la participación del Cuidado Infantil es totalmente voluntaria y que los servicios de PSCI se brindan sin costo alguno para el sitio.

Que el CCHP se reserva el derecho de descontinuar los servicios al sitio de Cuidado Infantil según los criterios establecidos por el financiador y/o la administración.

Que los materiales o artículos proporcionados por CCHP al sitio de Cuidado Infantil se distribuyen en función de la disponibilidad y están sujetos a cambios.

Que toda la información de salud se mantendrá confidencial y privada por parte de CCHP en la medida permitida por la ley.

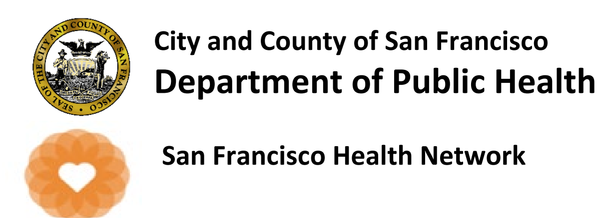
CCHP agradece la oportunidad de trabajar con el sitio de Cuidado Infantil para garantizar que todos los niños desde el nacimiento hasta los cinco años tengan acceso a cuidado infantil a temprana edad de alta calidad y otros servicios de apoyo.

____ _________________________

Nombre del Director/Personal del Cuidado Infantil Firma

____ _________________________

Nombre de la Enfermera Consultora de CCHP Firma



Maternal, Child, and Adolescent Health
Child Care Health Program
333 Valencia St, 3rd Floor
San Francisco, CA 94103

日期：　　　　　　　　　　　　　　　　　　　　　　中心牌照號碼:

Agreement between SF Child Care Health Program and Child Care Centers, Family Child Care Homes, and Family Resource Centers

三藩市兒童護理健康計劃(CCHP)與兒童托兒中心, 家庭托兒中心, 家庭資源中心的協議

中心名稱: ____

該中心將支持並致力於兒童護理健康計劃去促進兒童的身體健康。

該中心的責任包括:

- 通知家長/監護人 CCHP 兒童護理健康計劃所提供的服務
- 收集父母/監護人簽署的健康檢查同意書(如果適用)
- 與家庭, CCHP 兒童護理健康計劃員工, 和社區合作嘗試解決兒童的健康問題和顧慮

該中心將藉此有機會去充分了解以及為註冊家庭改善健康, 安全和營養

該中心將與註冊家庭, CCHP 兒童護理健康計劃員工和社區合作, 相互尊重和保持專業態度。

該中心的參與完全是自願的, CCHP 兒童護理健康計劃提供免費服務給托兒中心。

據資助者和/或管理層設定的標準, CCHP 兒童護理健康計劃保留權利向托兒中心停止提供服務。

CCHP 兒童護理健康計劃向托兒中心提供的物品或禮品將根據供應情況分發並可能隨時更改。

在法律允許的範圍內, CCHP 兒童護理健康計劃將對所有私人的健康信息保密。

CCHP 兒童護理健康計劃歡迎有機會與該中心合作, 確保所有 5 歲以下的兒童都能獲得高質量的早期托兒服務和其他支持服務。

______________________________　　　　　　______________________________
中心老闆/總監/員工的正楷姓名　　　　　　Signature 簽名

______________________________　　　　　　______________________________
CCHP Nurse Consultant's 護士顧問的正楷姓名　　　　　　Signature 簽名

CCHP HEALTH SCREENINGS

Health screenings are an essential part of the child's health and can identify potential issues that may interfere with a child's ability to learn. Not all families attend well child or dental appointments on the recommended schedule. CCHP offers free vision, hearing, nutrition, and dental screenings for your childcare site.

Dental screenings and fluoride varnish is available to all children ages 0-5 yo. Vision, hearing, and nutrition screenings are only offered to children ages 3-5 yo. Screenings will only be done on children whose parents/legal guardians have signed the CCHP consent forms.

A screening is not a diagnostic test. Screenings identify if a child needs further testing and assessment by a healthcare provider, to determine if an issue exists, and if any treatment is needed.

WHAT TO EXPECT:

1. The director or designee will gather all signed consent forms from parents who desire the health screenings and return them to CCHP staff at least 4 weeks prior to the first health screening.

2. The director or designee will plan the dates for screenings with CCHP staff.

3. The director or designee will provide CCHP an appropriate space for the health screenings and equipment (e.g. tables, chairs, electric outlet, water).

4. Staff will place name tags on children before health screenings.

5. CCHP staff will discuss instructions with staff, e.g. how many children at a time should be sent to the screening/waiting area.

6. CCHP will provide all screening result letters to the director or to the designee, if parents consented for results to be disclosed to the childcare.

Dental Screening and Fluoride Varnish – Ages 0-5

- CCHP staff will provide a circle time with puppets to demonstrate to children what will be done during the screening, engage the children in discussing dental health, and sing songs about brushing teeth.

- The RDH will do the oral screening to look for evidence of poor hygiene, gum disease, dental cavities, or infection.

- The RDH or a trained assistant will apply fluoride varnish (if parents consented).

- The child's dental health will be classified on the result letter as either Class 1 (healthy), 1+, 2 mild, 2 moderate, 2 severe, or Class 3 (most severe). Additional individualized recommendations may be also listed on the result letter such as brushing better on the gum line or back teeth, flossing, more frequent dental appointments, etc.

<u>Hearing Screening – Ages 3-5</u>

- Children under 3 years old can be screened if the parent/legal guardian has concerns or if childcare staff have concerns about the child's hearing.

- A certified audiometrist will conduct the hearing screening on children in a group of 2-4 children.

- The two hearing screening methods used are: conditional play pure tone and otoacoustic (OAE). The pure tone screening involves the child wearing headphones, the Audiometrist presents different tones at a specific volume. During this screening the child is instructed to place a block into a box whenever they hear a sound. The OAE screening is conducted by placing a foam tip similar to an earbud, which is inserted into the ear. It plays a range of tones and measures the sound that reflects back. The screening methods evaluate each ear separately. The audiometrist may also look inside the child's ear with an otoscope as needed.

- Result letters will indicate that the child passed, is referred for follow-up, or was unable/uncooperative with screening. Children who are unable/uncooperative are also referred for follow-up.

- Follow-up should be with the child's primary care provider for further assessment, testing, or treatment. Some children may need to be referred to an audiologist or ear nose and throat (ENT) doctor.

<u>Vision Screening – Ages 3-5</u>

- Before the screening, childcare staff should practice learning the names of shapes with the children. This will allow the children to be more successful during the screening. The shapes used during the screening are: circle, square, house, and apple.

- A Public Health Nurse will conduct a visual acuity screening using the LEA vision screening tool designed for children ages 3-5.

- Children's results will indicate either normal vision for age, referred for follow-up, or unable/uncooperative. Children who are 4 years or older and who are unable or uncooperative with the screening are also referred for follow up.

- For vision follow-up, the family can either make an appointment directly with an optometrist or have a repeat screening with the child's primary health care provider. If they fail the screening again, the provider will refer the child to an eye specialist (either an optometrist or ophthalmologist).

- Vision concerns for children under 3 years old should be referred to their primary health care provider.

- Observations should be made throughout the year for possible vision concerns. If the student begins to frequently and or consistently exhibit signs or symptoms, a referral should be made for the child to have a complete eye exam by an eye doctor. Signs of vision concerns include:

Table 3: Signs and Symptoms of a Possible Eye or Vision Problem

Student Signs	Student Symptoms
• Eye turns in or out at any time • Pupils/eyes appear to be different sizes • Red eyes and/or swollen eyelids • Excessive tearing • Droopy eyelids • Discharge from the eyes • Sensitivity to light • Excessive Blinking • Squints, closes, or covers one eye • Squints to see board or far away • Frequent headaches • Abnormal head posture or head tilt	• Double vision • Blurry vision • Hazy vision • Difficulty seeing small print • Eye pain

Nutrition Screening – Ages 3-5

- Health Worker will conduct a circle time with the children to discuss healthy nutrition.

- The Health Worker will measure a child's weight and height to determine their Body Mass Index (BMI) percentile.

- The Health Worker will use a device called the "Veggie Meter" to measure the level of a child's fruit and vegetable intake over the last 2 months. The device is similar to a pulse oximeter – a child simply places their finger into the device. The light waves shining through the skin will measure the child's levels of carotenoids. It is non-invasive and not painful at all.

- Result letters will notify parents of their child's BMI percentile and general fruit and vegetable intake. Resources and information on healthy nutrition and exercise is provided to parents.

- Children will be screened twice per year for BMI percentile and carotenoid.

Screening Follow-Up

If a child was referred for vision, hearing, or dental concerns, CCHP staff will provide a referral letter to be completed by the child's health care provider or dentist. If the referral letters are not returned to the childcare, then CCHP will call the families to follow-up on the referral and offer additional resources. Please let CCHP know if a family does not want to be contacted for follow-up.

HEALTH ADVOCATE ROLE DESCRIPTION

CCHP highly recommends each child care site or organization to designate a staff member to serve as the Health Advocate. This role should be a staff member who has shown interest and aptitude for prioritizing health and safety, teaching, and monitoring health indications for the children and the staff. The Director may choose to assign this role to a teacher, administrative staff, or a site supervisor. Sample role description:

FUNCTION:
Under the direction and supervision of the Childcare Director, implements a high-quality Health, Safety, and Nutrition component of the program, and collaborates with Child Care Health Program (CCHP) Staff and Public Health Nurse Consultants, families, and all childcare staff.

DUTIES AND RESPONSIBILITIES:
1. Acts as a liaison to CCHP staff and other health professionals in the community.
2. Assists the childcare in the implementation of Health, Safety, and Nutrition components of the program.
3. Assures that staff development includes ongoing training concerning the Health, Safety and Nutrition components.
4. Assists the Director/Owner in assuring staff are adhering to health procedures.
5. Ensures up-to-date information is disseminated to staff.
6. Monitors children's health records.
7. Monitors childcare program to assess Health, Safety and Nutrition status.
8. Logs data and prepares reports as necessary.
9. Assures that Health, Safety, and Nutrition related tasks are done in a timely manner.
10. Attends staff meetings and assures that Health, Safety, or Nutrition are on each agenda.
11. Consults with Nurse Consultants, staff, and parents on children's health issues.
12. Assures that individual care plans are completed for each child with a special health need.
13. Arranges and assists with conducting health screenings, referrals, and follow-up.

14. Assures medications are given according to policy.

15. Ensures that emergency and disaster plans are current, reviewed, and practiced.

16. Establishes health resources for the program.

17. Identifies and refers children at risk for further evaluation.

18. Other duties as assigned.

SAMPLE MINIMUM CANDIDATE REQUIREMENTS:

(You may modify job description and candidate requirements, this is a sample)

1. Teacher-qualifiable childcare employee

2. Interested in Health, Safety and Nutrition

3. CPR and First Aid certificates

4. Team player, capable of collaboration and leadership.

5. Able to communicate well with colleagues, parents, children, and health professionals.

6. Committed to decreasing health inequities, disparities, and improving outcomes for high-risk populations, Indigenous, People of Color, with a particular focus on Black, Latinx and Pacific Islander clients.

7. Able to meet goals objectives and accomplish outcomes as planned.

FORMAT FOR POLICIES AND PROCEDURES

Policies and Procedures must be clear and concise. Your childcare organization's policies can be more conservative, but not less conservative than state licensing requirements and local public health guidance. This manual contains SAMPLE policies that you may use as templates, or as guidelines for creating your own. We recommend the following format for your organization's Policy and Procedure manual:

TITLE

POLICY: A broad statement of what is to be accomplished.

PURPOSE: An explanation of the expected outcome.

PROCEDURE: A step-by-step system of carrying out the policy.

Policies and procedures are to be evaluated on a regular basis and as needed to ensure they are effective and up-to-date.

B. ADMISSIONS & ENROLLMENT

Admissions & Enrollment	B-01
Child's Health File Checklist	B-02
Children with Chronic Health Conditions	B-03
Allergies and /or Chronic Illness Form	B-04
Special Needs Pre-Service Planning	B-05
Special Needs Pre-Service Plan Template	B-06
Intoxicated or Impaired Adult Seeking Custody	B-07
Signing In and Out of Child Care	B-08

ADMISSIONS & ENROLLMENT

POLICY: Our Childcare admits children from the ages of ______ to ______, without regard to color, sex, religion, national origin, family sexual orientation or gender identity, lifestyle, or ancestry. Children with special needs will be enrolled if our site can reasonably accommodate the child's needs.
Family information will be kept confidential and shared as needed to meet the needs of the child and per state licensing and federal rules and regulations. Information will be shared to entities with written permission from parents or guardians.

PURPOSE: To ensure that every child receives a healthy, safe, and supportive experience.
To assure that we do not discriminate against any person or group.
To assist program staff in meeting all children's needs.
To protect the rights of the family and child.

PROCEDURE:

1. Parents requesting care will meet with childcare admission or enrollment staff.

    a. All incomplete forms will be returned to the parent for completion prior to the child's first day of attendance. The Physician's Report (LIC 701) is due per sites's policy and licensing requirements.

    b. Enrollment and all other information concerning the child and family compiled by this childcare site will be accessible only to the parents/guardians, childcare staff and entities with written permission from parents/guardians. "Confidentiality must be maintained to protect the child and family and is defined by law... (NCR, 2022)." The site will follow state and federal laws which are found in the following resources: CA DSS, NCR-Facility Records/Reports and HIPAA .

2. Parents/legal guardians will be given **all** pamphlets and documents required by licensing and also:

    a. A copy of Illness Inclusion / Exclusion Guidelines

    b. A copy of the Medication Policy and Procedures

    c. A copy of immunization requirements for childcare

3. Parents/legal guardians will be required to provide all financial and qualifying information required by funding terms and conditions, permission approvals required by licensing regulations and:

    a. Physician's Report (LIC 701):

        i. Parents/legal guardians need to follow site policy, or at minimum follow licensing requirements of turning in LIC 701 within 30 days of enrollment.

        ii. Physical assessment must have been within the last 12 months from enrollment date.

        iii. Form must be signed by Physician, Physician's Assistant (PA) or Nurse Practitioner (NP).

        iv. A TB risk assessment and indication must be performed and its conclusion.

    b. Immunization Status Record

        i. See section C-1 for details

        ii. Records must be submitted in writing from a medical provider or health organizations per CA Immunization Requirement.

        iii. Immunization must be current for age prior to child entering the classroom.

        iv. Enrollment staff or designee must enter and update immunization dates on the Immunization Record or California Immunization Registry (CAIR) according to CA Immunization Requirements.

        v. If the child has a qualifying medical condition that prevents or delays receiving immunizations, the child's healthcare provider must file a medical exemption through the CAIR website.

4. A child's health history including allergies, chronic conditions, and family health history. Use form LIC 702 or similar template.

    a. Health care provider verification of all allergies (food, medication, insect, airborne) and/or any chronic illness should be reflected on LIC 701 and on care plans.

5. Special Needs Preservice Plan if applicable (template available in section B-6).

San Francisco Department of Public Health Child Care Health Program

CHILD'S HEALTH FILE CHECKLIST *

CHILD'S NAME: ____

Required Documents Year:							Comments
Emergency Info (LIC 700)							
Pre-admission Health History Parents' Report (LIC 702)							
Medical Assessment including TB Risk Evaluation (LIC 701)							
Medical Care Plans and Medication Forms							
Consent for Medical Treatment (LIC 627) or Waiver							
Immunization Record							
Pre-Service Plans (infant, feeding, toileting, special needs))							
Individual Sleeping Plan (LIC 9227)							
Sunscreen Permission Form							
Mid-Day Toothbrushing Permission Form							
CCHP Health Screening Consent							
CCHP Health Screening Results							
Copy Provided to Parents:							
Admission Agreement							
Daily Health Check Policy							
Medication Policies							
Illness Policy Exclusion Guidelines							
Discipline Policy							
Environmental Hazards Notice							
Resource & Referral List							
Safe Sleep Pamphlet							
Medication Policies							
Lead Poisoning Prevention Flyer							
Immunization Requirements							
Notification of Parent's Rights (LIC 995)							
Personal Rights (LIC 613A)							

Please refer to licensing for updated requirements: LIC 311A and LIC 311D were updated in 2022

CHILDREN WITH CHRONIC HEALTH CONDITIONS

POLICY: The parent/legal guardian will provide the required care plan paperwork and emergency medications for children with chronic health conditions prior to the child's first day.

PURPOSE: To assure staff have appropriate instructions for care of children with chronic health conditions, including emergency care plans and emergency medications.
To comply with licensing regulations.
To protect the health of the children with chronic health conditions.

PROCEDURE:

1. Enrollment paperwork will identify if children have a chronic health condition such as allergies, asthma, seizures, diabetes, or any other medical condition that requires medication to be given at the childcare OR that may require specific care, accommodations, or emergency actions by childcare staff.

2. Prior to a new child starting on their first day, the parent/legal guardian will provide to the childcare the emergency care plan, medication orders, and the emergency medication, completed by the child's health care provider.

    a. If an existing child develops a newly diagnosed chronic health condition, the childcare staff will obtain the emergency care plan and emergency medications as soon as possible.

    b. The childcare reserves the right to temporarily suspend services until a care plan completed by a health care provider and emergency medications are provided to the childcare by the parent/legal guardian.

3. **The following is required for each child with a chronic health condition:**
    a. A written care plan / emergency action plan that is completed and signed by the child's healthcare provider, and signed by the parent/guardian consenting to the childcare provider executing the care plan.

        i. The care plan will describe which actions childcare staff should take if the child experiences certain symptoms, including life-threatening symptoms such as an allergic reaction, an asthma attack, a seizure, etc. Templates are provided in section M.

b. Emergency medication. E.g. epi-pen for allergies, an inhaler for asthma, emergency seizure medication, emergency diabetes medication, or others.

   i. See section E-25 for details on medication policies.

   ii. All medication must be in its original box, including over-the-counter (OTC) medications and prescriptions.

   iii. Prescription medication must have the original pharmacy label on it with the child's name, health care provider's name, instructions for use, dose, frequency, and expiration date.

   iv. The parent/guardian must provide the emergency medication to the childcare provider and have their own emergency medication to be kept at home. They may need to remind their healthcare provider of the need for a second prescription.

   v. All expired or unused medications should be returned to the parent/guardian for disposal. If the medication cannot be returned to the parent/guardian, it should be disposed of safely. See Medication Disposal in San Francisco for a list of drop off locations or how to send them by mail for disposal though the SF Environment Department. You can also visit How to Safely Dispose of Old Medicines - HealthyChildren.org for more information.

c. Medication administration instructions in writing from the health care provider. School staff is not authorized to determine when an "as needed" medication is to be given. Specific instructions are necessary. Templates are provided in section M.

   i. OTC medications without a prescription must also have specific instructions in writing from the parent/guardian. Use form LIC 9221.

d. Parent consent to administer medications, including all OTC medications. Templates are provided in section M, or use LIC 9221.

4. It is a licensing requirement to the have this paperwork in the child's medical file. As a best practice, it is **highly recommended** to also keep an extra copy with the medications in the classroom, and a copy in the go-bag for evacuations.

   a. Emergency medications and care plans are required to be taken with you during any evacuation or field trip.

5. Food allergies and substitute foods shall be posted where only staff can view it (ex: inside of cabinet).

6. In case of contact with an allergen or other medical emergency, childcare personnel will be prepared to administer emergency care. Episodes are documented on injury log and reported per licensing requirements.

7. Allergy episodes at the childcare will be avoided or appropriately handled. Each episode will be investigated by the childcare staff for cause and prevention, appropriate emergency care for the child and follow-up response by staff. The Nurse Consultant may be notified of each allergy episode while the child is in childcare.

8. All unusual incidents and 911 calls should be reported to licensing.

MEDICAL VERIFICATION FOR CHILDREN WITH ALLERGIES AND/OR CHRONIC CONDITIONS *

This form may be used in addition to Form LIC 701 Physician's Report and ***does not replace* LIC 701** and Allergy Care Plan. (Please use additional pages as needed)

Child's name:	Age:	Childcare Program Name:
Parent's name:	Phone:	Childcare Phone:

Allergies to:

Food	
Medicines	
Airborne	
Insect bites	
Other:	

Diet prescription

Foods to omit:	Substitutes:

Medical conditions:	Routine care adjustments:

Possible emergencies:	Instructions:

Medications needed:	Side effects or untoward reactions:

Licensed Health Professional:		Date:
Phone#	Fax#	Signature:

SPECIAL NEEDS PRE-SERVICE PLANNING

POLICY: Childcare personnel must have a signed verification form from a licensed health professional such as Physician, Nurse Practitioner, or Physician's Assistant, to provide the necessary care for the child. The childcare program will follow the Americans with Disabilities Act (ADA) laws.

PURPOSE:

To assure every child receives equal opportunity for the best quality care.
To work in collaboration with health care providers, parents/legal guardians, and other professionals to meet the child's needs.
To follow federal ADA laws.
To assure that no child suffers any injury while in childcare.

PROCEDURE:

Upon enrollment, if a parent/legal guardian states the child has special needs or a chronic health condition:

1. Alert the parent to the laws on special needs: Childcare and ADA

2. Begin a special needs pre-service plan with information provided by parent/legal guardian. Identify the following and determine if accommodating the child will be reasonable or impossible.

    a. What additional care is needed in a group setting? Does the child need additional one-to-one care aside from diaper changes?

    b. How much time is needed for the extra care?

    c. What might limit care in a group?

    d. What resources are available to assist with the limitation?

    e. How do parents meet the need at home? Can it be replicated?

    f. Does the child have medical equipment or supplies? What responsibility is expected from staff related to the equipment or supplies?

    g. How were parents/guardians trained on the special care needed? Can staff be trained? Time and cost of re-training new staff if there is staff turnover?

    h. How often the does child's condition change? Frequency of complications?

    i. How often are medical emergencies anticipated?

3. Determine if the childcare program can **reasonably** care for the child.

    a. Adequate staffing?

    b. All children will be safe and free from harm?

    c. Special needs child will receive equal opportunity and quality care?

    d. Are there other better alternatives for the child?

4. If special needs are discovered later, follow the same procedure as in step #1.

5. Once the decision is made to care for the child, a plan will be developed. See B-6 for a template.

6. If the child needs referrals to additional services and you are unsure where to refer them, contact your Nurse Consultant.

SPECIAL NEEDS PRE-SERVICE PLAN TEMPLATE

Time Allocation for Care:

Care Plan:

Eating:

Sleeping:

Diapering/Toileting:

Outdoor Play:

Circle Time:

Training for Staff:

Equipment:

Use:

Care:

Repair:

Child's Condition:

Observations:

Difficulties:

Emergencies Plan:

Staff Needs:

Child Group Needs:

Health Care Communication Means:

INTOXICATED OR IMPAIRED ADULT SEEKING CUSTODY

POLICY: Children will not be released into the care of an adult who appears to be intoxicated or otherwise impaired whether due to substance use, illness, or emotional crisis.

PURPOSE: To ensure the child is safe at all times.
To fulfill our ethical obligation to the children and families.

PROCEDURE:

1. If the concern is a safe trip home:

   a. Try to reason with the adult to call someone who can assure the child's safety.

   b. Offer to arrange a safe way home.

   c. DO NOT OFFER TO DRIVE THEM IN YOUR CAR.

2. If the concern is for the child's continued safety after leaving the childcare site:

   a. Call the custodial parent to change the arrangements for pick-up.

   b. If it is the custodial parent, call someone else on the emergency list.

   c. If necessary, call the police and Child Protective Services.

SIGNING IN AND OUT OF CHILD CARE

POLICY: The parent/guardian or authorized designee will sign the child in and out of the childcare, indicating times when the childcare staff are responsible for the child's care.

PURPOSE: To ensure that the child is properly cared for at all times.
To satisfy licensing regulations.
To provide staff a roster in case of an emergency.

PROCEDURE:

1. Documentation of authorized caregivers
   a. Only the custodial parent or legal guardian can authorize a person to bring or remove a child from care.

   b. Authorization must be in writing.

   c. The director or designee will keep a list of names, addresses, phone numbers and relationship to the child, of persons authorized to sign the child in and/or out.

2. Releasing a child to an authorized adult's custody
   a. Childcare personnel will ask to see picture ID of the adult.

   b. Childcare personnel will check the list of authorized adults for verification.

   c. If the adult is authorized to pick the child up, they will sign their name and the time on the appropriate date.

3. Unauthorized person seeking custody
   a. A child will never be released without the presence or written permission of the custodial parent or legal guardian.

   b. The staff will immediately contact the custodial parent or legal guardian if an unauthorized person seeks custody. Unless previous written permission has been given, the child will not be released.

   c. The police will be notified of any unauthorized adult insisting they gain custody of the child.

   d. Custodial parents or legal guardians cannot give authority to a minor under the age of 18 to pickup the child from childcare.

C. CHILDREN'S HEALTH FILES

Immunization Audit	C-01
Immunization Compliance Letter	C-02
Daily Health Check	C-03
Child's Daily Wellness Record	C-04
Child's Daily Attendance – Health Check Record	C-05
Medication Records	C-06
Illness Reports	C-07
Illness Report Form	C-08
Injury Reports	C-09
Injury Log	C-10
Sunscreen Permission	C-11
Sunscreen Permission Form	C-12
Mid-Day Toothbrushing	C-13
Mid-Day Toothbrushing Permission Form	C-14

IMMUNIZATION AUDIT

POLICY: Immunizations shall be current for age upon admission and audited on an on-going basis as needed for each child. An annual audit of all children's immunization records will be done and submitted to the California Department of Public Health as required for Child Care Centers by state law.

PURPOSE: To ensure that child's immunization is up to date.
To promote and follow state immunization laws.
To educate the parents on the benefit of immunization.

PROCEDURE:

Follow Child Care and Preschool Staff instructions found on the Shots for School website: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/School/childcare-tools.aspx. QR code available on next page.

How to Implement Immunization Requirements:

1. Notify parents of required immunizations and collect immunization records. See Parents' Guide to Immunizations Required for Pre-Kindergarten (Child Care) (also in Spanish).

2. Complete the blue California Pre-Kindergarten and School Immunization Record (CSIR/Blue Card/CDPH286), or equivalent record, by transferring vaccine dates from the child's personal immunization record. Blue Cards are available free from local health departments.

3. Determine if requirements are met by comparing the dates on the Blue Card to the Guide to Immunization Requirements for Pre-Kindergarten (Child Care) | Chinese

   a. You may also find the windows for immunization(PDF) (also in Spanish and Chinese) tool helpful.

4. If requirements are not met, the child **should not be enrolled until** the required vaccines are obtained, or catch-up schedule has been initiated, per state law. You may refer parents to their doctor with a Letter to Parents: Immunizations Needed | Spanish | Arabic | Farsi | Vietnamese | Chinese from CDPH, or you may use a CCHP template available in section C-2.

a. Families can usually request a “vaccine only” appointment with a registered nurse if they do not otherwise need to see the doctor for a physical exam. Vaccine only appointments are usually easy to obtain on short notice.

b. Visit the SFDPH Schools and Childcare Immunization page for a list of clinics taking new patients and offering catch-up immunizations for children (scroll to the San Francisco Immunization Programs for Children section): Immunization Information for Schools and Child Care .

c. Call 415-554-2955 for information about special immunization clinics for children and families who are having difficulty getting access to vaccines.

5. If a child is too young to receive required immunizations, or has started a catch-up schedule, they may be admitted conditionally.

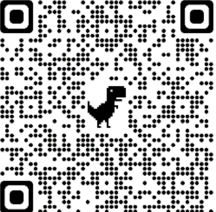
6. Keep a completed Blue Card, or equivalent record, on file for every child enrolled.

7. Every fall, submit Immunization Assessment Reports to the California Department of Public Health per state law. *(Submission to the health department is not required for Family Child Care Homes).*

    a. The Shots for Schools website has many resources and training videos on how to report immunization reports: resources and training (ca.gov)

8. Report contagious diseases (PDF) to your local health department

QR code for Shots for School Website:



IMMUNIZATION COMPLIANCE LETTER

Date: _______________

Dear Parents,

The State of California requires that all children attending childcare are up to date with immunizations appropriate for their age. We are required to review our records annually and advise parents of their child's need for immunizations, if any.

In reviewing the health records of ___________________, we find that we do not have a copy on file of:

Required:

- DPT/DTAP # _______
- Polio # _______
- MMR ____
- Hib #____
- Hep B # _______
- Varicella _____
- Current Physical Examination (within last 12 months) signed by a healthcare provider (LIC 701) ____

Please bring in a copy of the most recent immunization record or LIC 701 form.

If you qualify for a medical exemption for immunization, your health care provider must file your exemption with the state CAIR system.

We are authorized to allow ___ days for you to come into compliance. Please bring in the documents we need by this date ___________________. Thank you for your help.

Sincerely,
(Childcare Provider)

CARTA DE CUMPLIMIENTO DE VACUNACIÓN

Fecha: _____________

Estimado Padre/Tutor,

El Estado de California requiere que todos los niños que asisten a la guardería estén al día con las vacunas apropiadas para su edad. Estamos obligados a revisar nuestros registros anualmente y asesorar a los padres sobre las necesidades de vacunación de sus hijos, si corresponde.

Al revisar los registros de salud de __________________________, encontramos que no tenemos una copia en nuestros archivos de:

Requerido:

- DPT/DTAP # _______
- Polio # _______
- MMR ____
- Hib #____
- Hep B # _______
- Varicella _____
- Examen físico actual (dentro de los últimos 12 meses) firmado por un proveedor de atención médica (LIC 701) ______

Por favor traiga una copia del registro de vacunas más reciente o el formulario LIC 701.

Si califica para una exención médica de vacunación, su proveedor de atención médica debe presentar su exención ante el sistema CAIR estatal.

Estamos autorizados a permitirle ______ días para que usted cumpla con los requisitos. Por favor traiga los documentos que necesitamos para esta fecha _______________.

Gracias por su ayuda.

Atentamente,
Guardería/Centro de Cuidado infantil.

三藩市公共衛生署：兒童護理健康計劃

疫苗注射遵守信

日期: ___________________

尊敬的家長,

加州政府要求所有在托兒所的兒童都必須接受適齡的疫苗注射。三藩市公共衛生署必須依法每年檢查我們的健康記錄, 並建議家長讓他們的孩子接受所需的疫苗注射。

經檢查您的孩子:_________________________的健康記錄, 我們發現您的孩子缺少以下

所需的疫苗注射:

- 白喉/破傷風/百日咳 (DTAP) #_________
- 小兒麻痺 (POLIO) #________
- 麻疹、流行性腮腺炎、及德國麻疹 (MMR) ______
- 乙型流感嗜血杆菌 (HIB) #________
- B型肝炎 (HEP B) #________
- 水痘 (Varicella) ______
- 近一年內醫生簽名的身體檢查報告 (LIC 701) _______

請提供孩子最近的免疫記錄或 LIC 701 表格的副本。

如果孩子需要獲得醫療豁免，您的兒科醫生必須向州的 CAIR 系統提交豁免。

我們被授權允許您在___天內遵守規定。請在此日期____________________之前提交我們所需的文件。感謝您的幫助。

誠致敬意！

____

簽名

DAILY HEALTH CHECK

POLICY: The childcare provider will have a daily conversation with the parent/ guardian upon arrival concerning the child's health and well-being for that day. The health status of each child will be assessed and recorded daily.

PURPOSE: To assure early recognition and intervention of illness.
To understand what has transpired in the child's previous 24 hours.
To maintain a safe and healthy environment for all children and staff.
To assist program staff in meeting all children's needs.
To comply with licensing regulations.

PROCEDURE:

1. Determine the status at home of:

    a. Eating
    b. Sleeping
    c. Mood/Behavior
    d. Stool
    e. Urine
    f. Other

2. Conduct a daily health check of the child, observing by sight, sound, touch, and smell. Examine the child, fully clothed, in the presence of the parent. Assess in order:

    a. Head – **Look** for evidence of lice, injury, poor hygiene, skin discoloration, or rash.

    b. Eyes - **Look** for watery, red, runny eyes, or any sores/lumps on lids.

    c. Ears - **Look** for any drainage, tugging the ear, or swollen area.

    d. Nose - **Look** for sores or drainage. **Listen** for congestion.

    e. Mouth - **Look** for sores, cracked lips, dryness, rash, bright red tongue, white patches. **Listen** for hoarse voice, coughing. **Smell** for foul breath.

    f. Neck - **Feel** for skin temperature or swollen glands. **Look** for stiffness.

    g. Back/Chest/Arms - **Look** for evidence of pain. **Listen** for cough or congestion. (Only if there is some reason would you remove the clothes to look at these parts.)

    h. Tummy/Bottom/Legs - **Look** for limping or swollen tummy (Only if there is a reason, you may remove the clothes to look for evidence of pain/swelling.)

3. Discuss any concerns with the parents/guardians. Document the findings of both conversations and observations on:

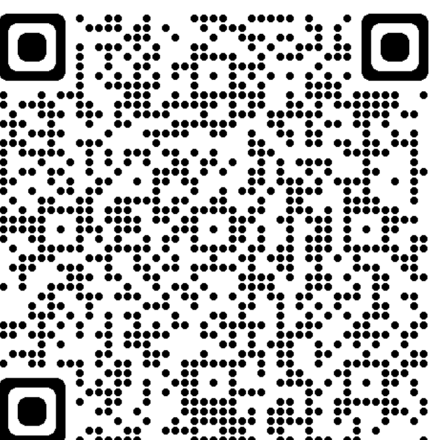
    a. Child's Daily Wellness Record (See C-4)

    b. Child's Daily Attendance/Health Check Record (See C-5)

4. The records will be kept in the classroom as a guide for care that day.

    a. The Child's Daily Wellness Record will be filed in the child's classroom file at the end of the week and will be available for review per licensing requirements and program policy.

Daily Health Checks in Early Care and Education Programs, UCSF Resource:
[Daily Health Check]



CHILD'S DAILY WELLNESS RECORD

Name: Week of:		Eating			Sleeping			Mood/Behavior	Stool			Urine	Other
		Normal	Less	More	Normal	Less	More		#	Color?	Firm?	#	
	At home												
MON.	**Child Care**												
	AM												
	PM												
	At home												
TUES.	**Child Care**												
	AM												
	PM												
	At home												
WED.	**Child Care**												
	AM												
	PM												
	At home												
THURS	**Child Care**												
	AM												
	PM												
	At home												
FRI.	**Child Care**												
	AM												
	PM												

CHILD'S DAILY ATTENDANCE/HEALTH CHECK RECORD

Group: **Month:**

For each child, for each day: Code top box "+" = present, "O" = absent, or "N" = not scheduled.
Code the bottom box "W" = well, or use a number from the bottom of the page.

Name:	Age	Hrs.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Total # of children:

Symptom Codes:

1 = Asthma/wheezing
2 = Behavior change w/no other symptoms
3 = Diarrhea
4 = Fever
5 = Headache
6 = Rash
7 = Respiratory (cold, cough, runny nose, earache, sore throat, pink eye)
8 = Stomachache
9 = Urine problems
10 = Vomiting
11 = Other (specify on the back)
12 = Unable to participate in the program

MEDICATION RECORDS

POLICY: All medications will have the required paperwork completed by the parent/guardian for OTC medications or by the child's healthcare provider for prescription medications. Medications given to a child in our care will be recorded each time a dose is administered. This document will become part of the child's permanent record.

PURPOSE: To accurately reflect the care given the child.
To demonstrate compliance with parents'/guardians' requests.
To assure that the physician's orders were followed responsibly by the staff.

PROCEDURE:

1. Follow procedures for accepting, storing, and administering medications. **See E-26 for details on medication policies, and E-27 through E-30 for additional documents on medication considerations.**

2. All doses given must be documented on an administration log and include the child's name, medication name, dose given, date and time given, and name of staff member that gave it.

    a. Form LIC 9221 has a section on it which may serve as the medication administration log.

    b. The site may use any template they wish to document medication administration as long as all information is captured.

    c. Click here for a sample medication administration log (ucsf.edu)

3. When medications are finished or expired, and the container is returned to the parent, the medication record goes to the Health Advocate or designee.

4. The Health Advocate will determine that every dose is accounted for, including refusals, absences, and any other reason that an anticipated dose was not given.

5. When the form is complete, it goes into the child's file.

GENERAL PARENT INSTRUCTIONS:

1. All prescription and non-prescription OTC (over the counter) medications shall be maintained with the child's name and shall be dated.

2. Prescription and OTC medications must be stored in the original bottle with unaltered label. Medications requiring refrigeration must be properly stored.

3. Prescription medications shall have instructions from the healthcare provider. Prescription and OTC medication shall be administered in accordance with the label directions. Health care provider instructions shall not conflict with the product label directions.

4. Instructions for both prescription and OTC medications cannot simply state "as needed". Specific reasons/symptoms for giving the medication must be listed in writing.

5. Written consent must be provided from the parent/guardian, permitting childcare facility personnel to administer medications to the child. Use LIC 9221.

6. Instructions for use from the parent/guardian shall not conflict with the prescription label or product label directions.

7. Prescription medication must have the original pharmacy label including the child's name, healthcare provider's name and phone number, dose, frequency, and expiration date. "As needed" medication must state the symptoms for why it should be given.

ILLNESS REPORTS

POLICY: Children who are excluded from childcare due to illness will follow program policy and licensing regulations on criteria for the child to return to class. These requirements may include submitting a medical clearance from a medical provider, or SFDPH, Communicable Disease and completing required isolation and quarantine. Childcare site's policy may be more restrictive, but not less restrictive than local or state guidelines.

PURPOSE: To assure the safety of children and staff.
To comply with infection control and prevention standards.
To comply with regulations for reporting outbreaks to SFDPH and CCL (See section E for details on reporting guidance).

PROCEDURE:

1. The teacher who excludes a child for illness may either fill out a referral to a health care provider (see E-22) or an internal form (see C-8) letting the other staff know what action was taken and why.

2. The form will inform the physician, the parent/guardian, and the other staff in the room, which policy applies and what criteria are necessary for the child to return to the group.

3. After the child returns to class, completed forms shall be given to the Health Advocate for review.

4. The Health Advocate will note any further clarification to explain the illness and the actions taken on a separate sheet of paper and attach it to the form.

5. When the form is complete, it goes into the child's file.

6. See section E for detailed information on childhood illness.

ILLNESS REPORT FORM

Child's Name: ___________________________ Symptoms: _______________________
Date: _____ Illness policy quoted: # _____ Written referral made to Dr: Y __ N __
Needed to return to class: ______________________________________ Initials: ___

Child's Name: ___________________________ Symptoms: _______________________
Date: _____ Illness policy quoted: # _____ Written referral made to Dr: Y __ N __
Needed to return to class: ______________________________________ Initials: ___

Child's Name: ___________________________ Symptoms: _______________________
Date: _____ Illness policy quoted: # _____ Written referral made to Dr: Y __ N __
Needed to return to class: ______________________________________ Initials: ___

Child's Name: ___________________________ Symptoms: _______________________
Date: _____ Illness policy quoted: # _____ Written referral made to Dr: Y __ N __
Needed to return to class: ______________________________________ Initials: ___

Child's Name: ___________________________ Symptoms: _______________________
Date: _____ Illness policy quoted: # _____ Written referral made to Dr: Y __ N __
Needed to return to class: ______________________________________ Initials: ___

INJURY REPORTS

POLICY: Children who are injured while in our care will have a record of the injury and first aid received. Documentation will be filed in the child's permanent record.

PURPOSE: To accurately reflect the care given the child.
To demonstrate the quality of the first aid delivered.

PROCEDURE:

1. Staff members responsible for first aid will possess a current first aid certification.

2. First aid shall be delivered according to accepted technique outlined in the current First Aid Manual.

3. Completed forms shall be given to the Health Advocate for review and logging.

4. The Health Advocate will note any further clarification necessary to explain the injury and the actions taken on a separate sheet of paper attached to the form.

5. When the form is complete, it goes into the child's file.

6. Parents/guardians and licensing will be notified of injuries per program policies and licensing regulations.

7. Unusual Incident/ Injury Report for Childcare Centers: LIC 624

8. Unusual Incident/Injury Report- Family Child Care Homes: LIC 624B

INJURY LOG

Date of Injury	Child's Name	Child's age and sex (M/F)	Child's Date of Admission	Nature and Location of Event	Part of Body and Equipment involved?	Action Taken	Child's Caregiver Notified	If Any: Medical Provider Name and Findings	Disposition of Event or Follow Up

SUNSCREEN PERMISSION

POLICY: All children over 6 months old will be protected from sun exposure by using broad- spectrum sunscreen. Sunscreen is considered an over-the-counter medication and will be handled as such. Parental permission must be obtained. Parents will provide mild, lotion-type, SPF 15 or above, PABA-free sunscreen for liberal use whenever the child will be exposed to sun. Parents will be asked to provide appropriate protective clothing, hats and sunglasses during summer months.

PURPOSE: To protect the health of the children; prolonged or overexposure to the sun may cause premature skin aging, skin wrinkling, or skin cancer.
To assist program staff in meeting the children's needs.
To protect the rights of the family and child.
To comply with licensing regulation for over-the-counter medications.

PROCEDURE:

1. Keep infants younger than 6 months out of direct sunlight. Find shade under a tree, umbrella, or the stroller canopy. **Do not put sunscreen on children under 6 months old** unless directed by their primary health care provider.

2. On enrollment and annually thereafter, parents will sign a Sunscreen Permission Form or a medication request form for sunscreen use, which will be kept in the child's health file.

3. Children should be dressed for sun in the summer months.

4. As long as parents/guardians have signed a Sunscreen Permission form for the child, the staff should apply sunscreen to all exposed skin when playing outdoors in the sun.

5. Review guidance on Caring for Our Children (CFOC) Sun Safety Including Sunscreen, found at https://nrckids.org/cfoc/database/3.4.5.1

6. Sunscreen Permission Form template is found in C-12 and also available at: https://cchp.ucsf.edu/sites/g/files/tkssra181/f/SunscreenAppConsent.pdf

PARENT/GUARDIAN'S PERMISSION TO APPLY SUNSCREEN TO HIS/HER CHILD

Name of Child: ____
(last, first)

As the parent/guardian of the above child, I recognize that too much exposure to UV rays may increase my child's risk of getting skin cancer someday. Therefore, I give permission for the staff at:

____
(name of child care program)

to apply a sunscreen product that is broad spectrum with SPF 15 or higher to my child, as specified below, when he/she will be playing outside, especially during the months of March through October and between the daily time of 10 a.m. and 4 p.m. I understand that sunscreen may be applied to exposed skin, including but not limited to the face (except eyelids), tops of ears, nose, bare shoulders, arms and legs.

I have *checked* and *initialed* below **all** applicable information regarding the child care program's choice in brand/type and use of sunscreen for my child:

❏ ___ I do not know of any allergies my child has to sunscreen.

❏ ___ My child is allergic to some sunscreens. Please use ONLY the following brand(s)/type(s) of sunscreen:

____

____

❏ ___ Staff may use the sunscreen of the program's choice following the directions and recommendations printed on the product container.

❏ ___ I have provided the following brand/type of sunscreen for use for my child:

____

____

❏ ___ For medical or other reasons, please do NOT apply sunscreen to the following areas of my child's body: ____

____

Parent/Guardian's Name: ______________________________ **Date:** ____________________

Parent/Guardian's Signature: ____

Health Care Provider's Signature (*optional*): ______________________________________

NOTE: DO NOT RELY ON SUNSCREEN ALONE TO PROTECT CHILDREN FROM SKIN CANCER!

Adapted from the *California Early Childhood Sun Protection Curriculum* (1998-Revised) from the Skin Cancer Protection Program, Cancer Prevention and Nutrition Section, California Department of Health Services. • http://www.dhs.ca.gov/cpns/skin/skin_resources.html

SUN-SMART POLICY FOR CHILD CARE PROGRAMS

Our Sun-Smart policy has been developed to ensure that all children and staff participating in this program are protected from skin damage caused by the harmful UVB and UVA rays of the sun. This policy will be implemented throughout the year, but with particular emphasis from March through October.

Sun-Smart strategies:

1. Encourage staff and children to wear hats with wide brims that protect their face, neck and ears whenever they are outside.
2. Encourage staff and children to wear sun-protective clothing (i.e., tightly woven, loose-fitting, full length, light-colored and light-weight) when temperatures are reasonable.
3. Encourage staff to wear sunglasses that block 100 percent of UVA and UVB rays (broad spectrum) whenever they are outside.
4. Provide sufficient areas of shelter and/or trees providing shade on the play yard.
5. Encourage children to seek and use available areas of shade for outdoor play activities.
6. Schedule excursions and all outdoor activities *before* 10 a.m. and *after* 4 p.m. (10 a.m. to 3 p.m. during the winter months) whenever possible. The availability of shade will be considered when planning excursions and outdoor activities during these times.
7. Children will be hydrated and encouraged to drink water before and during prolonged physical outdoor activities in warm weather.
8. Staff and parents/guardians will model sun safety behaviors by:
   - Wearing appropriate hats and clothing when outdoors.
   - Using broad spectrum SPF 15 or higher sunscreen for skin protection.
   - Seeking shade whenever possible.
9. Provide broad spectrum SPF 15 or higher (and *paba* and *alcohol* free, if possible) sunscreen for staff and children to use on exposed skin, except eyelids, 30 minutes before exposure to the sun and every two hours while in the sun, unless parent/guardian provides their own sunscreen for their child.
10. Parents/guardians will complete and sign the *Parent/Guardian's Permission to Apply Sunscreen to His/Her Child* (see reverse) and it shall remain on file at the program.
11. Include learning about the skin and ways to protect the skin from the UV rays of the sun into the program's curriculum and daily routines.
12. The *Sun-Smart Policy* will be reinforced in positive ways through parent newsletters, staff memos, bulletin boards and meetings. Signage shall be posted that reminds staff, parents and children to practice sun safety.
13. Staff and parents will be provided with educational materials and resources on sun safety and protection.

When enrolling their child, parents/guardians will be:

1. Informed of the program's *Sun-Smart Policy*.
2. Asked to provide a suitable hat for their child's use when outdoors in the care setting.
3. Required to provide permission for staff to apply sunscreen (and *optional*: health care provider's signature included on consent form).
4. Asked to provide a broad spectrum SPF 15 or higher sunscreen if their child is allergic to the program's offered brand/type.
5. Encouraged to practice *Sun-Smart* behaviors themselves.

RECOMMENDED STANDARD/OPTIONAL: Every child should have on file a standing order from their health care provider for the use of sunscreen (nonprescription medication) in the care setting, in addition to the parental consent to have sunscreen applied[1].

[1] American Academy of Pediatrics and American Public Health Association, (2002). *Caring for our children: National health and safety standards: Guidelines for out-of-home child care programs*, Second Edition. Elk Grove Village, IL.

MID-DAY TOOTHBRUSHING

POLICY: Staff will assist children with brushing their teeth after lunch, snack, or the time that works best for staff.
Toothbrushes will be stored in a hygienic manner.
Permission will be obtained from parents/guardians for children to participate in midday toothbrushing.

PURPOSE: To protect the health of the children, including their dental health.
To prevent dental caries and disease.
To teach children the importance of dental care.

PROCEDURE:

1. Contact CCHP for training and resources on implementing midday toothbrushing at your childcare site.

2. On enrollment, parents should sign a Midday Toothbrushing Permission Form, which will be kept in the child's health file.

3. Toothbrushing for infants should begin at the eruption of the first tooth.

4. Each child will have an individual toothbrush that is never shared with others.

5. Children's toothbrushes should not touch each other while stored. Toothpaste should be stored out of children's reach to avoid accidental ingestion.

6. Toothbrushes should be replaced every 3 months, or sooner if the brush becomes contaminated (e.g. falls on the floor), or the bristles appear frayed or damaged.

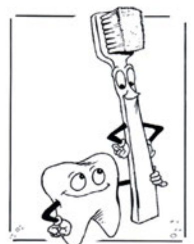
7. Toothpaste should contain fluoride, per the American Academy of Pediatric Dentistry Recommendation and American Academy of Pediatrics Fluoride Recommendation. Abundant research has established that fluoride in toothpaste (in the amounts specified above) has been found to be very **safe** for children and highly effective at preventing dental cavities.

8. **Use a rice-grain-size smear of toothpaste for children younger than 3 years old. Use a pea-size amount of toothpaste for children ages 3 years and older.**

9. Teach children to spit when they are developmentally ready. Otherwise, swallowing a small amount of toothpaste will not be harmful. If more than the above recommended amount of toothpaste is swallowed, contact the Poison Control Center for guidance.

City and County of San Francisco

Department of Public Health
Child Care Health Program
Maternal, Child & Adolescent Health
333 Valencia St., 3rd Floor
San Francisco, CA 94103



TOOTHBRUSHING PERMISSION SLIP

In response to the increasing number of young children with significant dental problems, I plan to institute a midday toothbrushing program. I hope you will allow your child to participate. Children will learn to brush their teeth and the importance of doing so. I have been (or will be) trained by a health professional to ensure that the program will be safe and sanitary for all participating children.

CHILDS NAME: ____

☐ Yes, I would like my child to participate in the toothbrushing program.

☐ No, I do not want my child to participate in the toothbrushing program.

IF YOU SAID YES:

There is a great deal of evidence that fluoride helps prevent cavities and does not have negative side effects. Therefore, the toothpaste we will be making available to the children will contain fluoride. However, if you decide you do not want your child to use fluoride, he or she may still take part in the program without using toothpaste.

☐ My child MAY use fluoride toothpaste

☐ My child may NOT use fluoride toothpaste.

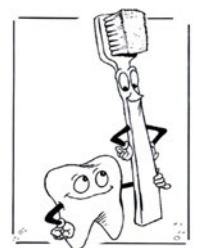
Remember that midday brushing is IN ADDITION to brushing their teeth at home twice a day (in the morning and at night) and NOT INSTEAD OF. Thank you and please let me know if you have any questions.

Parent/Guardian ________________________________

Signature ____________________________________ Date __________

City and County of San Francisco

Department of Public Health
Child Care Health Program
Maternal, Child & Adolescent Health
333 Valencia St., 3rd Floor
San Francisco, CA 94103



刷牙同意書

因應越來越多的孩童有顯著的牙齒疾病，我們打算舉行一個中午刷牙的計畫。我們希望您可以讓您的孩子參加。孩子會學習如何刷牙以及它的重要性。我已經 (或即將) 接受由健康專業人員的培訓, 以確保所有參與該計劃的兒童是安全和衛生。

孩子的名字_______________________________________

☐ 我**同意**讓我的孩子參加這個刷牙的計畫

☐ 我**不同意**讓我的孩子參加這個刷牙的計畫。

如果你同意：

有許多證據可以證明氟化物可以預防蛀牙而且完全沒有副作用。因此，讓孩子使用的牙膏裡會含有氟化物。然而, 如果你不希望你孩子使用有氟化物的牙膏，他或她仍然可以參加這計畫，只是我們不會提供牙膏。

☐ 我的孩子**可以**使用含氟牙膏

☐ 我的孩子**不可以**使用含氟牙膏

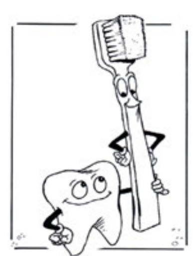
請謹記: 家長必須幫您的孩子刷牙直到８歲－孩子在學校自己刷牙除外。中午刷牙是**除了**家裡早晚兩次刷牙以外的，而**不代替**早晚的兩次。感謝您的配合! 若有任何疑問，歡迎與我們聯絡。

家長/監護人姓名(正楷) ____

家長/監護人簽名 ____ 日期 ________________

City and County of San Francisco

Department of Public Health
Child Care Health Program
Maternal, Child & Adolescent Health
333 Valencia St., 3rd Floor
San Francisco, CA 94103



PERMISO PARA PARTICIPAR EN UN PROGRAMA DE CEPILLARSE EN EL MEDIODIA

En respuesta al creciente número de niños jóvenes con caries serias, tengo la intención de instituir un programa de cepillarse en el mediodía. Espero que le dé a su hijo/a permiso para participar en este programa. Los niños van a aprender como cepillar los dientes y la importancia de hacerlo. He sido entrenado (o voy a ser entrenado) por un profesional de la salud para asegurar que el programa va a ser seguro y sanitario para todos los niños participantes.

NOMBRE DEL NI ÑO: ____

☐ Si, me gustaría que mi hijo participar en el programa de cepillar al mediodía.

☐ No, no me gustaría que mi hijo participar en el programa de cepillar al mediodía.

SI UD. DIJO QUE SI:

Hay tanta evidencia que el fluoruro ayudar en prevenir las caries y no tiene efectos secundarios negativos. Por eso, la pasta dental que vamos a usar contiene el fluoruro. Sin embargo, si Ud. decide que no quiere que su hijo use pasta con fluoruro, él o ella todavía puede participar en el programa sin usando la pasta.

☐ Mi hijo/a PUEDE usar la pasta con fluoruro.

☐ Mi hijo/a NO puede usar la pasta con fluoruro.

Por favor recuerde que cepillar al mediodía es ADEMÁS DE cepillar dos veces al día en la casa (una vez en la mañana y la otra en la noche). Gracias y por favor dime si tiene algunas preguntas.

Nombre del Padre of Guardián ____

Firma ____ Fecha ________________

3-8-23 (LAU)

D. SUPERVISION OF CHILDREN

Section	Page
Supervision of Children	D-01
Title 22 Staffing Ratios for Child Care Centers	D-02
Title 22 Staffing Ratios for Family Child Care Homes	D-03
Schedule of Supervision for Play Spaces	D-04
Discipline	D-05
Child Abuse	D-06
Suspected Child Abuse Report Form	D-07
Inappropriate Interactions Between Adults	D-08
Lost or Missing Children	D-09

SUPERVISION OF CHILDREN

POLICY: Children in our care will be supervised by staff at all times, even when sleeping. Staff to Child Ratios as required by Title 22 Community Care Licensing laws and regulations and/or by Title 5 Department of Education laws and regulations will be strictly followed at all times.

PURPOSE: To ensure every child has a healthy, safe, and supportive experience.
To prevent injuries and protect the health of the children.
To provide adult intervention when needed.

PROCEDURE:

1. Ratios: Depending on each center's funding, some childcare centers must follow both title 5 and title 22 regulations, and others only follow title 22 regulations. If both regulations apply to the center, the more restrictive regulations should be followed.

CHILD CARE CENTERS *QUICK REFERENCE GUIDE*

Requirements & Regulations

California Department of Social Services, Community Care Licensing Division; Health and Human Services, Office of Head Start; California Department of Education, Early Education and Support Division

Column 1 **COMMUNITY CARE LICENSING DIVISION (Title 22 and Health & Safety Code)**	Column 2 **HEAD START & EARLY HEAD START (45 Code of Federal Regulation and Head Start Act)**	Column 3 **DEPARTMENT OF EDUCATION – EARLY EDUCATION AND SUPPORT DIVISION (California Code of Regulation Title 5 and Education Code)**
CHILD RATIOS		
Title 22: 101216.3, 101416.5	***CFR 1306.32(a)(12), 1306.20(c), 1304.52(g)(4)***	***5 CCR § 18290; 5 CCR § 18291 and Title 5***
Preschool • 1 Teacher to 12 preschool children • 1 Teacher & Teacher Assistant to 15 preschool children Infant/Toddlers • 1 Teacher for every six toddlers • 1 Teacher for every four infants • 1 fully qualified teacher to visually observe no more than 12 sleeping infants	Preschool • 4-5 year olds: 17-20 children per class. • 4-5 year olds in double session classes: 15-17 children enrolled per class. • 3-yr. olds: 15-17 children enrolled per class. • 3 year olds in double session classes: 13-15 children enrolled per class. • Center based options must employ two paid staff persons (as teacher & a teacher aide or two teachers) for each class. Whenever possible, there should be a third person in the classroom who is a volunteer. Infant/Toddlers • 1 qualified teacher to 4 infants/toddlers • 8 infants/toddlers to a group	• Infants (birth to 18 months old) • 1:3 adult-child ratio, • 1:18 teacher-child ratio. • Toddlers (18 months to 36 months old) • 1:4 adult-child ratio • 1:16 teacher-child ratio • Preschool (36 months to kindergarten) • 1:8 adult-child ratio • 1:24 teacher child ratio Compliance with these ratios shall be determined based on actual attendance.

Note: Programs must follow the most stringent regulation if funding is layered. This document is intended to be a quick reference to common regulations and does not replace the full scope of the actual regulation.

Authored: Compiled and Authored by the California Head Start State Collaboration Office Community Care Licensing Workgroup Comprised of staff from the California Department of Education California Head Start State Collaboration Office, California Head Start Association, California Department of Social Service Community Care Licensing, Head Start Directors, and California Department of Education Early Education and Support Division. Revised 2016
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2. See sections D-2 for simplified flyers with Title 22 child to staff ratios for Child Care Centers, and section D-3 for ratios for Family Child Care Homes. (Current as of July 2023). These documents can be found at https://www.cdss.ca.gov/inforesources/child-care-licensing/how-to-become-licensed

3. Volunteers may be used to satisfy enhanced ratios but not required ratios.

4. Supervision of gross motor play - A written schedule will be prepared by the Director or designee and used to assign staff to supervise high-risk areas (see template provided in section D-4).

5. Details on ratios can be found in the Child Care Centers Quick Reference Guide

Capacity Regulations

For Child Care Center License

Preschool Ratios

1 Teacher: 12 Children

1 Teacher and 1 Aide: 15 Children

1 Fully Qualified Teacher and 1 Aide (with 6 semester units): 18 Children

Toddler Option Ratios

1 Teacher: 6 Toddlers

1 Fully Qualified Teacher and 1 Aide: 12 Toddlers

Capacity Regulations

For Child Care Center License

Infant Ratios

1 Teacher: 4 Infants

1 Fully Qualified Teacher and 2 Aides: 12 Infants

Toddler Option Ratios

1 Teacher: 6 Toddlers

1 Fully Qualified Teacher and 1 Aide: 12 Toddlers

Capacity Regulations

<u>For Child Care Center License</u>

School Age Ratios

1 Teacher: 14 Children

1 Fully Qualified Teacher <u>and</u> 1 Aide: 28 Children

Capacity Regulations

For Child Care Center License

Napping

Infant Ratios

1 Teacher or 1 Aide: 12 Napping Children

1 Teacher or 1 Aide: 12 Napping Children

1 Teacher or 1 Aide: 24 Napping Children

Capacity Regulations

<u>For Family Child Care Home License</u>

Small Family Child Care Home Capacity

4 infants ONLY (birth to 24 months)

or

6 children; no more than 3 infants and 3 older children over two

---

Optional Small Family Child Care Home Capacity

- **8** children
  - No more than 2 infants and 6 older children
  - At least 2 school age children
    - One child at least age 6
    - One child enrolled in and attending kindergarten, including transitional kindergarten or elementary school.

- Landlord consent <u>and</u> written parent notification are required when caring for more than 6 children.

Capacity Regulations

For Family Child Care Home License

Large Family Child Care Home Capacity

- **12** children
  - No more than 4 infants (birth to 24 months) and 8 older children over the age of 2
  - Qualified Assistant (14 years of age or older)

Optional Large Family Child Care Home Capacity

- **14** children
  - No more than 3 infants (birth to 24 months) and 11 older children
  - At least 2 school age children
    - One child at least age 6
    - One child enrolled in and attending kindergarten, including transitional kindergarten or elementary school.

- Landlord consent and written parent notification are required when caring for more than 12 children.
- When there isn't a qualified assistant, providers must follow Small Family Child Care Home regulations.

SCHEDULE OF SUPERVISION FOR PLAY SPACES

Week of: ____

Inspection	*Climbers*	*Swings*	*Slider*	*Tricycles*	*Other*
Monday:					

Tuesday:					

Wednesday:					

Thursday:					

Friday:					

DISCIPLINE

POLICY: All staff and caregivers at our childcare program will:

- Use positive guidance, redirection, and limit-setting
- Encourage children to be responsible for their actions
- Model fairness and respect
- Guide children to develop self-control
- Use discipline that is consistent, clear, and understandable to the child
- NEVER use physical punishment nor abusive language
- Physical restraint will only be used if necessary to ensure a child's immediate safety or that of others, and then only long enough for the child to gain control

PURPOSE: To foster the child's ability to develop self-discipline.
To teach acceptable social behavior.
To show children positive alternative behavior.
To assure the safety of all the children.

PROCEDURE:

1. Whichever technique is used, explain it to the child in age-appropriate language.

2. For acts of aggression and fighting (hitting, biting, etc.):

    a. Separate the children involved.

    b. Immediately comfort the injured child.

    c. Do first aid for any injury sustained.

    d. Notify parents of incident.

    e. Review the adequacy of caregiver supervision for this group, activity, age, and the appropriateness of the activity.

3. For disruptive behavior:

    a. Redirect the child's interest.

    b. Change activities.

    c. Separate to a smaller group.

    d. Try one-on-one attention for a short time.

4. For behavior problems that continue in children 18 months or older

    a. Discuss strategies for behavior change with the parent/legal guardian and the director.

    b. Use a time out until the child can gain control. Stay where you can observe the child while in time out.

    c. Using a “Time-In” technique instead of a “Time-Out”

5. For significant and severe behavior concerns:

    a. Involve the mental health consultant if available.

    b. Consult with parent/legal guardian about pursuing an assessment for possible developmental conditions, mental health services, behavior therapies, trauma related services, or other services.

    c. Ask parent/legal guardian if anything stressful is going on at home, or if the child has experienced any traumatic events. If yes, refer family for appropriate support services or mental health services.

    d. Consult with CCHP Nurse Consultant if unsure where to refer families.

Time-Out Best Practices:

1. Give a verbal warning and reason for request.
2. Give a verbal reason for time-out.
3. Remove child from the environment/group activity/stimulation.
4. Place child in a safe location, seated in a chair, where you can observe them for safety.
5. Short duration, about 3 minutes for ages 3-5.
6. Return to chair if child escapes.
7. Ask child to follow through with original request if time-out was for non-compliance.
8. Staff remain calm the entire time.
9. Use the intervention consistently.

10. Have realistic developmental expectations of the child, including children with developmental delays.

11. Discuss what happened with the child when they are feeling calm.

What is a Time-IN vs a Time-Out?

A time-out is a popular, evidence-based discipline technique, and it is effective at modifying behavior. Time-out is supported the AAP and the CDC. Growing evidence in child psychology is showing that children, and even adults, benefit from human connection, compassion, and emotional support (not isolation) when they are emotionally dysregulated.

Common criticisms of time-out include that time-outs can potentially increase emotional dysregulation for some children, do not teach children distress tolerance skills, isolate them when they need support, and may re-traumatize some children who have experienced abuse. Moreover, there is concern that time-outs may not always be properly implemented by caregivers and may lead to inappropriate and coercive use of time-out.

Advocates of trauma informed behavior approaches and positive parenting techniques encourage support and connection during times of emotional dysregulation. A time-in also involves removing the child from the environment, but it includes an adult connecting with the child in a quiet space to calm down and provide emotional support.

Steps for a Time-In:

1. Remove the child from the environment/group activity/stimulation.

2. A staff member sits with the child one-on-one for a few minutes, either holding a young child in their lap or sitting next to them.

3. Help the child to calm down by doing some deep breathing (smell the flowers, blow the candles). Provide comfort until they are calm enough to communicate with you or for you to communicate with them.

4. Give language to their emotions. For example, "I see you are **frustrated** (angry, sad, etc.) that a friend took your toy!" Ask them to listen to their bodies to see if they feel hungry or tired.

5. Determine if the child is calm enough to discuss what happened and what are alternative solutions for the future. Use simple, age-appropriate language.

6. Return to group activity when the child has regulated their emotions.

After either a time-out, a time-in, or any behavior incident:

1. Wait until the child is calm to discuss the incident and discuss what are alternative solutions for the future. Use simple, age-appropriate language.

2. Discuss what happened leading up to the incident and help the child understand their emotions right before the incident. Validate the child's feelings.

3. Help the child understand the impact of their actions.

    a. E.g. "It really hurt your friend when you hit him. It's not okay to hit other people no matter how we feel".

4. Suggest alternative ways of handling big feelings next time they happen.

    a. E.g. "I sometimes feel frustrated, too. What is something we can do other than throwing or hitting when we are frustrated? Let's try taking a deep breath and counting to 5 to see if that helps."

    b. "Next time you don't want to share a toy, instead of using your hands, let's use our words. Try saying "It's my turn with this toy right now."

    c. "Next time you feel angry let's use your words to tell a teacher or grown-up and we can help you."

5. Be careful with your words. Help the child separate that the child is a good child, but the behavior is bad. Avoid telling children that they are "bad", "naughty", "a trouble-maker", etc. Children will internalize these labels are a part of their identity as a bad child as they grow. Instead, focus on the **behavior** being bad / not acceptable / not allowed / not okay. Children who feel cared for and supported will respond more effectively to discipline/behavior modification attempts compared to children who only feel punished and shamed.

References:

Is It Time for "Time-In"?: A Pilot Test of the Child-Rearing Technique

Child Development – The Time Out Controversy: Effective or Harmful?

CDC: Steps for Time Out

AAP: Time Out

AAP: Many Parents Use Time-Out's Incorrectly

CHILD ABUSE

POLICY: Our childcare program will not tolerate any adult behavior which is abusive to children. Our childcare personnel will never use punishment which is harmful. Our staff will report observed or suspected abuse of children to authorities as required by law.

PURPOSE: To safeguard the children in our care.
To comply with the state mandatory reporting laws.

PROCEDURE:

1. **Prohibited Practices:**

    a. Corporal/physical punishment of any kind (any action which causes physical pain, i.e., spanking, pinching, hitting, shaking, pulling hair or limbs, etc.)

    b. Denial of food, rest, or bathroom opportunities.

    c. Abusive, threatening, or derogatory language, including yelling and belittling.

    d. Any form of public or private humiliation, including threats of physical harm.

    e. Any form of emotional abuse including rejecting, terrorizing, ignoring, isolating, or corrupting a child.

    f. Any sexual acts of any kind, including inappropriate touching.

2. Suspicion of Abuse May Include:

    a. Child has unexplained bruises or bruises which don't match the explanation.

    b. Child displays unusual or intense fears.

    c. Child has sexual knowledge beyond their level of understanding.

    d. Child is dirty, unkempt, tired, or withdrawn much of the time.

    e. Child verbalizes being abused or makes concerning statements that lead you to suspect possible abuse.

3. Reporting Abuse

a. All observations or suspicions of abuse or neglect will be immediately reported to the child protective services (CPS) agency no matter where the abuse may have occurred. The childcare should still make a report **even if** the parent/legal guardian tells you the situation has already been reported to CPS.

b. **Phone number for reporting in SF: 1-800-856-5553 or 415-558-2650.**

c. Follow the instructions of the CPS intake person.

d. Submit a written report within 36 hours.

   i. See section D-5 for the Suspected Child Abuse Report Form, or visit https://www.sfhsa.org/services/protection-safety/child-protective-services/mandated-reporters-child-abuse

e. If you are unsure if your concerns are reportable or not, call the CPS reporting hotline and ask if the situation is considered a mandated report.

f. Discuss every CPS report or potential report with the center's Director.

4. Report of Abuse by Childcare Staff

   a. Contact Licensing to report an unusual incident.

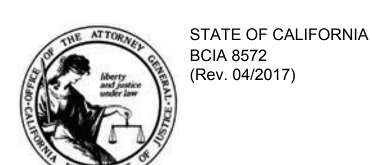
   b. Inform parents of child involved in the report.

   c. Suspend caregiver without pay pending the investigation or reassign to a role not involving the care of children.

   d. If abuse is substantiated, terminate the staff.

   e. If cleared, reinstate staff with all back pay.

5. All childcare staff must complete Child Abuse Mandated Reporter Training every 2 years per CCL licensing requirements. Citations can be issued by licensing if staff are not up to date on their training. Link to training: https://mandatedreporterca.com/



STATE OF CALIFORNIA
BCIA 8572
(Rev. 04/2017)

DEPARTMENT OF JUSTICE

SUSPECTED CHILD ABUSE REPORT
(Pursuant to Penal Code section 11166)

To Be Completed by Mandated Child Abuse Reporters
PLEASE PRINT OR TYPE

CASE NAME: ____________________

CASE NUMBER: ____________________

A. REPORTING PARTY

NAME OF MANDATED REPORTER | TITLE | MANDATED REPORTER CATEGORY

REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street City Zip | DID MANDATED REPORTER WITNESS THE INCIDENT? ☐ YES ☐ NO

REPORTER'S TELEPHONE (DAYTIME) | SIGNATURE | TODAY'S DATE

B. REPORT NOTIFICATION

☐ LAW ENFORCEMENT ☐ COUNTY PROBATION
☐ COUNTY WELFARE / CPS (Child Protective Services) | AGENCY

ADDRESS Street City Zip | DATE/TIME OF PHONE CALL

OFFICIAL CONTACTED - NAME AND TITLE | TELEPHONE

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS Street City Zip | TELEPHONE

PRESENT LOCATION OF VICTIM | SCHOOL | CLASS | GRADE

PHYSICALLY DISABLED? ☐ YES ☐ NO | DEVELOPMENTALLY DISABLED? ☐ YES ☐ NO | OTHER DISABILITY (SPECIFY) | PRIMARY LANGUAGE SPOKEN IN HOME

IN FOSTER CARE? ☐ YES ☐ NO

IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE:
☐ DAY CARE ☐ CHILD CARE CENTER ☐ FOSTER FAMILY HOME
☐ FAMILY FRIEND ☐ GROUP HOME OR INSTITUTION ☐ RELATIVE'S HOME

TYPE OF ABUSE *(CHECK ONE OR MORE)*:
☐ PHYSICAL ☐ MENTAL
☐ SEXUAL ☐ NEGLECT
☐ OTHER (SPECIFY) __________

RELATIONSHIP TO SUSPECT | PHOTOS TAKEN? ☐ YES ☐ NO | DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ☐ YES ☐ NO ☐ UNK

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

	NAME	BIRTHDATE	SEX	ETHNICITY		NAME	BIRTHDATE	SEX	ETHNICITY
1.					3.				
2.					4.				

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST. MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS Street City Zip | HOME PHONE | BUSINESS PHONE

NAME (LAST, FIRST. MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS Street City Zip | HOME PHONE | BUSINESS PHONE

SUSPECT

SUSPECT'S NAME (LAST, FIRST. MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS Street City Zip | TELEPHONE

OTHER RELEVANT INFORMATION

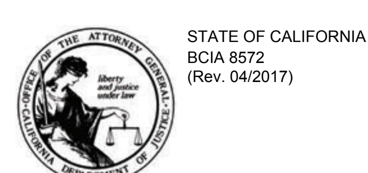
E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ☐ IF MULTIPLE VICTIMS, INDICATE NUMBER: __________

DATE/TIME OF INCIDENT | PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incident's involving the victim(s) or suspect)

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code section 11169 to submit to DOJ a Child Abuse or Severe Neglect Indexing Form BCIA 8583 if (1) an active investigation was conducted and (2) the incident was determined to be substantiated.



SUSPECTED CHILD ABUSE REPORT
(Pursuant to Penal Code section 11166)

DEFINITIONS AND GENERAL INSTRUCTIONS FOR COMPLETION OF FORM BCIA 8572

All Penal Code (PC) references are located in Article 2.5 of the California PC. This article is known as the Child Abuse and Neglect Reporting Act (CANRA). The provisions of CANRA may be viewed at: http://leginfo.legislature.ca.gov/faces/codes.xhtml (specify "Penal Code" and search for sections 11164-11174.3). A mandated reporter must complete and submit form BCIA 8572 even if some of the requested information is not known. (PC section 11167(a).)

I. MANDATED CHILD ABUSE REPORTERS

Mandated child abuse reporters include all those individuals and entities listed in PC section 11165.7.

II. TO WHOM REPORTS ARE TO BE MADE ("DESIGNATED AGENCIES")

Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department (not including a school district police or security department), the county probation department (if designated by the county to receive mandated reports), or the county welfare department. (PC section 11165.9.)

III. REPORTING RESPONSIBILITIES

Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof ***within 36 hours*** of receiving the information concerning the incident. (PC section 11166(a).)

No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC section 11172(a).)

IV. INSTRUCTIONS

SECTION A – REPORTING PARTY: Enter the mandated reporter's name, title, category (from PC section 11165.7), business/agency name and address, daytime telephone number, and today's date. Check yes/no whether the mandated reporter witnessed the incident. The signature area is for either the mandated reporter or, if the report is telephoned in by the mandated reporter, the person taking the telephoned report.

IV. INSTRUCTIONS (*continued*)

SECTION B – REPORT NOTIFICATION: Complete the name and address of the designated agency notified, the date/time of the phone call, and the name, title, and telephone number of the official contacted.

SECTION C – VICTIM (One Report per Victim): Enter the victim's name, birthdate or approximate age, sex, ethnicity, address, telephone number, present location, and, where applicable, enter the school, class (indicate the teacher's name or room number), and grade. List the primary language spoken in the victim's home. Check the appropriate yes/no box to indicate whether the victim may have a developmental disability or physical disability and specify any other apparent disability. Check the appropriate yes/no box to indicate whether the victim is in foster care, and check the appropriate box to indicate the type of care if the victim was in out-of-home care. Check the appropriate box to indicate the type of abuse. List the victim's relationship to the suspect. Check the appropriate yes/no box to indicate whether photos of the injuries were taken. Check the appropriate box to indicate whether the incident resulted in the victim's death.

SECTION D – INVOLVED PARTIES: Enter the requested information for Victim's Siblings, Victim's Parents/Guardians, and Suspect. Attach extra sheet(s) if needed (provide the requested information for each individual on the attached sheet(s)).

SECTION E – INCIDENT INFORMATION: If multiple victims, indicate the number and submit a form for each victim. Enter date/time and place of the incident. Provide a narrative of the incident. Attach extra sheet(s) if needed.

V. DISTRIBUTION

Reporting Party: After completing form BCIA 8572, retain a copy for your records and submit copies to the designated agency.

Designated Agency: ***Within 36 hours*** of receipt of form BCIA 8572, the initial designated agency will send a copy of the completed form to the district attorney and any additional designated agencies in compliance with PC sections 11166(j) and 11166(k).

ETHNICITY CODES

1 Alaskan Native	6 Caribbean	11 Guamanian	16 Korean	22 Polynesian	27 White-Armenian
2 American Indian	7 Central American	12 Hawaiian	17 Laotian	23 Samoan	28 White-Central American
3 Asian Indian	8 Chinese	13 Hispanic	18 Mexican	24 South American	29 White-European
4 Black	9 Ethiopian	14 Hmong	19 Other Asian	25 Vietnamese	30 White-Middle Eastern
5 Cambodian	10 Filipino	15 Japanese	21 Other Pacific Islander	26 White	31 White-Romanian

INAPPROPRIATE INTERACTIONS BETWEEN ADULTS

POLICY: Our childcare program will not tolerate any adult behavior which is abusive to children. Our childcare personnel will never use punishment which is harmful. Our staff will report abuse to children, observed or suspected, to authorities as required by law.

PURPOSE: To safeguard the children in our care.
To comply with the state mandatory reporting laws.

PROCEDURE:

1. Adults who are using foul language or inappropriate behavior of any sort will be asked to leave the premises.

2. If the offending adult does not leave, the children will be taken to another area.

3. Altercations between adults, whether staff, parent/legal guardian, or visitor, will not be tolerated.

4. If staff members have a disagreement, it is to be taken to an office or break room to work out, with words, quietly. If a mediator is needed, the site supervisor or director should be summoned.

5. If parents/legal guardians have a disagreement on the premises, they must go outside of the site. If a mediator is needed, a staff member may try to help them verbalize their issues.

6. If adults begin to push, shove, punch, slap, or brandish a weapon, call 9-1-1 and get the children to safety.

7. Inform parents/legal guardians and newly hired personnel at their first orientation meeting of this policy, and that there will be zero tolerance for inappropriate behaviors at the childcare site.

LOST OR MISSING CHILDREN

POLICY: The childcare program will have a written plan and protocol to strategically search for a missing child.

PURPOSE: To effectively locate a missing child and notify appropriate personnel.

PROCEDURE:

1. When a child is discovered to be missing, notify the director or site supervisor immediately.
2. The director or designee shall deploy all available employees to search the immediate premises for the child.
    a. Start at the child's last known whereabouts.
    b. Search all areas which looks appealing to a child of developmental age.
    c. Call the child's name repeatedly in a friendly (not panicked) voice.
3. Begin by calling the child's home and anywhere else they might have gone.
4. If the child is not found on the premises, **call 911 to alert the police.**
5. One person should interview staff.
    a. Ask *who* last saw the child, *what* was the child doing and *where*.
    b. Ask if anyone saw anything suspicious around the area.
    c. Ask if the child was acting differently today.
    d. Ask if anyone knows of anything upsetting the child.
6. Taking all available employees and volunteers, start searching the neighborhood and surrounding areas.
7. One person must become the liaison to the police and a spokesperson to the parent.
8. Report the unusual incident to Licensing (required).
9. **After the incident, debrief with staff to discuss what circumstances led to the lapse in supervision, and what policies, staffing, or facility/environment changes need to be made to prevent missing children moving forward.**

E. CHILDHOOD ILLNESS

Illness Policy	E-01
Inclusion Exclusion Guidelines Updated 2023	E-02
Contagious Disease Alert System	E-03
Chickenpox (Varicella) Parent Alert	E-04
Pink Eye (Conjunctivitis) Parent Alert	E-05
Non-Polio Enterovirus Parent Alert	E-06
Fifth Disease Parent Alert	E-07
Hand Foot and Mouth Disease Parent Alert	E-08
Herpes Simplex (Cold Sores) Parent Alert	E-09
Impetigo (a.k.a Infantigo) Parent Alert	E-10
Head Lice Parent Alert	E-11
Pinworm Parent Alert	E-12
RSV (Respiratory Syncytial Virus) Parent Alert	E-13
Ringworm Parent Alert	E-14
Viral Gastroenteritis Parent Alert	E-15
Scabies Parent Alert	E-16
Streptococcal Infection Parent Alert	E-17
Thrush Parent Alert	E-18
Get Help Immediately	E-19
Reportable Illness	E-20
Health Information Exchange Policy	E-21
Information Exchange Form for Children with Health Concerns	E-22
Management of Illness	E-23
Medical Evaluation	E-24
Medications Policies	E-25
Administering Medications	E-26
Accepted Medication Administration Techniques	E-27
Symptoms of Adverse Reactions	E-28
Medication Incident Form	E-29
Taking a Child’s Temperature	E-30

ILLNESS POLICY

POLICY: Children who are mildly ill, but do not qualify for exclusion, will be accepted for care in the regular program. Children who become ill with excludable symptoms while at childcare, will be cared for away from the group until the child is picked up by an authorized adult. Specialized care plans will be followed.

PURPOSE: To insure every child a healthy, safe and supportive experience.
To protect the health of everyone in the group.
To assist program staff in meeting all children's needs.
To protect the rights of the family and child.

PROCEDURE:

1. Understand the reason for excluding a child.

    a. The illness prevents the child from comfortably participating in daily activities.

    b. The illness requires more care than the childcare staff are able to provide without compromising the health and safety of the other children.

    c. The symptoms or illness are any of those specified on the "Inclusion - Exclusion Guidelines".

2. Conditions for which you would not automatically exclude a child:

    a. When instructed not to exclude the child by a health care provider or the Public Health Dept.

    b. Non-contagious conditions, such as chronic medical conditions or disabilities.

The final decision to exclude a child from care is made by the staff of the childcare program. Staff may consult with SFDPH Communicable Disease (CD) and/or CCHP Nurse Consultant for questions.

INCLUSION/EXCLUSION GUIDELINES

Signs and/or symptoms observed	What should staff do?	What needs to happen in order for the child to return?	Dr.'s note required?
1. Unable to take part comfortably in regular activities.	Exclude	Able to take part in activities.	Not needed
2. Level of care or attention needed jeopardizes health & safety of others.	Exclude	Able to be comfortable within ratio.	Not needed
3. Head lice	Exclude at the end of the day	Once treatment is started https://www.cdph.ca.gov/Programs/CID/DCDC/pages/headlice.aspx	Not needed
4. Pink Eye (Conjunctivitis)	Exclude	Symptoms resolved, able to participate in daycare activities, meeting childcare criteria such as medical clearance from a medical provider. Revised by CD 11/9/22.	Yes
5. Ear pain (tugging at ear) Ear drainage (with or without tubes)	Observe Exclude	Watch for fever or increase in pain. Medicine started.	Not needed Yes
6. Nose/Mouth Mucus Sores	 Observe Exclude	 Watch for other symptoms. See a doctor. *Fever and antibiotic guidelines apply.	 Not needed Yes
7. Sore throat First complaint With fever*	 Observe Exclude	 Watch for other symptoms. See a doctor. *Fever and antibiotic guidelines apply.	 Not needed Yes

Signs and/or symptoms observed	What should staff do?	What needs to happen in order for the child to return?	Dr.'s note required?
8. Stiff neck			
Infant	Exclude	See a doctor.	Yes
Child	Observe	Watch carefully for fever and headache.	Not needed
With fever and/or headache	Exclude	Cleared by MD, perhaps Health Dept.	Yes

Signs and/or symptoms observed	What should staff do?	What needs to happen in order for the child to return?	Dr.'s note required?
9. Rashes			
First noticed	Observe	Observe for change and other symptoms.	Not needed
Rash (with fever or behavior change)	Exclude	See a doctor.	Yes
Skin sores (weepy/scaly)	Exclude	Medicine and covering for sore.	Yes
Diaper rash (simple)	Observe	Document appearance/air dry.	Not needed
Diaper rash (with bumps or sores)	Exclude	Medication and rash clearing.	Yes

Signs and/or symptoms observed	What should staff do?	What needs to happen in order for the child to return?	Dr.'s note required?
10. Fever 100.4 F (38 C) on any sites (axillary, forehead, by mouth) WITHOUT behavior change or NO other symptoms	Observe	For other symptoms, exclude if with symptoms or behavior change.	Not needed
Infants and children 100.4 F (38 C) or above on any sites WITH behavior change or other symptoms	Exclude	Temperature normal 24 hours without taking fever reducing medicine and meeting childcare admission criteria.	Yes
Under 2 months old with 100.4 F (38 C) any site WITH or WITHOUT behavior change	Exclude	Temperature normal 24 hours without taking fever reducing medicine and meeting childcare admission criteria.	Yes

Signs and/or symptoms observed	What should staff do?	What needs to happen in order for the child to return?	Dr.'s note required?
11. Respiratory Uncontrolled coughing or sneezing Difficulty breathing Wheezing	Exclude Exclude Exclude	Return when controlled. Breathing easily with or without medication. Breathing easily with or without medication.	Not needed Yes Yes
Confirmed COVID-19 cases	Exclude	Child has been fever free for 24 hours without using fever reducing medication AND other COVID-19 symptoms are mild and improving. (last updated by CDPH on Jan, 2024). Child should mask when around other people indoors for the 10 days* after he/she become sick or test positive (if no symptoms). The child may remove mask sooner than 10 days if he/she had two sequential negative tests at least one day apart. Children under 2 y.o should not wear mask due to risk of suffocation. Visit the following website for most current COVID-19 guidelines and resources:https://www.sf.gov/youve-tested-positive-covid-19 https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/COVID-19-Isolation-Guidance.aspx https://www.sf.gov/topics/coronavirus-covid-19	Not needed

Signs and/or symptoms observed	What should staff do?	What needs to happen in order for the child to return?	Dr.'s note required?
12. Abdominal pain			
First complaint	Observe	Watch for other symptoms.	Not needed
Continues for 2 hours, or increases in severity.	Exclude	Pain gone, no diarrhea.	Not needed

13. Vomiting			
One small amount, no fever.	Observe	Child may rest in class.	Not needed
Two or more episodes in 24 hours.	Exclude	Return 12 hours after last vomiting.	Not needed
Tested positive for communicable disease	Exclude	Until cleared by Public Health Dept.	Yes

14. Loose or watery bowel movements			
Cannot be contained in diaper.	Exclude	When symptoms are gone.	Not needed
Three or more episodes in 24 hours.	Exclude	When symptoms are gone.	Not needed
Diarrhea is causing "accidents" in toilet-trained children.	Exclude	When symptoms are gone.	Not needed
Tested positive for communicable disease	Exclude	Until cleared by Public Health Dept. Note: *Recommend seeking medical attention if diarrhea cause is unknown and symptoms worsen, ex. blood in stool, signs of dehydration, loose bowel movement greater than 10 in 24 hrs.* *References:* Mayo Clinic, 2021 Diarrhea Care in the ER | Central California Hospitals | Dignity Health	Yes

15. Antibiotic therapy	Exclude	After 24 hours or per MD.	Yes

Illnesses which have been <u>diagnosed</u>	What should staff do?	What needs to happen in order for the child to return?	Dr.'s note required?
1. **Chickenpox**	Exclude	Until all lesions crusted (usually after 5 days) and **cleared by Public Health Dept (CDPH,8/23).**	Yes
2. Hand-Foot-and –Mouth Disease (HFMD)	Exclude	When exclusion criteria are resolved. See Parent Alert. Children with HFMD should be kept home from daycare or school until 24 hours after resolution of fever and mouth sores have healed (Revised by CD 9/16/22) See Parent Alert. For Outbreaks. follow CD Outbreak Instructions*	No
3. **Hepatitis A**	Exclude	Until 7 days after hepatitis symptoms (ex. headache, malaise, anorexia, nausea, vomiting, diarrhea, abdominal pain, or dark urine) *and* jaundice starts and **cleared by Public Health Dept (CDPH, 9/21).**	Yes
4. Impetigo	Exclude	24 hours after treatment has begun.	Yes
5. **Measles**	Exclude	Until 4days after onset of rash and **cleared by Public Health Dept (CDPH, 8/23).**	Yes
6. **Meningitis**	Exclude	Bacterial: After treatment **and cleared by Public Health Dept.** Viral: when child can participate in activities and **cleared by Public Health Dept.**	Yes
7. **Mumps**	Exclude	Until 5 days after onset of swelling and **cleared by Public Health Dept (CDPH, 7/22).**	Yes

Illnesses which have been diagnosed	What should staff do?	What needs to happen in order for the child to return?	Dr.'s note required?
8. **Pertussis (whooping cough)**	Exclude	Until 5 days after antibiotic begins, 21 days if no antibiotics, 6 weeks for less than 1 yo, and **cleared by Public Health Dept (CDPH, 5/22).**	Yes
9. Ringworm	Exclude at end of school day	Once treatment is started and area is covered.	No
10. **Rubella (German measles)**	Exclude	Until 7 days after onset of rash and **cleared by Public Health Dept (CDPH, 9/23).**	Yes
11. **Salmonella**	Exclude	Until two successive authentic specimens of feces taken at intervals of not less than 24 hours, beginning at least 48 hours after cessation of specific therapy, if any was administered, and **cleared by Public Health Dept (CDPH, pg. 10,3/20).**	Yes
12. Scabies	Exclude	24 hours after treatment.	Not needed
13. **Shingles**	Exclude	Until all lesions crusted (usually after 5 days) and **cleared by Public Health Dept (CDPH,8/23).**	Yes
14. **Shigella**	Exclude	Restrict/ exclude until 2 consecutive stool specimens, taken at least 24 hours apart, and collected at least 48 hours after cessation of antibiotics, are negative, and **cleared by Public Health Dept (CDPH,4/2020).**	Yes
15. **Strep Throat or other streptococcal infection**	Exclude	Until 24 hours after antibiotic treatment has started and **cleared by Public Health Dept.**	Yes

16.**Tuberculosis (TB)**	Exclude	Until treatment has begun, fever is gone, and **cleared by Public Health Dept.**	Yes

Notes: Illnesses listed in bold are reportable to the Health Department.

Childcare sites may follow a more conservative site policies in management of ill children in accordance with childcare licensing rules and regulations.

For multiple cases, outbreaks or questions, contact your CCHP Nurse Consultant or the SF Department of Public Health, Communicable Disease: 1-415-554-2830

References:

California Department of Public Health. CDPH Home (ca.gov)

Caring for our Children. (2023). https://nrckids.org/cfoc/database/3.6.1.1

Centers for Disease and Control. https://www.cdc.gov/

SF Disease Control and Control. https://www.sfcdcp.org/communicable-disease/

Revised 9/20/24

CONTAGIOUS DISEASE ALERT SYSTEM

POLICY: The childcare program will inform staff and parents/legal guardians of known illnesses and exposures at the childcare.

PURPOSE: To alert and educate parents on diseases and possible health problems. To provide staff instructions and guidance. To protect everyone and prevent spread of the disease.

PROCEDURE:

1. Upon enrollment, parents will be informed to notify staff immediately if their child is diagnosed with a contagious illness. The childcare will notify parents/guardians and staff members if any child, staff, or person in the program is diagnosed with contagious illnesses.

2. The childcare will have a designated place for posting Parent Alerts or Exposure Notices.

3. The Health Advocate, supervisor, or designee will date and post the appropriate Parent Alert or Exposure Notice and review the Parent Alert/Exposure Notice and infection control practices with staff and families. The site may seek guidance and assistance from Nurse Consultant and the SF Department of Public Health, Communicable Disease (415-554-2830). The confidentiality of the child or staff should be maintained.

4. If new cases are reported, the exposure notice stays up and the date is changed. Consult SF Department of Public Health, Communicable Disease for further instructions if needed.

5. The Parent Alert Form can be removed after discussion with SF Department of Public Health, Communicable Disease's recommendation after reviewing the incubation period (see "How Long Before Symptoms Appear?") of the last reported case.

The alerts for these illnesses have been included here.

a. Chickenpox
b. Conjunctivitis (Pink Eye)
c. Non-Polio Enterovirus
d. Fifth Disease
e. Hand Foot and Mouth Disease
f. Herpes Simplex (Cold Sores)
g. Impetigo
h. Lice
i. Pinworms
j. Respiratory Syncytial Virus (RSV)
k. Ringworm
l. Viral Gastroenteritis (inc. Rotavirus and Norovirus)
m. Scabies
n. Strep Infection
o. Thrush

Contact the City and County of San Francisco Department of Public Health, Communicable Disease unit at 415-554-2830 to report the following diseases:

Childcare guidance, instructions and Parent Alerts/ Exposure Notices will be provided by the SF Public Health Department, Communicable Disease.

Click on each disease name to get more information.

- Hepatitis A What is Hepatitis A - FAQ | CDC
- Measles Measles (Rubeola) | CDC
- Meningococcal disease Meningococcal Disease | CDC
- Pertussis Whooping Cough (Pertussis) | CDC
- Salmonella Questions and Answers | Salmonella | CDC
- Shigella Questions & Answers | Shigella – Shigellosis | CDC
- Typhoid/Paratyphoid Fever Home | Typhoid Fever | CDC
- Vomiting/Diarrhea (more than usual number of cases)
- **Also call if you suspect an outbreak of any disease.**

PARENT ALERT

Contagious disease exposure in room ____________ on __________.

CHICKENPOX (Varicella)

WHAT IS IT? A virus that is preventable by immunization, though cases are possible in vaccinated individuals. It usually starts with fever, tiredness, loss of appetite then after 1-2 days rash will follow. The rash will turn into itchy, fluid-filled blisters that eventually will turn into scabs usually after 5-7 days (CDC, 2021).

WHERE DID IT COME FROM? It came from another infected person.

WHEN CAN YOU CATCH IT? From 1–2 days before rash onset and continuing until all lesions are crusted (usually about 5-7 days) (CDC, 2021).

HOW CAN YOU CATCH IT? Through direct contact or touching the blisters and/or fluid from the lesions, or by breathing the same air or aerosols of an infected person. It may also be transmitted by touching the blisters of someone with Shingles (CDPH, 2022)

HOW LONG BEFORE THE SYMPTOMS APPEAR? Rash onset will start 14 to 16 days but more commonly 10 to 21 days after exposure.

WHAT ARE POSSIBLE COMPLICATIONS? Those who are immunocompromised may have serious complications such as pneumonia, bacterial skin infection, swelling of the brain, dehydration, blood stream infections and death. Children with chickenpox should not be treated with aspirin. This can lead to Reye's Syndrome .

WHAT SHOULD YOU DO?

1. See a health professional.
2. Notify the childcare program to alert other parents.
3. Wash towels and pillowcases daily with hot water and soap and use EPA-approved disinfectant or bleach.
4. Wash hands after caring for the child.
5. Clean and disinfect areas.

WHAT WILL THE STAFF DO?

1. Post this notice.
2. Meticulous handwashing.
3. Wash and clean everything used by the child with hot water and soap. Disinfect using EPA-approved disinfectant.
4. Exclude children and staff with symptoms consistent with chickenpox until cleared to return.
5. If there are unvaccinated persons in the childcare program, refer to their medical provider and seek Public Health Department's advice if needed.

WHAT CAN YOU DO FOR THE ILL CHILD?

1. Calamine lotion and a cool bath with added baking soda, uncooked oatmeal, or colloidal oatmeal may help relieve some of the itching.
2. Encourage increase in fluid intake as child may have difficulty eating.
3. Use mitts on babies, or clip fingernails of older children to prevent scratching.
4. Provide a comfortable environment for rest and relaxation.
5. Follow medical provider's medication and treatment plan.

WHEN CAN THE CHILD RETURN TO CLASS? Infectious persons should be isolated until ALL lesions are crusted (usually about 5 days) or after receiving clearance from medical provider or Public Health Department. *If you have any questions, please contact your childcare provider and healthcare provider.*

References: CDC, 2021, CDPH,2022

PARENT ALERT

Contagious disease exposure in room/location ______________________on _________.

PINK EYE (CONJUNCTIVITIS)

WHAT IS IT? A syndrome beginning with tearing and irritation followed by discharge from one or both eyes. Can be caused by virus or bacteria.

WHERE DID IT COME FROM? Usually from another infected person.

WHEN CAN YOU CATCH IT? During the entire time that symptoms are present.

HOW CAN YOU CATCH IT? Children under five (5) years of age are most susceptible and catch it by directly touching the contagious discharge, or by touching surfaces that have been contaminated by respiratory tract, secretions (eye discharge or nasal mucus), and thru the air by coughing and sneezing (CDC,2019).

HOW LONG BEFORE THE SYMPTOMS APPEAR? Usually 24 to 72 hours after contact.

WHAT ARE POSSIBLE COMPLICATIONS? Usually none, perhaps recurrence of symptoms.

WHAT SHOULD YOU DO?

1. See a health professional.
2. Notify the childcare to alert other parents.
3. Wash towels and pillowcases daily with hot water and bleach.
4. Wash hands after caring for the child.

WHAT WILL THE STAFF DO?

1. Post this notice.
2. Meticulous handwashing.
3. Wash everything used by the child with a germicidal solution.
4. Exclude children with pink eye who are symptomatic, with fever, behavior change, or inability to participate in day care activities.

WHAT CAN YOU DO FOR THE ILL CHILD? Apply medication as directed.

WHEN CAN THE CHILD RETURN TO CLASS? When SYMPTOMS RESOLVE, able to participate in day care activities and meeting childcare admission criteria such as medical clearance from a medical provider. *If you have any questions, please contact your childcare provider and healthcare provider.*

Reference: https://www.cdc.gov/conjunctivitis/index.html (English)
https://www.cdc.gov/conjunctivitis/index-sp.html (Spanish)

PARENT ALERT

Contagious disease exposure in room ____________ on __________.

NON-POLIO ENTEROVIRUS

WHAT IS IT? A very contagious infection that can cause mild symptoms such as fever, cold symptoms, skin rash, mouth blisters and muscle and body aches.

WHERE DID IT COME FROM? Someone else with a similar illness. Three better-known non-polio enteroviruses are enterovirus D68 (EV-D68), enterovirus A71 (EV-A71), and coxsackie virus A6 (CV-A6). EV-D68 usually causes respiratory illness. EV-A71and CV-A6 are known to cause hand, foot, and mouth disease.

WHEN CAN YOU CATCH IT? All during the illness and up to 30 days after the person is well.

HOW CAN YOU CATCH IT? Non-polio enteroviruses can be found in an infected person's feces (stool), eye, nose, and mouth secretions (such as saliva, nasal mucus, or sputum), and blister fluid, and mother to infant prenatally.

HOW LONG BEFORE THE SYMPTOMS APPEAR? Three (3) to six (6) days after coming in contact with the disease (Hennepin County PHD, 2015). Other infected persons may not show symptoms.

INFECTIOUS PERIOD? During illness and possibly for several weeks after illness (through contact with stool). Infected persons who may not seem sick are still able to spread infection.

WHAT ARE POSSIBLE COMPLICATIONS?
Although rare, enteroviruses can sometimes cause more serious illness, like viral meningitis (infection of the covering of the spinal cord and brain) or acute flaccid myelitis (sudden onset of weakness in one or more arms).

WHAT SHOULD YOU DO?

1. Careful handwashing often with soap and water for at least 20 seconds.
2. Careful disposal of diapers.
3. Careful cleaning of changing table and toilet. Disinfect using EPA-approved disinfectants or diluted bleach solution.
4. Avoid touching eyes, nose, and mouth with unwashed hands.

5. Avoid close contact, such as kissing, hugging, and sharing cups or eating utensils, with people who are sick.
6. Cover your coughs and sneezes with a tissue or shirt sleeve, not your hands.
7. Clean and disinfect frequently touched surfaces, such as toys, doorknobs, and cell phones, especially if someone is sick.
8. Stay home when you are sick and keep sick children out of school.
9. Reduce fever with Tylenol and seek medical advice if needed.
10. Encourage restful activities.

WHAT WILL THE STAFF DO?

1. Careful handwashing.
2. Careful cleaning of all toys and equipment.
3. Follow childcare site's infection prevention and control policy.
4. Notify parents using Parent Alert and childcare licensing if needed.
5. Consult with Nurse Consultant and/or San Francisco Communicable Disease Control for multiple cases.

WHEN CAN THE CHILD RETURN TO CLASS? Exclude until 24 hours after diarrhea and/or vomiting has stopped. For mild, cold-like symptoms, no exclusion, as long as the child is well enough to participate in routine activities. (Hennepin County PHD, 2015). *If you have any questions, please contact your childcare provider and healthcare provider.*

References: CDC, 2020, Hennepin County PHD, 2015

PARENT ALERT

Contagious disease exposure in room ____________on___________.

FIFTH DISEASE (Human Parvovirus B19)

WHAT IS IT? Fifth Disease (also known as Erythema Infectiosum) is a viral infection. Initial symptoms are usually mild and may include fever, headache, runny nose, fatigue and muscle aches. Red "slapped cheek" rash appears 4 to 14 days after these signs and symptoms. This characteristic rash is followed shortly by a lacelike-appearing rash proceeding from trunk to arms, buttocks and thigh, and can come and go for several weeks. Some infected individuals do not have any signs or symptoms.

WHEN CAN YOU CATCH IT? Fifth Disease is contagious *until* the rash appears. Disease is usually mild and will go away on its own.

HOW CAN YOU CATCH IT? The virus spreads through respiratory secretions, such a saliva, sputum, or nasal mucus, when an infected person coughs or sneezes, or from surfaces or hands that have been coughed, sneezed, or drooled upon. A previous infection with Fifth Disease seems to provide immunity.

HOW LONG BEFORE SYMPTOMS APPEAR? 4 to 14 days but can be as long as 21 days.

WHAT ARE POSSIBLE COMPLICATIONS? Usually mild for children and adults who are healthy. At risk for serious complications for immunocompromised individuals such as pregnant or suspect to be pregnant women, with chronic anemia, leukemia, cancer, organ transplants, or HIV infection.

WHAT SHOULD YOU DO?

1. Seek medical advice from your pediatrician.
2. Contact your physician if you think you might be pregnant.
3. Use good hand-hygiene, cleaning and disinfecting contaminated items.

WHAT WILL THE STAFF DO?

1. Sanitation of contaminated items. Proper disposal of dirty facial tissues.
2. Practice good handwashing and prevent contact with respiratory secretions.
3. Follow site's infection control policy and distribute Parent Alert.

WHAT CAN YOU DO FOR THE INFECTED CHILD? Follow proper hand hygiene, respiratory etiquette and medical advice.

WHEN CAN THE CHILD RETURN TO CLASS? When child feels well enough to participate and meeting criteria to return to class. *If you have any questions, please contact your childcare provider and healthcare provider.*

References: About Fifth Disease | CDC, 2019, Managing Infectious Diseases in Child Care and Schools. American Academy of Pediatrics, 5th Edition, pg. 95.

PARENT ALERT

Contagious disease exposure in room/location _______________ on ________________.

HAND, FOOT, AND MOUTH DISEASE
(Coxsackievirus and Other Related Viruses)

WHAT IS IT? A virus that causes fever, sore throat, sores in the mouth, and a rash on the palms and soles lasting 7 to 10 days.

WHERE DID IT COME FROM? It came from an infected person.

WHEN CAN YOU CATCH IT? As long as the illness persists, or longer if in contact with stool.

HOW CAN YOU CATCH IT? Through contact with respiratory droplets from an infected person (talking, coughing, sneezing), through contact with contaminated objects, or through contact with the feces of an infected person.

HOW LONG BEFORE SYMPTOMS APPEAR? Usually 3 to 5 days after contact.

WHAT ARE POSSIBLE COMPLICATIONS? Dehydration, fingernail, and toenail loss, viral (aseptic meningitis), encephalitis or paralysis.

WHAT SHOULD YOU DO?

1) Teach child to cover mouth and nose with tissue or shoulder when sneezing
2) Keep child home if unable to participate, if feverish, or if having difficulty drinking liquids.
3) Dispose of tissues and diapers in a sealed plastic bag.
4) Alert teacher to the diagnosis.
5) Meticulous handwashing!!

WHAT WILL THE STAFF DO?

1) Exclude children with fever, mouth sores and severe symptoms.
2) Meticulous hand washing!!

WHAT CAN YOU DO FOR THE INFECTED CHILD?

1) Extra rest for the duration of the fever.
2) Feed bland, cool liquids while the mouth is sore.
3) Sponge baths and Tylenol to reduce fever. Never give aspirin to children.

WHEN CAN THE CHILD RETURN TO CLASS? When child is able to participate, no fever for 24 hours without use of fever-reducing medicines, mouth sores have healed, and caregivers are able to care for child and group safely. *If you have any questions, please contact your childcare provider and healthcare provider.*

Reference: https://www.cdc.gov/hand-foot-mouth/index.html (English) https://www.cdc.gov/hand-foot-mouth/index-sp.html (Spanish)

PARENT ALERT

Contagious disease exposure in room ____________on___________.

HERPES SIMPLEX (COLD SORES)

WHAT IS IT? A viral infection that can cause a variety of signs and symptoms in different age groups. In early childhood, herpes simplex most commonly causes blister-like sores in the mouth, around the lips, and skin that is in contact with the mouth, such as a sucked thumb or finger.

First or primary infection symptoms may include: fever, irritability, tender, swollen lymph nodes, painful, small fluid-filled blisters (called vesicles) in the mouth and on the gums and lips. Vesicles weep clear fluid, bleed, and are slow to crust over. After the first infection, subsequent infections may occur with clusters of blisters on the lips, commonly called cold sores or fever blisters. Virus can be spread by people with or without symptoms.

WHERE DID IT COME FROM? It came from the infected saliva of another human or open sores. Certain triggers can make the virus active including: illness, sun exposure, menstrual period, injury, emotional stress, and surgery.

WHEN CAN YOU CATCH IT? While lesions are present and for at least 1 week *during primary infection*. During reactivations, people are most contagious for 3 to 4 days after symptoms first appear.

HOW CAN YOU CATCH IT? By getting infected saliva in one's mouth (sharing bottles, pacifiers, spoons, kissing, etc.) and touching infected sores then scratching your skin.

HOW LONG BEFORE SYMPTOMS APPEAR? Two (2) to fourteen (14) days after contact.

WHAT ARE POSSIBLE COMPLICATIONS? Complications are rare. Rare complications can include eye infections, vaginitis, encephalitis, or in the case of a child with a skin condition, a full body rash (eczema herpeticum).

WHAT SHOULD YOU DO?

1. Meticulous handwashing!!

WHAT WILL THE STAFF DO?

1. Exclude children with mouth sores who are drooling and/or cannot take liquids by mouth.
2. Sanitize toys etc.
3. Meticulous handwashing!!
4. Follow childcare site's infection control policies and distribution of Parent Alert.

WHAT CAN YOU DO FOR THE INFECTED CHILD?

1. Provide plenty of rest and fluids.
2. The lesions can be painful and interfere with eating; serve cool bland foods.
3. Use pain relievers if suggested by the physician.
4. Ill child to stay home and avoid close contacts with immunocompromised or unvaccinated individuals.

WHEN CAN THE CHILD RETURN TO CLASS? Child's mouth ulcers and vesicles have resolved, is no longer drooling, able to take liquids by mouth, and meeting inclusion criteria e.g. no fever and able to participate with the group. *If you have any questions, please contact your childcare provider and healthcare provider.*

References: WHO, 2023 , Managing Infectious Diseases in Child Care and Schools, American Academy of Pediatrics, 5th Edition.

PARENT ALERT

Contagious disease exposure in room __________ on ___________.

IMPETIGO (AKA INFANTIGO)

WHAT IS IT? A common bacterial skin infection, usually around the nose and mouth, on the arms or legs. It can start as red, itchy sores that break open and leak a clear fluid or pus. As it heals, a "honey-colored" scab forms over the sore (CDC, 2022).

WHERE DID IT COME FROM? A person's own nose, or from another person with the same bacteria. Infants and children are most susceptible. Common in children 2 to 5 years old.

HOW AND WHEN CAN YOU CATCH IT? The bacteria can spread to others if someone touches untreated sores or comes into contact with fluid from the sores (CDC, 2022). Also, by touching contaminated surfaces or clothing, and through cuts and wounds.

HOW LONG BEFORE SYMPTOMS APPEAR? Variable. It usually takes 10 days for sores to appear after someone is exposed.

WHAT ARE POSSIBLE COMPLICATIONS? Spread of the lesions to other parts of the body, further damage by scratching. Very rarely, impetigo complications include kidney problems and rheumatic fever (a disease that can affect the heart, joint, brain and skin).

WHAT SHOULD YOU DO?

1. Seek medical advice.
2. Keep your child out of class until 24 hours after antibiotic treatment is started.
3. Alert the teacher of the diagnosis.
4. Wash hands before and after touching the sores.

WHAT WILL THE STAFF DO?

1. Follow infection control and exclusion of children with the same kind of sores.
2. Use special care in handwashing.
3. Cover open sores.

WHAT CAN YOU DO FOR THE INFECTED CHILD?

1. Clean the infected area and apply medication as recommended by your physician.
2. Cover the infected area to avoid contact with others.
3. Dispose of tissues, cotton, etc. that have touched the sore in a sealed plastic bag.
4. Help your child not to touch the area and clip fingernails to reduce further injury.
5. Wash his/her hands often.

WHEN CAN THE CHILD RETURN TO CLASS? After 24 hours of treatment with antibiotics and lesions are covered. If you have any questions, call your childcare provider and healthcare provider.

Reference: (CDC, 2022)

PARENT ALERT

Contagious disease exposure in room/location _________________________on _________.

HEAD LICE (Pediculosis)

WHAT IS IT? Head lice are small insects that live on the scalp, behind ears and near the neckline of a person. They attach their eggs to a person's hair shaft with a sticky, glue-like substance and feed on blood. They do not cause diseases.

WHERE DID IT COME FROM? Head lice lives in the head of a person and can spread by sharing infested objects such as scarves, combs, brush, headphones, hat, pillow, and personal clothing. Lice do not fly or jump.

WHEN AND HOW CAN YOU CATCH IT? Head lice can spread through head-to-head contact with an infested person or sharing infested objects. Lice do not care if your head is clean, dirty, dry, oily, short hair, long hair, young or old. They just crawl and feed to the nearest warm head.

HOW LONG BEFORE THE SYMPTOMS APPEAR? Tickling or crawling feeling, intense itching and scratching on scalp, irritability and difficulty sleeping at night may start right away. Lice is hard to see, and nits (eggs) may be found upon inspection.

WHAT ARE POSSIBLE COMPLICATIONS? Scratching vigorously can cause infection, but normally there are no complications from head lice.

WHAT SHOULD YOU DO?

1. Check your children's head daily and wash your hands after checking.
2. If your child has lice:
   a. Inspect and treat all family members with medication at the same time. Wash your hands.
   b. Wash (hot water) or dry clean all items that have touched the hair or scalp.
   c. Thoroughly vacuum stuffed furniture and carpeting.
   d. Anything that cannot be washed, dry cleaned, or vacuumed, i.e., stuffed toys, hats, etc.) should be sealed in a plastic bag for two (2) weeks. Lice die after 2 days without food.
   e. Notify the childcare for parent notification or posting Parent Alert if applicable.
   f. See a health professional if head lice infestation is NOT resolved after multiple head lice treatments. A prescription for head lice treatment may be needed.

WHAT WILL THE STAFF DO?

1. Staff will follow policies and procedures on parent notification and posting Parent Alert.
2. Meticulous handwashing and ensuring children's belongings are labeled, stored and not touching per childcare national standards (Caring for our Children, Chapter 5.)
3. "If lice are seen on a child at school, parents/caregivers should be notified at the end of the school day and given a copy of CDPH Head Lice Flyer "(CDPH, Dec 2022), (CDC).
4. Check children's head daily for at least 2 weeks and follow site's policies and procedures for head lice.
5. Review and follow the latest recommendations from CDC or CDPH.

WHEN CAN THE CHILD RETURN TO CLASS? After treatment is completed and no lice found, or when meeting admission criteria set by the childcare program. *If you have any questions, please contact your childcare provider and healthcare provider.*

References: CDC, CDPH, National Resource Center For Health and Safety In Child Care and Early Education

PARENT ALERT

Contagious disease exposure in room ____________on ___________.

PINWORM

WHAT IS IT?
Small, white, threadlike worms (0.25-0.5" long) that live in the large intestine.

WHAT ARE THE SIGNS OR SYMPTOMS?

- Most people have no signs or symptoms.
- Itching and irritation around the anal or vaginal area.

WHERE DID IT COME FROM?

- Fecal-oral route: Contact with feces of children who are infected. This generally involves an infected child contaminating his own fingers and then touching an object that another child touches. The child who touched the contaminated surface then puts her fingers into her own mouth or another person's mouth.
- By sharing toys, bedding, clothing, toilet seats, or baths. The eggs are light and float in the air.
- Pinworm eggs remain infective for 2 to 3 weeks in indoor environments.
- Infestation with pinworms commonly clusters within families.

WHEN CAN YOU CATCH IT?

- Incubation period: 1 to 2 months or longer from the time of ingesting the pinworm egg until an adult worm migrates to the anal area
- Contagious period: As long as the female worms are discharging eggs to the skin around the anus

WHAT ARE POSSIBLE COMPLICATIONS? Usually none. Possibly secondary infection from scratched skin.

WHAT CAN YOU DO FOR THE AFFECTED CHILD?

- Use good hand-hygiene
- Keep the child's fingernails short.
- Observe children for rectal scratching.
- Carefully dispose of diapers and handwashing materials after use.
- Bathe the child in the morning to remove a large proportion of eggs that are laid at night.
- Avoid shaking bedding or underwear to prevent spreading ova through the air.
- See doctor for medication and use as directed (entire family should be examined).
- Treatment may be necessary for the whole family and the group of children who share a common environment.

WHAT WILL THE STAFF DO?

- Report the infection to the staff member designated by the childcare program or school for decision-making and action related to care of ill children. That person, in turn, alerts possibly exposed family and staff members to watch for symptoms.
- Suspect pinworms if a child has intense itching around the anal or vaginal area.
- Refer the person with the infection to a health professional for treatment recommendations.
- Avoid shaking bedding or underwear to prevent spreading ova through the air.
- Wash children's hands directly after using the toilet and before hands are involved with putting something into their mouths.
- Wash toys frequently.
- Clean and sanitize surfaces used for eating, toileting, hand hygiene, food preparation, and diapering.

EXCLUDE FROM GROUP SETTING?
No.

WHEN CAN THE CHILD RETURN TO CLASS?

- The **child does not need to be excluded**, unless they have a fever, or does not feel well enough to participate. If you have any questions, please contact your childcare provider and healthcare provider.

Adapted from Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide. 4th ed. 2022

PARENT ALERT

Contagious disease exposure in room/location _______________ on _________.

RESPIRATORY SYNCYTIAL VIRUS (RSV)

WHAT IS IT? A virus that infects the lungs and airways causing the common cold and other respiratory symptoms. One of most common diseases of early childhood (younger than 4 yo).

WHERE DID IT COME FROM? Being in close contact with an infected person and touching objects contaminated with RSV virus.

WHEN CAN YOU CATCH IT? Most contagious from 3-8 days after infection and may become contagious 1-2 days before showing symptoms. However, young infants or those with weakened immune systems can be contagious for as long as 4 weeks after infection. Most common during winter and early spring.

HOW CAN YOU CATCH IT? The virus is spread when an infected person coughs, sneezes, or talks, and/or touch objects contaminated by the virus. The virus can live on surfaces for many hours and 30 minutes or more on hands.

HOW LONG BEFORE THE SYMPTOMS APPEAR? Symptoms usually appear within 4 to 6 days of infection.

WHAT ARE POSSIBLE COMPLICATIONS? Bronchiolitis, Pneumonia, and breathing difficulties.

WHAT SHOULD YOU DO?

1. Wash your hands often and keep your hands off your face.
2. Prevent contact with respiratory secretions by following respiratory etiquette, covering coughs and sneezes.
3. Clean and disinfect surfaces.
4. Stay home when you or your child is sick.
5. Notify the Childcare provider if your child is sick so they can alert other parents.
6. See a healthcare provider and return to healthcare provider if symptoms worsen.

WHAT WILL THE STAFF DO?

1. Post this notice.
2. Practice meticulous handwashing and respiratory etiquette.
3. Exclude children meeting exclusion criteria like fever, difficulty breathing, and unable to participate in activities (American Academy of Pediatrics, 5th Ed, pgs. 147-148).
4. Inform family members and staff who may have been exposed.
5. Clean and disinfect surfaces.

WHAT CAN YOU DO FOR THE ILL CHILD?

1. Pain and fever control.
2. Encourage fluids to prevent dehydration.
3. Encourage plenty of rest.
4. Follow healthcare provider's treatment.

WHEN CAN THE CHILD RETURN TO CLASS? When child is cleared by healthcare provider to return to class or exclusion criteria are resolved. If you have any questions, please contact your childcare provider and healthcare provider.

Reference: https://www.cdc.gov/rsv/high-risk/infants-young-children.html (English)
https://www.cdc.gov/rsv/high-risk/infants-young-children-sp.html (Spanish)

PARENT ALERT

Contagious disease exposure in room _________________ on _______________.

RINGWORM (Tinea)

WHAT IS IT? A contagious fungal infection of the body or scalp. On the skin, the lesions are red, circular patches with raised edges and a flat, clear central area. On the scalp, the lesions are patchy areas of dandruff-like scaling or redness with or without hair loss.

WHERE DID IT COME FROM? From a person or animal with the fungus, and contaminated surfaces like towels, clothing, damp areas like locker rooms and public shower areas.

WHEN CAN YOU CATCH IT? As long as the other person or animal has the lesions. "Once the child begins treatment with a medication taken by mouth, the child is no longer considered infectious (Managing Infectious Diseases in Child Care and Schools, 5th ed, pg. 149)."

HOW CAN YOU CATCH IT? By direct contact with a lesion or bandages, clothing, sheets, etc. that have been in contact with a lesion.

HOW LONG BEFORE THE SYMPTOMS APPEAR? Symptoms typically appear between 4 and 14 days after the skin comes in contact with the fungi that cause ringworm (CDC, 2020).

WHAT ARE POSSIBLE COMPLICATIONS? Involvement of more areas of the body. Temporary baldness if on scalp.

WHAT SHOULD YOU DO?

1. Wash hands after touching your child.
2. Avoid touching the infected area or contaminated clothing.
3. Keep child's hands and feet clean and dry.
4. Keep fingernails and toenails short and clean.
5. Examine household contacts for similar symptoms.
6. Don't share ill child's personal belongings like combs, towels or nail clippers with other people.
7. Seek medical advice, medicate as ordered by a medical provider.
8. Clean and disinfect household.

WHAT WILL THE STAFF DO?

1. Check other children for lesions.
2. Use germicidal solution on all toys and equipment.
3. Wash sheets from infected child's cot or crib.
4. Distribute Parent Alert for staff and family to watch for symptoms.

WHAT CAN YOU DO FOR THE AFFECTED CHILD?

1. Use an antifungal medication as ordered by the physician.
2. Keep skin lesions covered.
3. Observe for spreading. Inform medical provider if treatment is not effective.

4. Wash hands frequently.

WHEN CAN THE CHILD RETURN TO CLASS? After medication is started. Cover the lesions with clothing or bandage. If you have any questions, please contact your childcare provider and healthcare provider.

Reference: CDC, 2020, Managing Infectious Diseases in Child Care and Schools, 5th ed, pg. 149

PARENT ALERT

Contagious disease exposure in room/location ___________________________on _________.

VIRAL GASTROENTERITIS (Includes Rotavirus and Norovirus)

WHAT IS IT? *Norovirus* causes inflammation of the stomach or intestines. This is called acute gastroenteritis. A person usually develops symptoms 12 to 48 hours after being exposed to norovirus. Most people with norovirus illness get better within 1 to 3 days (CDC, 2021).

Rotavirus commonly causes severe, watery diarrhea and vomiting in infants and young children. Children may become dehydrated and need to be hospitalized and can even die. Rotavirus vaccine can protect children and prevent severe hospitalization (CDC, 2021).

WHAT ARE POSSIBLE COMPLICATIONS? Dehydration in young children, hospitalization and fatalities may occur.

HOW CAN YOU GET THE ILLNESS? You can get infected by touching poop or contaminated surfaces with virus and putting your hand inside your mouth, and/or eating contaminated food. People may spread the virus through feces (poop) or vomit.

Tiny amounts of invisible particles can spread the illness, so just because a surface is not visibly contaminated it *still* should be cleaned. Vomit can release infectious particles into the air, so bathrooms should be cleaned using a mask and ventilated as soon as possible.

People including children may remain infectious for days to up to 2 weeks after their symptoms have gone away, so bathroom cleaning and handwashing remains important even after people are feeling better.

WHAT SHOULD YOU DO?

1. See your medical provider. Give plenty of fluids. Medicate child as prescribed.
2. Stay home if sick.
3. Wash hands after caring for the child. Handwash with soap and water rather than hand sanitizer, as it is less effective for norovirus; effective handwashing includes vigorously rubbing hands together for at least 20 seconds total, taking care to scrub all areas of the hands, especially fingertips and thumbs, and the backs of the hands.
4. Clean and disinfect surfaces in the home (to minimize household spread) with EPA approved disinfectant or bleach which is effective against norovirus (can mix 1 cup bleach into 1 gallon water), including bathrooms, any area contaminated by vomit or diarrhea, and surfaces that are touched often like faucet handles, doorknobs, etc.
5. Prompt laundering of any possibly contaminated clothes and linens.
6. Handle dirty things using gloves and mask to avoid inhaling particles or getting virus on hands.
7. Follow recommendations from SF Department of Public Health, Communicable Disease and CDC, 2021.
8. Notify the Childcare provider so they can alert the other parents.

WHAT WILL THE STAFF DO?

1. Post this notice.
2. Exclude children with fever, vomiting, diarrhea, nausea or stomach pain with unknown cause.
3. Meticulous handwashing. Wash hands after caring for the child. Handwash with soap and water rather than hand sanitizer, as it is less effective for norovirus; effective handwashing includes vigorously rubbing hands together for at least 20 seconds total, taking care to scrub all areas of the hands, especially fingertips and thumb, and the backs of the hands.
4. Clean, sanitize and disinfect properly. Clean and disinfect surfaces at the childcare facility with EPA approved disinfectant or bleach which is effective against norovirus (can mix 1 cup bleach into 1 gallon water), including bathrooms, any area contaminated by vomit or diarrhea, and surfaces that are touched often like faucet handles, doorknobs, etc.
5. Prompt laundering of any possibly contaminated clothes and linens.
6. Handle dirty things using gloves and mask to avoid inhaling particles or getting virus on hands.
7. Follow recommendations from SF Department of Public Health, Communicable Disease and CDC (2021).
8. Notify Public Health Department and childcare licensing for outbreaks or questions.

WHEN CAN THE CHILD RETURN TO CLASS? Any ill staff, attendees, visitors, or volunteers should stay home for 48 hours ***after*** they no longer have symptoms (SF CDC, 2021) and meet childcare admission criteria. *If you have any questions, please contact your childcare provider and healthcare provider.*

REFERENCES:

SF CDCP. (2021). https://www.sfcdcp.org/wp-content/uploads/2018/01/Daycare-GI-Checklist-Recommendations-10.2021.pdf

CDC. (2021). https://www.cdc.gov/norovirus/about/symptoms.html

CDC. (2021). https://www.cdc.gov/rotavirus/index.html

EPA. (2022). https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants

PARENT ALERT

Contagious disease exposure in room ______________ on ______________.

SCABIES (Sarcoptic Itch, Acariasis)

WHAT IS IT? An infestation of the skin by small insects called mites

WHAT ARE THE SIGNS & SYPTOMS?

- Rash, severe itching (increased at night).
- Itchy red bumps or blisters found on skinfolds between the fingers, toes, wrists, elbows, armpits, waistline, thighs, genital areas, abdomen, and lower buttocks.
- Children younger than 2 years are likely to be infested on the head, neck, palms, and soles of feet or in a diffuse distribution over the body.

HOW CAN YOU CATCH IT? Prolonged and close person-to-person contact.

WHEN CAN YOU CATCH IT?

- Incubation period
  - 4 to 6 weeks for those who have never been infected
  - 1 to 4 days for those who have been previously infected (Repeated exposures tend to be milder but produce symptoms earlier after exposure.)
- Contagious period: Until the insect infestation is treated

WHAT ARE POSSIBLE COMPLICATIONS? Usually none. Sometimes skin irritation from chemicals or over-treatment.

WHAT SHOULD YOU DO?

- Consult with a medical professional for medication
- Report the infection to the staff member designated by the childcare program/preschool for decision-making and action related to care of ill children.
- Treatment of the affected child and family by a health professional, usually with a cream containing 5% permethrin. Use the medicine exactly as ordered.
- Family members and very close contacts should be treated at the same time as the child, even if no signs or symptoms are present.
- Launder bedding and clothing (hot water and hot drying cycle) worn next to skin during the 3 days before start of treatment.
- Items that cannot be laundered should be placed in plastic bags for at least 4 days. Scabies mites cannot survive away from humans for more than 4 days.
- Wash hands well after care of child.

WHAT WILL THE STAFF DO?

- Alerts possibly exposed family and staff members to watch for symptoms.
- Send home all articles of clothing used by the child.

- Launder bedding and clothing (hot water and hot drying cycle) worn next to skin during the 3 days before start of treatment.
- Items that cannot be laundered should be placed in plastic bags for at least 4 days. Scabies mites cannot survive away from humans for more than 4 days.
- Practice careful hand washing.
- Contact the child's health professional if itching continues for several weeks after treatment. This could represent a reinfestation.

EXCLUDE FROM GROUP SETTING?

- **Yes**, until treatment is completed (usually overnight).

WHEN CAN THE CHILD RETURN TO CLASS?

- When the treatment is completed (usually overnight) or until treatment course as prescribed has been completed.
- If treatment is started before the next day, no exclusion is necessary.
- If you have any questions, please contact your childcare provider and healthcare provider.

Adapted from Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide 4th ed. 2022

PARENT ALERT

Contagious disease exposure in room ______________ on ________________.

STREPTOCOCCAL INFECTION
(Strep Throat and Scarlet Fever)

WHAT IS STREP THROAT? A disease caused by group A Streptococcus bacteria

WHAT IS SCARLET FEVER?

- A fine red rash that makes the skin feel like sandpaper. Scarlet fever is caused by a toxin produced by a strep infection of the throat or another area of the body. The rash is usually quite prominent in the armpits and groin area, often making the creases in the bend of the elbow and back of the knee pinker than usual. Sometimes, the area around the mouth has a pale appearance.
- Children who have scarlet fever are generally not any sicker than children with strep throat who do not have the rash.

WHAT ARE THE SIGNS & SYMPTOMS?

- Some of the following symptoms may be present:
  - Sore throat
  - Fever
  - Stomachache
  - Headache
  - Swollen lymph nodes in neck
  - Decreased appetite
- Strep throat is much less likely if there is
  - Cough
  - Congestion
  - Runny nose
- Children younger than 3 years with group A streptococcal infection rarely have a sore throat. Most commonly, these children have a persistent nasal discharge (which may be associated with a foul odor from the mouth), fever, irritability, and loss of appetite.

HOW CAN YOU CATCH IT?

- Respiratory (droplet) route: Contact with large droplets that form when a child talks, coughs, or sneezes. These droplets can land on or be rubbed into the eyes, nose, or mouth. The droplets do not stay in the air; they usually travel no more than 3 feet and fall onto the ground.
- Contact with the respiratory secretions from or objects contaminated by children who carry strep bacteria.
- Close contact helps the spread of the infection.

WHEN CAN YOU CATCH IT?

- Incubation period: 2 to 5 days.
- Contagious period: The risk of spread is reduced when a person who is ill with strep throat is treated with antibiotics. Up to 25% of asymptomatic school children and a small number

of adults carry the bacteria that cause strep throat in their nose and throat and are not ill. In outbreaks, a higher proportion of children with no symptoms of illness may be carriers. The risk of transmission from someone who is not sick but is carrying the bacteria is low.

WHAT ARE POSSIBLE COMPLICATIONS? (Usually none, but)

- Some who are not treated develop complications, including ear infections, sinusitis, abscesses in the tonsils, or infection of the lymph nodes (i.e., tender and warm swollen glands). Indications for testing include a sudden development of sore throat, fever, headache, pain on swallowing, abdominal pain, nausea, vomiting, and enlarged, tender lymph nodes in the front part of the neck without a runny nose.
- A rare but very serious complication of strep throat is the development of rheumatic heart disease, a condition that affects the valves and function of the heart. Children younger than 3 years are very unlikely to get strep throat infection or develop rheumatic heart disease. Therefore, testing these younger children is generally not recommended, especially if they show signs of a viral illness like runny nose or cough.

WHAT SHOULD YOU DO?

- Seek advice and treatment from a medical professional and contact childcare/preschool if Strep/Scarlet Fever are confirmed.
- See that child gets adequate rest to avoid complications.
- Seek medical attention if stiff joints, red hard skin areas or shortness of breath occur
- Complete the full course of medicine (usually antibiotics) as prescribed.
- Wash hands frequently.

WHAT WILL THE STAFF DO?

- Exclude sick child.
- Alerts possibly exposed family and staff members to watch for symptoms.
- Ventilate and air out classroom.
- Clean and sanitize mouthed toys
- Practice meticulous handwashing.

EXCLUDE FROM GROUP SETTING?

- **Yes**.

WHEN CAN THE CHILD RETURN TO CLASS?

- At least the first <u>12 hours</u> of antibiotic treatment has been given.

AND

- The child can participate, and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

If you have any questions, please contact your childcare provider and healthcare provider.

Adapted from Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide 4th ed. 2020

PARENT ALERT

Contagious disease exposure in room _____________ on _____________.

THRUSH (Candidiasis)

WHAT IS IT? A yeast infection predominately produced by Candida albicans, causing mouth infections in young infants.

WHAT ARE THE SIGNS AND SYMPTOMS:

- White patches on the inside of cheeks and on gums and the tongue
- Usually causes no other signs or symptoms

HOW CAN YOU CATCH IT?

- C. albicans is present in the intestinal tract and mucous membranes of healthy people.
- A warm environment (e.g., mouth) fosters growth and spread.
- Person-to-person transmission (although very rare) may occur from a woman to her baby when the mother has a vaginal yeast infection and from breastfeeding babies to their mothers when babies with thrush infect mothers' nipples.

WHEN CAN YOU CATCH IT?

- Incubation period: Unknown.
- Contagious period: The yeast that causes thrush is widespread in the environment, normally lives on the skin, and is found in the mouth and stool. Mild infection of the lining of the mouth is common in healthy infants. Thrush can occur during or after antibiotic use. Repetitive or severe thrush could signal immune problems.

WHAT ARE POSSIBLE COMPLICATIONS? Usually none.

WHAT SHOULD YOU DO?

- Wash hands carefully.
- See a medical professional. Treatment of individuals who have an infection so the quantity of fungus in any area is reduced to levels the body can control.
- Wash and sanitize toys, bottles, and pacifier nipples after they have been mouthed.
- Do not allow sharing of mouthed objects between children without first washing and sanitizing them
- Change bed sheets daily and launder with detergent.

WHAT WILL THE STAFF DO?

- Wash and sanitize toys, bottles, and pacifier nipples after they have been mouthed.
- Do not allow sharing of mouthed objects between children without first washing and sanitizing them
- Practice careful handwashing.
- Monitor other children for thrush.

WHAT CAN YOU DO FOR THE AFFECTED CHILD? Use the medicine exactly as prescribed. Do not stop when lesions are cleared. Finish the dosage.

EXCLUDE FROM GROUP SETTING?
No.

WHEN CAN THE CHILD RETURN TO CLASS? The **child does not need to be excluded**, unless they have a fever, or does not feel well enough to participate. *If you have any questions, please contact your childcare provider and healthcare provider.*

Adapted from Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide Guide. 4th ed. 2022

GET MEDICAL HELP IMMEDIATELY

POLICY: When there is a medical emergency, childcare staff will try to contact the parent/legal guardian first but may prioritize 911 to get help immediately depending on the type of emergency.

PURPOSE: To provide the best care for the child.

PROCEDURE:

1. If unable to reach the parent, initiate the EMS system by dialing 911
2. Parents may give consent to the childcare provider to call the primary care provider for consultation if necessary.
3. For life-threatening conditions listed below, call 911 and parent/legal guardian. For non-life threatening conditions, call parent/legal guardian to bring child to urgent care.
4. **See section H-1 through H-5 for additional information on medical emergencies.**

SIGNS OF AN EMERGENCY:
If a child could die or be permanently disabled, it is an emergency!

Call 911 or the local emergency number to have the emergency team come to you right away *if you cannot wait, such as for:*

- Choking
- Stopped breathing or turning blue
- Possible poisoning (call the nearest Poison Control Center)
- Head injury with passing out, throwing up, or not behaving normally
- Injury to neck or spine
- Severe burn
- Seizure that lasted 3 to 5 minutes
- Bleeding that cannot be stopped

Go to an emergency department or call 911 or the local emergency number for help for problems such as:

- Trouble breathing
- Passing out, fainting

- Severe allergic reaction with trouble breathing, swelling, hives
- High fever with headache and stiff neck
- High fever that does not get better with medicine
- Suddenly hard to wake up, too sleepy, or confused
- Suddenly not able to speak, see, walk, or move
- Heavy bleeding
- Deep wound
- Serious burn
- Coughing or throwing up blood
- Possible broken bone, loss of movement, or if the bone is pushing through the skin
- A body part near an injured bone is numb, tingling, weak, cold, or pale
- Unusual or bad headache or chest pain
- Fast heartbeat that does not slow down
- Throwing up or loose stools that do not stop
- Mouth is dry, no tears, no wet diapers in 18 hours, soft spot in the skull is sunken

When to go to an Urgent Care Clinic

When a child has a problem, do not wait too long to get medical care. If the problem is not life threatening or risking disability, but you are concerned and you cannot see your regular healthcare provider soon enough, go to an urgent care clinic.

The kinds of problems that an urgent care clinic can deal with include:

- Common illnesses, such as colds, the flu, earaches, sore throats, minor headaches, low-grade fevers, and rashes

- Minor injuries, such as sprains, bruises, minor cuts and burns, minor broken bones, or minor eye injuries

- For all other non-urgent matters, contact the primary care provider.

Reference: Medline, 10/22/22
https://medlineplus.gov/ency/patientinstructions/000594.htm

REPORTABLE ILLNESSES AND OUTBREAKS

POLICY: Reportable communicable diseases and outbreaks will be reported to the SF Department of Public Health, Communicable Disease within 24 hours of the childcare provider's knowledge.

PURPOSE: To protect the children, staff, and families from communicable disease. To comply with the law, Title 17 CA Code of Regulations, childcare licensing, and site policies and procedures.
To access health information per site policies, and may include enforcement of Health Insurance Portability and Accountability Act HIPAA (CDC,2022).

PROCEDURE:

1. Some diseases must be reported to the Public Health Department even if there's 1 case per Title 17. Other diseases are to be reported to Public Health ex. OUTBREAK of 2 or more cases at the childcare from different households.

2. The Health Advocate or designee will review and acquire an updated list of reportable diseases at least annually by visiting SF Disease Prevention and Control . Click on the Confidential Morbidity Report (CRM) Form for the most up to date list of diseases.

Confidential Morbidity Report (CMR) Form/ Reportable Diseases and Conditions

- Confidential Morbidity Report (CMR) Form List of reportable diseases and conditions, as well as timeframes for reporting, are found on page 2 of the form – Effective February 2022
- Confidential Morbidity Report (CMR) Form – February 2022 "What's New?"

3. The updated list will be placed in the policy and procedure manual. A copy of the list will be shared with each parent upon enrollment of their child.

4. As soon as childcare provider becomes aware of a communicable disease exposure and reportable disease case OR an outbreak at the childcare site:

   a. Call the SF Department of Public Health, Communicable Disease at **415-554-2830**.

   b. Provide the Public Health Department with:
      - Name of the reportable disease
      - Child's name

- Age
- Address and home telephone
- Parent's name
- Doctor's name (if known)
- Date of onset of symptoms (if known)
- Caller's name and title
- Childcare site name, address and telephone.
- Last day child was in childcare
- Respond to the investigator’s inquiry

c. Review and follow instructions from the Health Department and licensing office, and per site policy.

5. Any outbreak of 2 or more cases of communicable illnesses (from different households) at the childcare site will be reported in the same manner. The Health Department will provide further instructions on actions to take.

a. Immediately start a log, or use a template (example on next page)
- Reportable disease
- Children's names
- Classroom
- Onset date of symptoms
- Date of diagnosis
- Date/s of childcare attendance (Exposure dates)
- Treatment received
- Date excluded from childcare
- Date returned to class

b. Follow up on each case per site policy or as instructed by the Public Health Department. Document your investigation.

c. After notifying the Health Department, be sure to notify Community Care Licensing, your childcare organization's leadership, and your CCHP Nurse Consultant.

The childcare site may create a log to track a current outbreak. This log might be requested by the SFDPH,Communicable Disease. See sample below:

Reporting Facility: | Contact Person: | Phone Number: | Date:

Street Address: | Setting of Exposure (school, childcare center, etc.): ____________________

County: | Estimated Number of Exposed: Students __________ Employees __________

Demographics					Case Location			Symptoms							Outcome			Notes
	Name (Last, First)	Student or Employee (S/E)	Sex (M/F)	Age	Grade	Homeroom Number	Teacher/Instructor	Symptom Onset Date (MM/DD/YY) and Time (incuding AM or PM)	Nausea (Y/N)	Vomiting (Y/N)	Diarrhea (≥3 loose stools within 24 hours) (Y/N)	Bloody Diarrhea (Y/N)	Abdominal Cramps (Y/N)	Fever (Y/N)	Date of Last Diarrhea or Vomit (MM/DD/YY) and Time (including AM or PM)	Medical Visit (Y/N)	Stool Specimen (Y/N)	Additional Comments (e.g. other symptoms, exposure details, etc.)
Ex	Doe, Jane	S	F	11	5	D-129	Smith	09/17/16 10:10 AM	Y	Y	N	N	Y	N	9/19/2016 1:30PM	Y	Y	Sibling is also ill; stool sent to Kaiser
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		
11																		
12																		
13																		
14																		
15																		

Return to: ______________________________

Reference:
https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Norovirus-School-Toolkit.pdf

HEALTH INFORMATION EXCHANGE

POLICY: The child’s and family’s right to privacy will be protected at all times. The childcare will request medical or health information only when necessary for the child’s care. The childcare provider will share child's or family’s medical information only when authorized by the parent or legal guardian.

PURPOSE: To assure that pertinent health information is shared with the appropriate individuals.
To protect the privacy of our families.
To provide the best quality of care for our children.

NOTE: The child’s parent is the first source of information about the child. There are times when parent/legal guardian, staff, or health consultants have questions about a child’s health, safety, nutrition, behavior, or outside influences. Staff and health consultants may discuss issues with medical providers and other consultants after obtaining consent and release of information form from parent/legal guardian. They are ethically bound to honor the family’s right to privacy and will assist the staff in providing the best care possible for the child.

PROCEDURE:

1. Use the form entitled “Information Exchange” (E-22) when:
   a. When a child is ill, and you need a doctor’s note to return
   b. When you have questions about a condition which the parent can’t answer
   c. When you believe the health care provider should assess something which you have been observing.
2. Fill out the top portion completely. List your concerns and questions clearly.
3. Be specific about what you would like the physician to observe. Be careful not to diagnose the child.
4. Give the form to the parent/legal guardian to sign. Keep a copy of the signed request in the child’s file.
5. Have the parent deliver the form to the health care provider and return the completed form to the site.
6. If the form is to be returned by mail, enclose a self-addressed, stamped envelope.

Information Exchange Form for Children with Health Concerns

Dear Health Care Provider:
We are sending you this Information Exchange Form along with a Consent for Release of Information Form (see back) because we have a concern about the following signs and symptoms that we and/or the parents have noted in this child, who is in our care. We appreciate any information you can share with us about this child in order to help us care for him/her more appropriately, and to assist us to work more effectively with the child and family. Thank you!

To be filled out by Child Care Provider:

Name of Child Care Program:____
Telephone:_________________________ Address: ______________________________

We would like you to evaluate and give us information on the following signs and symptoms:
____
____
____
Questions we have regarding these signs and symptoms are:
____
____
____

Date___/___/____Child Care Provider Signature: ______________________________
Child Care Provider Printed Name: ____

To be filled out by Health Care Provider:

Health Care Provider's Name: ___________________________ Phone: ______________
Address: ____
Diagnosis: ____
Recommended Treatment:____
____
____
Side effects of any medication prescribed that we should be aware of: ____________
____
Should the child be temporarily excluded from care? Yes ☐ No ☐
If yes, how long?____

What should we be aware of in caring for this child at our facility (special diet, treatment, education for parents to reinforce your instructions, signs and symptoms to watch for, etc.)?
____
____
Please attach additional pages if needed.

Date__ _/___ /___ Health Care Provider Signature: ___________________________
Health Care Provider Printed Name: ____

Consent for Release of Information Form

I,____give my permission for
(Parent/Guardian)

____to exchange health information with
(Sending Professional or Agency)

____.
(Receiving Professional or Agency)

This includes access to information from my child's medical record that is pertinent to my child's health and safety. This consent is voluntary and I understand that I can withdraw my consent for my child at any time.

This information will be used to plan and coordinate the care of:

Name of Child:____
(Print full name.)

Date of Birth:___/___/_____

Parent/Guardian Signature:____ Date___/___ /_____

Parent/Guardian Name:____
(Print full name.)

Parents or Guardians signing this document have a legal right to receive a copy of this authorization.

Note: In accordance with the Health Insurance Portability and Accountability Act (HIPPA) and applicable laws, all personal and health information is private and must be protected.

Adapted from: Pennsylvania Chapter of the American Academy of Pediatrics (1993) Model Health Care Policies. Bryn Mawr: PA: Authors

MANAGEMENT OF ILLNESS

POLICY: Children who become ill with excludable symptoms while at the childcare will be cared for away from the group until the child is picked up by an authorized adult.

PURPOSE: To ensure every child receives a healthy, safe, and supportive experience.
To protect the health of everyone in the childcare.
To assist staff in meeting all children's needs.
To protect the rights of the family and child.

PROCEDURE:

1. If a child appears ill, repeat the daily health check for symptoms.
2. Document the symptoms on the Attendance/Health Check Record.
3. Inform the Director or designee.
4. The Director or designee will notify the parent and inform of guidelines. (i.e., child must leave the childcare site and not return until at least 24 hours after fever is gone and meeting childcare admission criteria.)
5. Reassure the child and use the appropriate care plan below to care for the child.
6. Document the childcare interventions for the ill child.
7. Put a copy in the child's file and send a copy with the parent.

Suggested plan of care while child is at the childcare site until picked up:

1. **Fever**
    a. Dress child lightly. Excess clothing will cause the temperature to rise.
    b. Encourage drinking plenty of fluids such as water, diluted juices, or popsicles to prevent dehydration.
    c. Keep the room comfortably cool.
    d. Discourage overexertion. (Stanford Medicine, 2023)
    e. Review and follow Inclusion and Exclusion Guidelines on fever.

2. **Vowing and/or diarrhea**

a. For an infant or young child who is vomiting, keep them lying on their stomach or side as much as possible Treating Vomiting - HealthyChildren.org

b. Avoid foods and liquids when vomiting.

c. If there is no suspicion of the child ingesting poison or unsafe objects, offer small sips of water.

d. Repeat sips of water if tolerated. Give clear liquids only unless there is a special plan of care from a medical provider.

e. Report to the parent/legal guardian the child's vomiting and diarrhea info, ex. Number of episodes, color of watery stool, distinctive smell.

3. **Respiratory Congestion**

a. AAP child care exclusion recommendations (2023): Any child with respiratory illness symptoms (cough, runny nose, or sore throat) and a fever should not attend their child care program. They can return once their fever associated with these symptoms has been gone for at least 24 hours without the use of fever-reducing medicine.

b. Offer clear liquids and plenty of rest - follow respiratory etiquette: https://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm

c. Wash hands frequently.

d. Follow inclusion and exclusion criteria guidelines.

MEDICAL EVALUATION

POLICY: The Director, Health Advocate or designee may recommend or require that a child be seen by a health care provider to clear an ill child for readmission to class. When a physician's evaluation is required, the staff member may give the parent an Information Exchange form or specific medical evaluation form to have filled out, signed, and returned to the site.

PURPOSE: To assure children's medical needs are addressed and met.
To ensure infection control and prevention is followed and implemented by the childcare.
To access health information per site policies in accordance with the Health Insurance Portability and Accountability Act of 1996 HIPAA (CDC,2022).

PROCEDURE:

1. Explain the reason for the referral to the parent.

2. Give a completed form to the parent.

    a. Fill in the child's personal information.

    b. Note any pertinent facts (i.e. medicated with Tylenol at 2:00 PM for temp of 102° F per child's medical plan of care).

    c. Request evaluation and requirements per licensing and site guidelines (i.e. Child has a fever of 102 F and right eye with green discharge. See a medical provider for clearance to return to class).

    d. Sign and have the parent sign as well.

3. Keep a copy of the referral form with the Child's Daily Health Inspection Checklist until returned.

4. Follow-up:

    a. Referral form signed by the health care provider and returned with the child.

    a. Send to the site supervisor or Health Advocate.

b. Follow care plan of the child.

c. If the child does not return within two days, call the parent to find out the status of the child. Ask if there is pertinent information that should be shared with the childcare site such as medical diagnosis.

d. Document the response on the copy of the referral form.

5. Determine if an exposure notice must be posted, action taken in the classroom, and/or reporting to the SF Communicable Disease Control at 415-554-2830 and childcare licensing is needed.

MEDICATION POLICIES

POLICY: The Director or designee will assure that all policies and procedures around medications are strictly enforced. This includes but is not limited to accepting, storing, administering, and documenting administration of medications, obtaining appropriate instructions and paperwork for each medication, and appropriately handling medication errors.

PURPOSE: To safely and accurately administer medication.
To protect the health of the children.
To assist program staff in meeting all children's needs.
To protect the rights of the family and child.
To protect the staff and organization from legal liability.
To prevent medication errors and possible serious harm to children.

PROCEDURE:

1. The Director or designee will assure:

   a. Medications are safely stored, handled, administered, documented, and disposed of according to policy and procedure.

   b. Medication errors will be reported to the parent and follow-up will be done with the responsible employee.

   c. Disaster policies and procedures include how medications will be administered in an emergency or during an evacuation.

2. Teachers will administer medications to children at the childcare, only with approval of the Site Director and after receiving training from the parent/legal guardian or the Nurse Consultant. Only authorized staff members can administer medication to children.

3. Prescription and over-the-counter (OTC) medication shall be administered in accordance with the label directions. Health care provider instructions shall not conflict with the product label directions.

4. Prescription medications will be in the **original bottle**, properly labeled with:

   a. The child's name

   b. The medication name

c. The amount to be given (dosage)

d. The times to be given

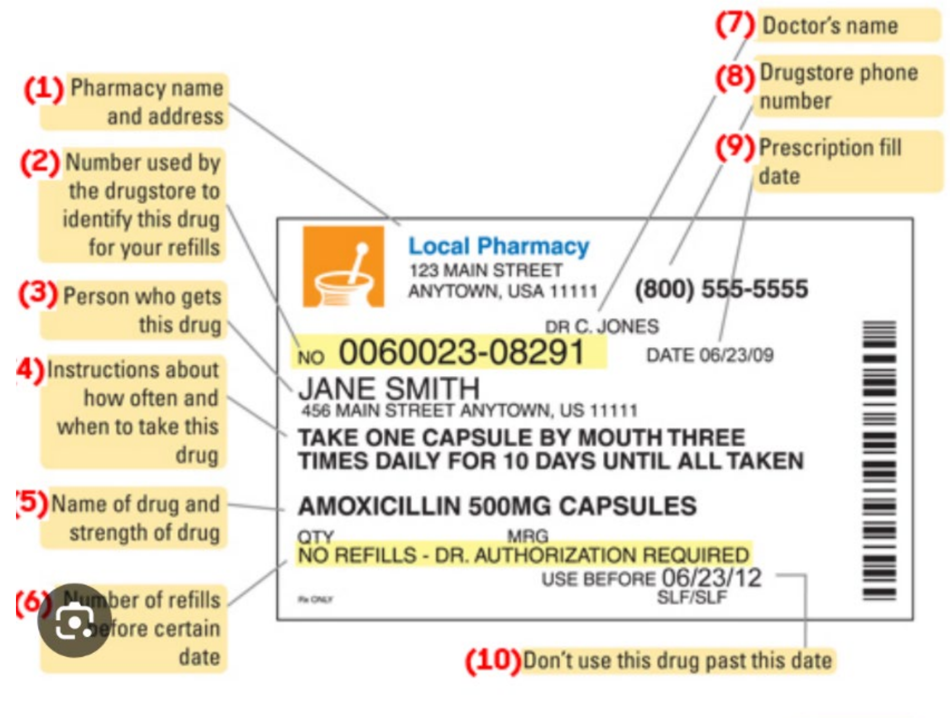
e. How many days it should be given

f. The prescribing health care provider's name and number

g. The expiration date

h. If the medication is to be given "as needed", it must state the specific symptoms for which it should be given.

i. Warnings regarding safety.



5. Written consent must be provided from the parent/legal guardian, permitting childcare facility personnel to administer medications to the child. Use LIC 9221.

6. For non-prescription OTC medications, the parent must complete the parent instructions on form LIC 9221 indicating the medication name, dosage, frequency, and how many days to give the medication.

a. **Instructions for both prescription and OTC medications cannot simply state "as needed". Specific symptoms for giving the medication must be listed in writing.**

b. Instructions for use from the parent/legal guardian shall not conflict with the prescription label or product label directions.

7. Teachers should not agree to a parent request to give a new medication until it has been confirmed that the required paperwork has been properly completed and submitted to the Director.

8. Upon receiving form LIC 9221 and the medication, review the following:

   a. The date the form is signed.

   b. Medication is in its original packaging (including the box).

   c. Prescription medications have a label with the details specified above in #4.

   d. Medication is not expired.

   e. The health care provider's instructions, the parent/legal guardian's instructions, and the product label are consistent.

   f. Child's name is the same as the one on the medication bottle.

   g. Name of the medication is the same on the medication bottle and the form.

   h. Dosage and times are correct on the medication label and the form.

   i. Number of days as ordered by the doctor: if not noted, use site policy.

   j. Any special instructions. Clarify with parent/legal guardian if needed.

   k. Parent has signed the form to give permission.

9. Medications will be given **within 30 minutes** of the time specified. Activities, meals, and naps will be carefully planned to ensure that medications are given in a timely manner.

10. Every dose given should be documented on an administration log and include the child's name, medication name, date and time given, and name of staff who gave it.

11. Non-refrigerated medications and emergency medications are to be stored in safe place that is **inaccessible to children**. As a best practice recommendation and per site policy, consider having controlled medications in a locked box that is inaccessible to children and with key readily available.

12. When indicated on the label, medication will be stored in a refrigerator. If stored in a refrigerator, it should be inaccessible to children for safety (e.g. child-proof lock or in a fridge in an area where children do not have access).

13. Measuring devices will be used for accurately measuring doses.

14. All expired or unused medications should be returned to the parent/legal guardian for disposal. If the medication cannot be returned to the parent/legal guardian, it should be disposed of safely. See www.sfenvironment.org/safe-medicine-disposal for a list of drop off locations or how to send them by mail for disposal though the SF Environment Department. You can also visit How to Safely Dispose of Old Medicines - HealthyChildren.org for more information.

15. Keep a list of medication expiration dates and communicate with parents/legal guardians about expiring medications that will need to be replaced soon.

16. All field trips must make it possible for a child's medication to be transported, stored, and given properly in a timely manner. Emergency medications such as asthma inhalers or epi-pens must be brought on all field trips.

17. All medications must be taken outside with you during an evacuation, including drills.

18. The Health Advocate or designee will determine that every dose is accounted for, including refusals, absences, and any other reason that an anticipated dose was not given.

19. If 9-1-1 is ever called for a child, EMS should be notified of the child's medications.

20. If a child develops a side effect to the medication that is not life-threating, **notify parents/legal guardian immediately and inform them that they must check with the doctor before giving more medication.** Ask if they wish to pick up the child or if they want you to monitor.

21. In the event of a medication error of any sort:

    a. **Contact parents/legal guardians and also the Poison Control Center at 1-800-222-1222. Link: https://calpoison.org/**

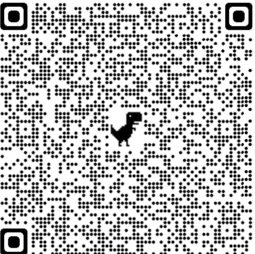
b. **ALWAYS contact Poison Control immediately if** a child received the wrong medication, or the wrong dose, a dose too soon, or is having an adverse reaction to a medication.

c. **If a child shows signs of a severe adverse reaction, call 9-1-1.**

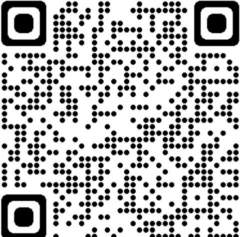
d. Fill out the Medication Error Form (see E-29) and submit to the Site Director.

e. Conduct a review of the circumstances that led to the medication error (root cause analysis). Determine what changes to policies, staffing, the environment need to occur in order to prevent such medication errors in the future. Review medication policies with all staff.

22. For more detailed information on medication policies and care plans for children with medications, you may review and apply the information found at SFUSD notification for administration of student medications at school if applicable. Link and QR code: https://www.sfusd.edu/services/know-your-rights/student-family-handbook/chapter-3-family-resources-and-rights/310-medication-and-emergency-care-plan-forms/3102-notification-administration-student-medications-school



QR Code to SF Environment Department for Safe Medication Disposal in SF:



ADMINISTERING MEDICATIONS

POLICY: Medications will be administered as safely as possible. Special attention will be given to prevent medication errors by reviewing that the right medication and the right dose is given to the right child, at the right time, in the right way. Medication errors will be reported and documented per policy.

PURPOSE: To safely and accurately administer medication.
To protect the health of the children.
To protect the staff and organization from legal liability.
To prevent medication errors and possible serious harm to children.

PROCEDURE:

Remember the 5 R's: **Right Medication** is given to the **Right Child** using the **Right Amount** at the **Right Time** given by the **Right Route**

1. Always Check

    a. Parental Permission – must be in writing and filed in the child's record

    b. Medication Label –the child's name, dosing instructions, special instructions

    c. Expiration Date – the medication is not expired

    d. Allergies and Reactions – check before giving medication if the child has allergies and watch for reactions afterward

2. Medications will be given **within 30 minutes** before or after the time specified. Activities, meals, and naps will be carefully planned to ensure that medications are given in a timely manner.

3. Assure that all supplies are present and clean.

    a. Medication cups/syringes for liquid medications

    b. Disposable gloves

    c. Cotton-tipped applicators for creams/ointments

   d. Medication

   e. Medication Administration Forms with instructions

4. Wash hands now and between each child you give medications to. If it is impossible to wash your hands (*playground*), it is permissible to use hand sanitizer.

5. See each child individually.

6. Informally assess the condition being treated and observe for any symptoms of side effects. Use this opportunity to talk to the child about being familiar with their medication and only taking the one that belongs to them.

7. Make sure you have the correct child. Do not give medication if you are unsure.

8. Check the name on the label of the medication you are dispensing.

9. Check the dosage. For liquid medication, pour into cup/draw up with syringe at eye level to measure.

10. Immediately before giving it, double-check the instructions for dosage, time to be given, right medication, right child, right route, and any other instructions.

11. Administer according to Accepted Techniques. (See E-27).

12. Document immediately on the medication administration log.

13. Use standard form to notify parents of medication given.

14. If the child is absent or does not receive a scheduled dose for any reason, document that information on the medication administration log.

15. In the event of an error of any sort:

16. **Contact parents/legal guardian and the Poison Control at 1-800-222-1222. Link: https://calpoison.org/**

17. **ALWAYS contact Poison Control immediately if a child received the wrong medication, or the wrong dose, a dose too soon, or is having an adverse reaction to a medication.**

18. **If a child shows signs of a severe adverse reaction, call 9-1-1.**

19. Fill out the Medication Incident Form (see E-29) and submit to the Site Director.

Resources

How to Give Medications to Children - Royal Children's Hospital, Australia:

Administering Medications at School - American Academy of Pediatrics, 2016

ACCEPTED MEDICATION ADMINISTRATION TECHNIQUES

Before and after administering any medication, wash hands thoroughly!

1. **DIAPER CREAMS, OINTMENTS, ETC.:**

   a. Gently remove old medication with baby wipes (wipe front to back).

   b. Apply new cream sparingly with gloved hand.

2. **NOSE DROPS:**

   a. Lay young child down, or if old enough to hold still, seat the child with head tipped back.

   b. Seek help to hold an infant's head and hands.

   c. Without touching the dropper to the nose, drop the correct number of drops into the first nostril, allow time for a breath, and then put drops in the other.

   d. Keep the head back for a few seconds and then sit the child up.

   e. Wipe drainage with a tissue.

   f. If the dropper inadvertently touches the nose, wash with soap and water and dry thoroughly.

3. **EYE DROPS (LIQUID):**

   a. Lay young child down, or if old enough to hold still, seat the child with the head tilted back.

   b. Seek help to hold an infant's head and hands.

   c. Pull down the child's lower eyelid with a gloved hand.

   d. Without touching the dropper to the eye or eyelid, drop the prescribed number of drops into the center of the eyelid.

   e. Allow the child to blink several times, then put the drops in the other eye using a clean glove and the same procedure.

   f. If the dropper inadvertently touches the eye or lid, wash with soap and water and dry thoroughly.

4. EYE OINTMENT:

a. Lay a young child down or if old enough to hold still, seat the child with the head tilted back.

b. Seek help holding an infant.

c. Pull down the lower eyelid using a gloved hand. Do the unaffected eye first if applicable.

d. Squeeze ointment between the lower lid and the eye in one steady stream, from the outside corner toward the nose.

e. Change glove and apply medication to the other eye if ordered. Ointments may cause temporary fuzzy vision. This can be frightening for the child and can also be dangerous if the child is allowed to return to active play immediately. Have the child sit quietly until his vision clears.

f. If tube inadvertently touches the eye, wash the tip with soap and water and dry thoroughly.

5. EAR DROPS:

a. Lay a young child down, or if old enough to hold still, seat the child with head tipped to the side.

b. Seek help with holding an infant.

c. Straighten ear canal (If an infant, gently pull the ear lobe straight back; for older children, pull the ear lobe up and back.)

d. Put the prescribed number of drops in the canal without touching the dropper to the ear.

e. Fold the lobe over the ear and hold it in place for a few seconds.

f. Turn head to the other side and repeat. (If dropper inadvertently touches the ear, wash with soap and water and dry thoroughly.)

6. LIQUID ORAL MEDICATIONS (BY MOUTH):

a. Pour exact amount into med cup. Hold at eye level to check accuracy.

b. Children who are old enough should be encouraged to drink on their own, holding the cup.

c. Infants should be held, and the medicine poured slowly into their mouth, followed quickly by sips from a bottle of water; or medicine can be poured into a nipple for sucking.

d. If a syringe is used, aim the syringe into the cheek/side of mouth.

e. **DO NOT PUT MEDICICATION INTO A BOTTLE OF LIQUID.**

7. ORAL MEDICINES – PILLS AND CAPSULES

a. If the child is able to swallow them easily, follow with at least 4 ounces of water.

b. If unable to swallow, pills may be crushed or opened and placed in one 1 tablespoon of applesauce and followed by 4 ounces of water.

c. Read the product label for instructions to confirm if a pill can be crushed.

Resource: [How to Give Medications to Children - Royal Children's Hospital - Australia]

POSSIBLE SYMPTOMS OF ADVERSE REACTIONS TO MEDICATIONS

ANTIBIOTICS

1. Rash
2. Diarrhea
3. Worsening of condition
4. Elevation of fever
5. Anaphylaxis – the most severe form of reaction with breathing problems.

ASTHMA MEDICINES

1. Excitability / Irritability
2. Behavior change
3. Vomiting

DECONGESTANTS

1. Excitability
2. Grogginess
3. Nosebleeds

- Notify parents/legal guardian immediately and inform them that they must check with the doctor before giving more medication.
- Follow your plan of care for side-effects.
- Monitor the child.
- If a child shows signs of a severe adverse reaction, (e.g. Anaphylaxis, etc.) **call 9-1-1.**

MEDICATION INCIDENT FORM

Name of Childcare Site:	Classroom:
Child's Name:	DOB:
Date/Time of Incident:	Medication Name:
Staff's Name Completing this Report:	Date of Report:
Site Supervisor/Director:	

CATEGORIES

☐ Medication was given to the wrong child	☐ Incorrect time of medication
☐ Incorrect amount of medication	☐ Incorrect route of administration
☐ Incorrect medication	☐ Child refused or spit the medication
☐ Incorrect storage of medication	☐ Forgot to give the medication
☐ Given expired medication Date expired: ___________	☐ Missing medication ☐ parent did not provide ☐ lost onsite
☐ Expired (Choose all that applies) ☐ consent ☐ order ☐ medication ☐ care plan (annually) ☐ any changes	☐ Adverse reaction to medication. Symptoms: ☐ Rash ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Headache ☐ Body Pain ☐ Shortness of Breath ☐ Dizziness ☐ Other_________________________

REPORT DETAILS

ACTION TAKEN (Choose all that applies)

☐ Parent/Guardian notified	☐ Licensing notified and LIC 624 submitted
☐ Called 911	☐ Monitored child until parent/guardian pick-up
☐ Hospitalized	☐ Contacted Poison Control (1-800-222-1222)
☐ Other:	

HARM CAUSED

☐ **No Harm** - Near miss; no symptoms; no treatment

☐ **Mild Harm** - Symptoms were mild, temporary, and short term

☐ **Moderate Harm** - Symptoms required additional treatment or the incident caused permanent harm or loss of function

☐ **Severe Harm** - Symptoms required major treatment to save the child's life or the incident shortened life expectancy

☐ **Death** - There is reason to believe that the incident caused or hastened child's death (Complete LIC 9187 Death Report Form)

TAKING A CHILD'S TEMPERATURE

POLICY: Temperatures will be taken per site policy. Digital thermometers will be used. **Do NOT** use mercury thermometers as it can break and release highly toxic mercury fumes.

PURPOSE: To detect illness early in order to minimize the spread of infection and ensure the child is safe to attend childcare.
To protect the health of the children and staff.

There are some regulation requirements that apply only to child care centers licensed with mildly ill children programs. Unless it is part of the incidental medical services (IMS)*, **staff should NOT offer taking Rectal temperatures** in child care centers or family child care homes. Regardless of parent's consent, this should not be practiced in a child care setting unless it is part of IMS (CDSS, 2023). (See Title 22, Division 12, Chapter 1, Subchapter 4 for licensing information regarding IMS)

BACKGROUND:

When Does Your Child Have a Fever?

- Average body temperature is around 98.6° F (37.0° C)
- A fever is an elevated body temperature with these readings:
  - Forehead or Ear temperature: 100.4° F (38.0° C) or higher
  - Oral (mouth) temperature: 100° F (37.8° C) or higher
  - Under the arm (armpit) temperature: 99° F (37.2° C) or higher
- Caution: Ear temperatures are not accurate before 6 months of age

Where to Take the Temperature

- Rectal* temps are the most accurate but are **not recommended** in the child care setting. Forehead temps (temporal) are the second most accurate. Oral and ear temps are also accurate if done properly. Temps done in the armpit are the least accurate. Armpit temps are useful for screening at any age.
- **Age under 3 months old:** An armpit temp is the safest and is good for screening if taken right. New research shows that forehead temps may also be accurate under 3 months of age. If the armpit temp is above 99° F (37.2° C), re-check it and notify

the parents/guardians. If young babies under 3 months old have a fever, they should get medical advice right away (not the next day) at either their doctor's office, an urgent care, or possibly an emergency room.

- **Age 3 months to 4 years old:** Forehead temps are the best. An ear thermometer can be used after 6 months old. An armpit temp is good for screening if it is taken right.
- **Age 4 years and older:** Safe to take the temp orally (by mouth). Ear and forehead thermometers are also good.
- Digital (electronic) thermometers are easily found in stores. Most of them give an accurate temp in 10 seconds or less. The AAP suggests you replace any glass thermometer with one of these products.
- **Refer to the Inclusion/Exclusion Guidelines.**

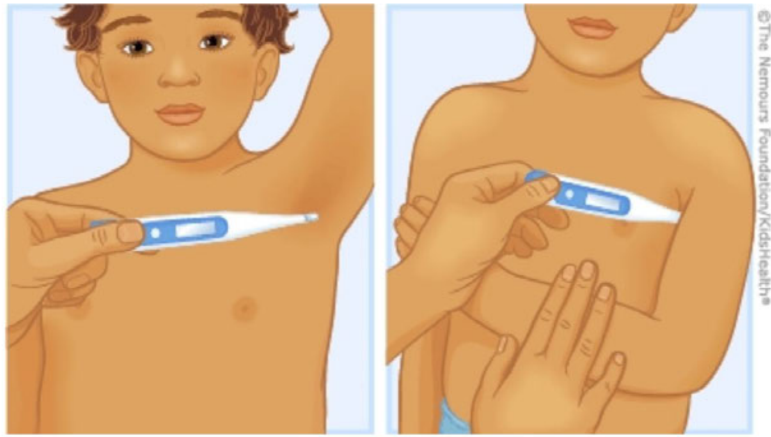
Signs and/or symptoms observed	What should staff do?	What needs to happen in order for the child to return?	Dr.'s note required?
Fever 100.4 F (38 C) on any sites (axillary, forehead, by mouth) WITHOUT behavior change or NO other symptoms	Observe	For other symptoms, exclude if with symptoms or behavior change.	Not needed
Infants and children 100.4 F (38 C) or above on any sites WITH behavior change or other symptoms	Exclude	Temperature normal 24 hours without taking fever reducing medicine and meeting childcare admission criteria.	Yes
Under 2 months old with 100.4 F (38 C) any site WITH or WITHOUT behavior change	Exclude	Temperature normal 24 hours without taking fever reducing medicine and meeting childcare admission criteria.	Yes

PROCEDURE:

Armpit Temperature: How to Take

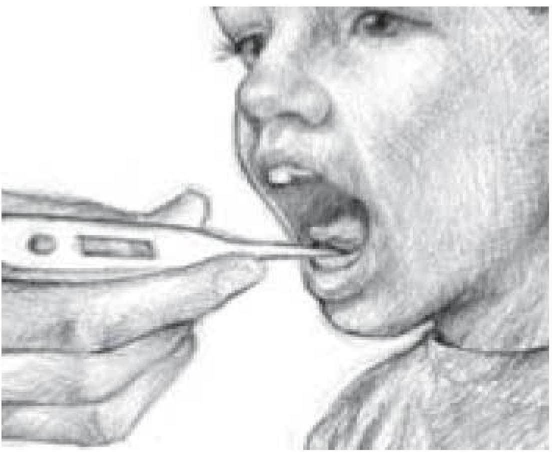
- Age: Any age for screening
- Put the tip of the thermometer in the armpit. Make sure the armpit is dry.
- Close the armpit by holding the elbow against the chest. Do this until it beeps (about 10 seconds). The tip of the thermometer must stay covered by skin.

- The child has a fever if the armpit temp is above 99.0° F (37.2° C). If you have any doubt, take the child's temp by forehead.



Oral Temperature: How to Take

- Age: 4 years and older
- If the child had a cold or hot drink, wait 30 minutes.
- Put the thermometer under one side of the tongue towards the back. It's important to put the tip in the right place.
- Have your child hold the thermometer with his lips and fingers. Don't use the teeth to keep in place. Keep the lips sealed until it beeps (about 10 seconds).
- The child has a fever if the temp is above 100° F (37.8° C).



Ear Temperature (Tympanic): How to Take

- Age: 6 months and older (not accurate before 6 months)
- This thermometer reads the heat waves coming off the eardrum.
- A correct temp depends on pulling the ear backward. Pull back and up for children over 1 year old.
- Aim the tip of the ear probe between the opposite eye and ear.
- Caregivers like this thermometer because it takes less than 2 seconds. It also does not need the child to cooperate. It does not cause any discomfort.
- Caution. Being outdoors on a cold day will cause a low reading. Your child needs to be inside for 15 minutes before taking the temp.
- Earwax, ear infections and ear tubes do not keep from getting correct readings.

Forehead Touch Temperature: How to Take

- Age: Any age
- This thermometer reads the heat waves coming off the temporal artery. This blood vessel runs across the forehead just below the skin.
- Place the sensor head at the center of the forehead touching the skin.
- Slowly slide the thermometer across the forehead toward the top of the ear. Keep it in contact with the skin.

- Stop when you reach the hairline.
- Read your temp on the display screen.
- Note: some newer forehead thermometers don't need to slide across the forehead. Follow the box directions on how to take the temp.
- Used in more doctor's offices than any other thermometer.
- Caregivers like this thermometer because it takes less than 2 seconds. It also does not need the child to cooperate. It does not cause any discomfort.
- Caution: forehead temperatures must be digital. Forehead strips are not accurate.

Forehead No-Touch Temperature: How to Take

- Age: any age
- Aim the thermometer at the center of the forehead.
- Stay less than 1 inch (2.5 cm) away. Do not touch the forehead.
- Do not move the thermometer.
- Press the measurement button.
- How to use of non-contact infrared thermometers (NCITs) (FDA, 2020)

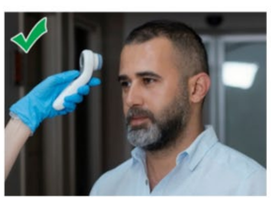


Figure 1: Correct Use – Forehead unobstructed, and NCIT perpendicular to forehead and used at distance identified in manufacturer's instructions.

Figure 2: Incorrect Use – Not perpendicular to forehead

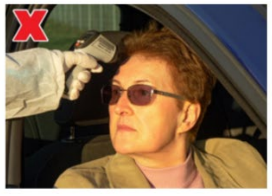


Figure 3: Incorrect Use – Forehead exposed to direct sunlight outdoors

Remember: Fever is just one sign of illness, but an important one. Parent/guardians should consult child's healthcare provider for any questions about fever.

References:

American Academy of Pediatrics, 2020

FDA, 2020

Seattle Children's Hospital, 2023

F. ILLNESS PREVENTION

Universal Precautions	F-01
Handwashing and Hand Sanitizer	F-02
Diapering	F-03
Toileting	F-04
Water Play	F-05
Clean and Dirty Areas	F-06
Infection Control for Staff	F-07
When to Clean, Sanitize, or Disinfect Requirements	F-08
General Cleaning and Sanitizing	F-09
Safer Cleaning, Sanitizing and Disinfecting	F-10
Infection Control for Janitorial	F-11

UNIVERSAL PRECAUTIONS

POLICY: Handling of blood, urine, feces, vomit, or drainage will be done safely according to the "Universal Precautions" guidelines as prescribed by the Centers for Disease Control.

PURPOSE: To protect the health of children and staff from communicable disease in bodily fluids.

PROCEDURE:

1. Put on disposable gloves.
2. Use only disposable products to clean up bodily fluids.
3. Get a plastic bag large enough to hold everything you will dispose.
4. Dispose all used tissue, paper towels, diapers, gauze, cotton and/or bandages, into the plastic bag.
5. Wash child's hands and anything else that touched bodily fluids with soap and warm water.
6. Disinfect any area spilled, splashed, or contaminated with the bodily fluid. Launder contaminated clothes or linen in hot water and soap.
7. Remove your gloves at this point and put them into the bag. Tie the bag closed and put it inside another plastic bag.
8. Dispose the bag in a plastic lined trash can.
9. **WASH YOUR HANDS THOROUGHLY WITH SOAP AND RUNNING WATER IMMEDIATELY!**
10. Any exposure to bodily fluids from open cut, eyes or mouth must be reported to supervisor. Healthcare provider should be contacted if suspected of infectious disease exposure.

HANDWASHING

POLICY: All staff will wash their hands according to procedure:

- Before, during, and after preparing food
- Before and after eating food
- Before and after caring for someone who is sick
- Before and after treating a cut or wound
- After using the toilet
- After changing diapers or cleaning up a child who has used the toilet
- After blowing your nose, coughing, or sneezing
- After touching an animal, animal feed, or animal waste
- After handling pet food or pet treats
- After touching garbage
- If your hands are dirty

Nails will be well manicured and smooth. Jewelry will be minimal while working with children.
Handwashing posters will be hung over every sink. Posters in different languages can be found at https://www.cdc.gov/handwashing/when-how-handwashing.html

PURPOSE: To protect the health of children and staff by minimizing the spread of germs.

PROCEDURE:

1. Wet hands thoroughly with running water.
2. Use liquid soap from a dispenser.
3. Use vigorous scrubbing motions for at least 20 seconds.
4. Wash all surfaces of hands:
   a. Palms
   b. Back of hands
   c. Between fingers
   d. Under nails
   e. Wrists

5. Rinse hands thoroughly under clean, running water.

6. Dry hands with a disposable towel.

7. Turn off faucets with the paper towel.

HAND SANITIZER

1. Washing hands with soap and water is the best way to get rid of germs in most situations. If soap and water are not readily available, use an alcohol-based hand sanitizer that contains at least 60% alcohol (check label).

2. How to Use Hand Sanitizer
   a. Apply the product to the palm of one hand (read the label for the correct amount).

   b. Rub the surfaces of your hands and fingers until they feel dry. This should take around 20 seconds.

Caution! Swallowing alcohol-based hand sanitizer can cause alcohol poisoning if more than a couple of mouthfuls are swallowed. Keep it out of reach of young children and supervise their use.

Remember:

- Hand sanitizers are drugs.

- Keep hand sanitizer out of eyes.
- Use hand sanitizer in well-ventilated areas.
- Supervise children while using hand sanitizer.
- Hand sanitizer is flammable.
- Check FDA's Do Not Use List to determine if your hand sanitizer is safe.
- Do not make your own sanitizer.

References

https://www.cdc.gov/handwashing/when-how-handwashing.html

Safely Using Hand Sanitizer: https://www.fda.gov/consumers/consumer-updates/safely-using-hand-sanitizer

DIAPERING

POLICY: Children will be diapered only in a designated diaper-changing area according to procedure. Diaper-changing area will not be used for other purposes. Sinks near diaper-changing area will not be used for food preparation. Diaper-changing table will have a smooth surface with a three-inch lip around the edge. Surface will be covered with a disposable liner while being used. Diapering area will be supplied with disposable wipes, diluted germicidal solution spray for disinfecting, and a trash can with a step open lid plastic liner.

PURPOSE: To contain fecal contaminants in a small area.
To protect children and staff from the spread of germs.

PROCEDURE:

1. Gather all supplies: gloves, child's clean diaper, change of clothing as needed, wipes, creams (if applicable and provided by parent).
2. Put on latex disposable gloves.
3. Place child on the paper-covered diapering surface. Never turn your back or step away from the diaper changing surface due to the risk of falls.
4. Remove outer clothing and place on the paper covering.
5. Remove diaper and set it on the paper covering out of reach of the child.
6. For girls, wipe from front to back with a disposable wipe. For boys, wipe the penis like a finger. **Never** retract or pull back the foreskin in uncircumcised young boys.
7. Dry the diaper area or allow area to air-dry.
8. If parent has provided diaper cream or ointment and has completed the medication paperwork, apply diaper cream or ointment per parent's or doctor's written instructions.
9. Remove your gloves and place them with the used diapers and wipes.
10. Put a clean diaper on the child.

11. Remove child from the diaper changing surface.
12. Wash child's hands.
13. Return child to the group.
14. Put wet or soiled clothes into a plastic bag to go into a cubby.
15. Wrap diaper and wipes in the paper cover.
16. Dispose of all contaminated trash.
17. Spray the area with soap & water solution and scrub with paper towel.
18. Spray with Disinfectant solution. Leave it to air dry for a few minutes
19. **WASH YOUR HANDS THOROUGHLY!**

Diapering your Newborn
https://www.ucsfbenioffchildrens.org/education/diapering-your-newborn

Diaper Changing Steps for Childcare Settings
https://www.cdc.gov/hygiene/childcare/childcare.html

English Poster: https://www.cdc.gov/hygiene/pdf/diapering-childcare-508.pdf

Spanish Poster: https://www.cdc.gov/hygiene/pdf/diapering-childcare-esp-508.pdf

Video: (2020) Standing Diapering Procedure

TOILETING

POLICY: Children who are able to or trying to use the toilet will be supervised and assisted by a staff member.
Child who needs to be changed because of an accident will be changed in the bathroom. Child may stand on the floor or climb onto a changing surface, which is located in or near the bathroom. Diaper changing area can be used.
Toileting/diapering area will be supplied with soap & water solution for cleaning and disinfectant/germicidal spray solution, a trash can with a step-open lid and plastic liner, and a step stool for climbing up to the surface.

PURPOSE: To contain fecal contaminants in a small area.
To protect the children and staff from the spread of germs.

PROCEDURE:

1. Gather the child's diaper, pull-up, and change of clothing as needed.
2. Put on latex disposable gloves.
3. Decide with the child whether they want to stand or lay down on the changing surface.
4. Remove clothing and put wet or soiled clothes into a plastic bag to go into a cubby.
5. Remove pull-up/underwear.
6. For girls, assist as needed to wipe from front to back with a disposable wipe. For boys, assist as needed to wipe the penis like a finger. **Never** retract or pull back the foreskin in uncircumcised young boys.
7. Remove your gloves and place them with the used diapers and wipes.
8. Help the child put on clean pull-up/underwear.
9. Make sure child washes hands well.
10. Dispose of all contaminated trash.
11. Spray the area with germicidal solution, and scrub with paper towel. Leave it to air dry for a few minutes.
12. **WASH YOUR HANDS THOROUGHLY!**

WATER PLAY

<u>POLICY:</u> Water play at the childcare shall consist of water tables, sprinklers, pouring and running water. Swimming and wading will be at a public pool, maintained according to the requirements of the Public Health Department as a community swimming place. Diapered children will follow the diaper rules set forth by community swimming place. No children should be left unattended during water play by staff members.

<u>PURPOSE:</u> To protect the health of children and staff.
To reduce the spread of communicable diseases.
To assist program staff in meeting all the children's needs.
To protect the rights of the family and child.

<u>PROCEDURE:</u>

1. Empty all water vessels that are not in current use.

2. All water activity will be closely supervised.

3. Children will wash their hands BEFORE and AFTER water play to prevent the spread of germs and infection.

4. Swimming at public facilities:

   a. A qualified lifeguard must be present.

   b. Infants and toddlers are excluded from this activity.

   c. Diapered children will follow the diaper rules set forth by community swimming place.

   d. Ratio of 1:4 must be maintained.

CLEAN AND DIRTY AREA (SINKS)

POLICY: The childcare facility will have rooms arranged to promote good health and avoid the spread of illness. Foot traffic will not pass through a contaminated/dirty area (i.e., diaper changing area) to a clean area (i.e., food prep area).

PURPOSE: To avoid spreading contamination to a vulnerable "clean" area.
To minimize the general cleaning that needs to be redone.
To protect the health of the children and staff in that room.

PROCEDURE:

1. Plan your room arrangement on paper.
2. Use different colored pens to map out the route of:
    a. Parents as they enter
    b. Children coming in from the yard
    c. Staff going to and coming from the food preparation area
    d. Staff taking children to be diapered
    e. Staff getting medicine out
    f. Staff bringing the first aid kit to the play space.
3. Do not allow dirty areas to cross over into clean areas.
    a. The bathroom and diapering area are dirty.
    b. The play area is semi-dirty.
    c. The napping room is semi-clean.
    d. The food preparation, eating, and medicine area are clean.
4. Sinks in the "dirty areas" and used for:
    a. Handwashing after toileting
    b. Emptying floor wash water

c. Or any materials that are visibly dirty

5. Sinks in "clean areas" and used for:

    a. Washing hands before eating

    b. First Aid (and disinfected immediately after use)

    c. Rinsing food and eating utensils

INFECTION CONTROL
Staff Guidelines

POLICY: The staff will maintain the environment in an acceptably clean and orderly fashion according to the National Performance Standards for childcare and licensing requirements.

PURPOSE: To protect the health of the children and staff from communicable diseases and allergens.
To assure a constant level of cleanliness and sanitation.
To model health and hygiene habits for the children and families.
To comply with licensing requirements.

PROCEDURE:

1. Handwashing per procedure.
2. Clean up all areas after use:
    a. Sweep floors.
    b. Spot-clean carpet stains.
    c. Wipe tables and chairs after eating.
    d. Mop up spills on floors.
3. Avoid clutter.
4. Clean, Sanitize, and Disinfect per Title 22 regulations – see section F-8 or at this link: Clean, Sanitize, Disinfect per CCL
5. Each staff should complete IPM training (which will include info about cleaning and disinfecting) annually through the DPR website:
https://www.cdpr.ca.gov/docs/schoolipm/

Additional information on cleaning and disinfecting;

a. Toys: https://www.ottawapublichealth.ca/en/professionals-and-partners/cleaning-and-disinfection-of-toys.aspx

b. Title 22. Child Care Center General Licensing Requirements https://www.cdss.ca.gov/ord/entres/getinfo/pdf/ccc6.pdf

c. Caring for Our Children: https://nrckids.org/CFOC

d. Selection and Use of a cleaning, sanitizing, or disinfecting product: https://nrckids.org/files/appendix/AppendixJ.pdf

Clean, sanitize or disinfect?

This table shows areas in a child care center required to be cleaned, sanitized, or disinfected per California child care licensing regulations. If more stringent, "Best Practices" are included per Caring for Our Children (CFOC) National Health and Safety Performance Standards Guidelines for Early Care and Education Programs, Appendix K. The CFOC standards are not enforceable, and included only as a reference. Be sure to always follow child care licensing requirements.

For more information, contact the California Department of Pesticide Regulation's Child Care IPM Program at ccipmlist@cdpr.ca.gov.

Area	Process	Frequency	Code	Best Practice*, if more stringent
Food Areas				
Food areas (kitchen, food preparation and storage areas, equipment)	Clean	Maintained	Title 22 §101227 (a)(18),(20)	Clean and Sanitize tables and food preparation surfaces before and after each use. Clean and Sanitize countertops and food preparation appliances daily.
Dishes and utensils	Clean and Sanitize	After use	Title 22 §101227(a)(21)	N/A
Toilet Areas				
Toilets	Maintained sanitary	Maintained	Title 22 §101239(e)(4)	Clean and disinfect daily
Potty Chairs	Clean and Disinfect	After use	Title 22 §101428(e)(2)	N/A
Hand washing sinks and faucets, bathing facilities	Maintained sanitary	Maintained	Title 22 §101239(e)(4)	Clean and disinfect daily
Floors	Clean	Maintained	Title 22 §101238(a) and 101238.3(b)	Clean and disinfect daily
Sleeping Areas				
Napping Equipment	Clean and Disinfect	Weekly or if soiled	Title 22 §101239.1(b)(4)	N/A
Sheets	Clean	Weekly or if soiled	Title 22 §101239.1(c)(3)	N/A
Blankets	Clean or Change	If soiled	Title 22 §101239.1(c)(4)	Clean monthly
General Areas				
Entire center	Maintained sanitary	Maintained	Title 22 §101238(a)	N/A
Floors (non-infant)	Clean	Maintained	Title 22 §101238.3(b)	Clean daily
Door and cabinet handles	Clean	Maintained	Title 22 §101238(a)	Clean and disinfect daily
Drinking fountains	Clean	Maintained	Title 22 §101238(a)	Clean and disinfect daily
Computer keyboards	Clean	Maintained	Title 22 §101238(a)	Clean and sanitize after use. Use sanitizing wipes, do not spray.

*Caring for Our Children National Health and Safety Performance Standards Guidelines for Early Care and Education Programs, Appendix K http://cfoc.nrckids.org/

[SCCIPM 30 (5/2020)]

Clean, sanitize or disinfect?

Area	Process	Frequency	Code	Best Practice*, if more stringent
Infant-Specific Care				
Floors (not carpet)	Clean and Disinfect	Daily	Title 22 §101438.1(c)(1)	N/A
Carpeted floors and large rugs	Vacuum	Daily	Title 22 §101438.1(c)(2)	Clean monthly
	Clean	Every 6 months		
Small rugs	Vacuum or shake out	Daily	Title 22 §101438.1(c)(2)(A)	N/A
	Wash	Weekly		
Walls and partitions	Clean and Disinfect	Weekly	Title 22 §101438.1(c)(3)	N/A
Highchairs and feeding chairs	Clean and Disinfect	After use	Title 22 §101439(f)	N/A
Diaper changing table and pads	Clean and Disinfect	After use	Title 22 §101428(d)(7)	N/A
Diaper changing area (including walls, floors, dispensers, counter tops, sinks, drawers, and cabinets)	Clean and Disinfect	After use or if soiled	Title 22 §101428(d)(7)(B) and §101438.1(c)(4),(5)	N/A
Diaper pails	Clean and Sanitize	Daily	Title 22 §101428(d)(3)(A)	Clean and disinfect daily
Linens (center-provided)	Clean and Sanitize	Daily or if soiled	Title 22 §101438.1(e)	N/A
Crib mattresses	Clean and Disinfect	Daily and when soiled or wet	Title 22§101439.1 (b)(4)(B)	N/A
Mouthed objects	Clean and Disinfect	Daily or more often if necessary	Title 22 §101438.1(c)(1)	N/A

*Caring for Our Children National Health and Safety Performance Standards Guidelines for Early Care and Education Programs, Appendix K http://cfoc.nrckids.org/

GENERAL SANITATION

POLICY: The Director or designee will assure that the childcare environment looks and smells clean and that all cleaning procedures are followed at all times.

PURPOSE: To inhibit the spread of disease.
To protect everyone from allergens.
To assure a constant level of cleanliness.

PROCEDURE:

1. Regularly cleaning surfaces in your facility helps prevent the spread of germs that make people sick.

2. **Cleaning** with commercial cleaners that contain soap or detergent decreases the number of germs on surfaces and reduces risk of infection from surfaces in your facility. Cleaning alone removes most types of harmful germs (like viruses, bacteria, parasites, or fungi) from surfaces.

3. **Sanitizing** reduces the remaining germs on surfaces after cleaning.

4. **Disinfecting** can kill harmful germs that remain on surfaces after cleaning. By killing germs on a surface after cleaning, disinfecting can further lower the risk of spreading disease.

5. If you do sanitize or disinfect, clean surfaces first because impurities like dirt may make it harder for sanitizing or disinfecting chemicals to get to and kill germs.

6. Consider the type of surface and how often the surface is touched. Generally, high touch surfaces are more likely to spread germs. If the space is a high traffic area, you may choose to clean more frequently or disinfect in addition to cleaning.

7. **When to Clean Surfaces:** Clean high-touch surfaces regularly (for example, pens, counters, shopping carts, door handles, stair rails, elevator buttons, touchpads, restroom fixtures, and desks). Clean other surfaces when they are visibly dirty.

8. **How to Safely Clean Various Surfaces**

    a. In most situations, cleaning regularly is enough to prevent the spread of germs. Always wash your hands with soap and water for 20 seconds after cleaning. Follow these tips to safely clean different surfaces in your facility:

b. **For hard surfaces, such as counters, light switches, desks, and floors:** Clean surfaces with soap and water or with cleaning products appropriate for use on the surface.

c. **For soft surfaces, such as carpet, rugs, and drapes:**

   i. Clean the surface using a product containing soap, detergent, or other type of cleaner appropriate for use on these surfaces.

   ii. Launder items if possible, according to the label's instructions. Use the warmest appropriate water setting and dry items completely.

   iii. Vacuum surfaces such as carpets and rugs and dispose of the dirt safely.

d. **For laundry items, such as clothing, towels, and linens:**

   i. Use the warmest appropriate water setting and dry items completely.

   ii. It is safe to wash dirty laundry from a person who is sick with other people's items.

   iii. Clean clothes hampers or laundry baskets according to guidance for surfaces.

e. **For electronics, such as tablets, touch screens, keyboards, remote controls, and ATM machines:** Consider putting a wipeable cover on electronics, which makes cleaning and disinfecting easier. Follow the manufacturer's instructions and recommendations for cleaning the electronic device.

f. **For outdoor areas, such as patios and sidewalks:**

   i. Spraying cleaning or disinfection products on low-touch surfaces in outdoor areas—such as on sidewalks, roads, or groundcover—is **not** necessary, effective, or recommended.

   ii. Clean high-touch surfaces made of plastic or metal, such as grab bars, play structures, and railings when visibly dirty.

   iii. Cleaning and disinfection of wooden surfaces (such as wood play structures, benches, and tables) are **not** recommended.

9. When to Disinfect:

a. Disinfection is needed when the surface is contaminated with bodily fluid (e.g. blood, feces, urine, vomit, saliva, wound drainage, etc.) and if the space is highly contaminated (e.g. high-traffic area, rooms where people have been ill, etc.).

b. During certain disease outbreaks, local health authorities might recommend specific disinfection procedures to reduce the risk of spreading disease within the facility.

c. Please follow CCL requirements on surfaces needing to be disinfected. See F8 for details on surfaces needing to be disinfected and frequency of disinfection.

10. How to Disinfect Safely

a. To disinfect, use an EPA-registered disinfecting product for the specific harmful germ (such as *viruses or bacteria) if known. Not all disinfectants are effective for all harmful* germs.

b. Clean the surface with soap and water first. Always read the label on disinfecting products to make sure the products can be used on the type of surface you are disinfecting (such as a hard or soft surface, food contact surface, or residual surface).

c. Follow these important safety guidelines when using chemical disinfectants:

- Open doors and windows and use fans or HVAC (heating, ventilation, and air conditioning) settings to increase air circulation in the area.

- Wear the recommended protective equipment (for example, gloves or goggles) to protect your skin and eyes from potential splashes, as recommended by Section 8 of the product's Safety Data Sheet. [PDF – 7 pages]

- After you apply the disinfectant to the surface, leave the disinfectant on the surface long enough to kill the germs. This is called the contact/wet time. You can find the contact time listed in the Safety Data Sheet and in the directions. The surface should stay wet during the entire contact time to make sure germs are killed.

- Ensure safe use and proper storage of cleaning and disinfection products, including storing them securely and using PPE needed for the products.

- If the product instructions tell you to dilute the product with water, use water at room temperature (unless the label says otherwise). Note: Disinfectants activated or diluted with water may have a shorter shelf life.

- Clearly label all cleaning or disinfection solutions.

- Store and use chemicals out of the reach of children and animals.

- Do not mix products or chemicals with each other as this could be hazardous and change the chemical properties.

- Do not eat, drink, or breathe cleaning or disinfection products into your body or apply directly to your skin. These products can cause serious harm.

- Do not wipe or bathe pets with any disinfection products.

- Immediately after disinfecting, wash your hands with soap and water for 20 seconds.

In most cases, fogging, fumigation, and wide-area or electrostatic spraying are not recommended as primary methods of surface disinfection and have several safety risks, unless the product label says these methods can be used.

See EPA's Cleaning and Disinfecting Best Practices [PDF – 1 page]

(Adapted from CDC, 2022)

Review and follow guidelines from California School and Childcare IPM

Safer Cleaning, Sanitizing, and Disinfecting

Choose Safer Products

Cleaners

- *Look for:*
  - A Safer Choice,
  - A UL ECOLOGO, or
  - A Green Seal logo
- *Avoid:*
  - Perfumes and dyes
  - Antibacterial ingredients

Sanitizers and Disinfectants

- *Look for:*
  - An EPA Registration Number
  - A Design for the Environment (DfE) logo https://tinyurl.com/DfElist
  - Safer active ingredients: citric acid, lactic acid, ethanol, or hydrogen peroxide
- *Avoid:*
  - Pressurized containers that spray fine mist
  - WARNING, DANGER, or POISON on the label

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Limpieza, higienización y desinfección más seguras

Elija productos más seguros

Limpiadores

- *Busque:*
  - Una opción más segura
  - Un logotipo UL ECOLOGO
  - Un logotipo Green Seal
- *Evite:*
  - Los perfumes y tintes
  - Los ingredientes antibacterianos

Productos higienizantes y desinfectantes

- *Busque:*
  - Un número de registro de la EPA
  - Un logo de diseñado para el medioambiente ("Design for the Environment") https://tinyurl.com/DfElist
  - Ingredientes activos más seguros: ácido cítrico, ácido láctico, etanol o peróxido de hidrógeno
- *Evite:*
  - Los aerosoles presurizados con un rociado fino
  - Los productos que contienen avisos de ADVERTENCIA, PELIGRO o VENENO en la etiqueta

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更安全的清潔、消毒和殺菌

選擇更安全的產品

清潔劑

- *尋找：*
  - 更安全的選擇,
  - UL ECOLOGO，或是
  - 綠標籤標誌
- *避免：*
  - 香水和染劑
  - 抗菌成分

消毒劑和殺菌劑

- *尋找：*
  - EPA註冊號碼
  - 環保設計（DfE）標誌 https://tinyurl.com/DfElist
  - 更安全的活性成分：檸檬酸、乙醇或過氧化氫
- *避免：*
  - 噴灑細沫的加壓容器
  - 標籤上的警告、危險或毒藥

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Safer Cleaning, Sanitizing, and Disinfecting

Use the Right Tool for the Job

THE JOB: Remove dirt, grime, and some germs from most surfaces and objects.

THE RIGHT TOOL:
A Cleaner

- Remove clutter to make cleaning easier.
- Use a mild soap, detergent, or cleaning product.
- Use microfiber cloths and mops.
- Use a vacuum cleaner with a HEPA filter for carpets and other soft surfaces.

Routine cleaning is enough for most surfaces and objects.

THE JOB: Kill most germs on kitchen and food surfaces, utensils, and mouthed toys.

THE RIGHT TOOL:
A Sanitizer

- Use an EPA registered sanitizer after cleaning kitchen and food surfaces.
- Use a dishwasher with a sanitizing cycle for dishes, utensils, and mouthed toys.
- If you don't have a dishwasher, use an EPA registered sanitizer after cleaning dishes, utensils, and mouthed toys.

THE JOB: Kill nearly all the germs on surfaces soiled with blood or body fluids.

THE RIGHT TOOL:
A Disinfectant

- Use an EPA registered disinfectant for:
  - toilet and diapering areas and surfaces.
  - any surfaces soiled with blood, feces, or body fluids.
  - high-touch surfaces during a disease outbreak.

Always clean surfaces before applying a sanitizer or disinfectant!

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Limpieza, higienización y desinfección más seguras

Use el producto adecuado para cada tarea

TAREA: Eliminar la suciedad, la mugre y algunos gérmenes de la mayoría de las superficies y objetos.

PRODUCTO ADECUADO:

Un limpiador

- **Ordene antes para facilitar la limpieza.**
- **Use un jabón, detergente o producto de limpieza suaves.**
- **Use trapos y trapeadores de microfibras.**
- **Use una aspiradora con filtro HEPA para alfombras y otras superficies blandas.**

La limpieza de rutina es suficiente para la mayoría de las superficies y objetos.

TAREA: Eliminar la mayoría de los gérmenes en las superficies de la cocina y utilizadas para los alimentos, los utensilios y los juguetes que se llevan a la boca.

PRODUCTO ADECUADO:

Un desinfectante químico

- **Use un desinfectante aprobado por la EPA después de limpiar la cocina y las superficies utilizadas para los alimentos.**
- **Use un lavavajillas con un ciclo de desinfección para platos, utensilios y juguetes que se llevan a la boca.**
- **Si no tiene lavavajillas, use un desinfectante aprobado por la EPA después de lavar los platos, utensilios y juguetes que se llevan a la boca.**

TAREA: Matar casi todos los gérmenes en superficies manchadas con sangre o fluidos corporales.

PRODUCTO ADECUADO:

Un desinfectante

- **Use un desinfectante aprobado por la EPA para:**
  - **áreas y superficies del baño y cambio de pañales.**
  - **cualquier superficie sucia con sangre, heces o fluidos corporales.**
  - **superficies que se tocan mucho durante un brote de enfermedad.**

¡Siempre limpie las superficies antes de aplicar un producto higienizante o un desinfectante!

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更安全的清潔、消毒和殺菌

使用適合工作的工具

工作：從大部分的表面和物體移除塵土、汙垢和一些細菌。

正確的工具：
清潔劑

- 去除雜亂，使清潔更容易。
- 使用溫和肥皂、清潔劑或清潔產品。
- 使用超細纖維布和拖把。
- 在地毯和其他柔軟表面使用具有高效濾網（HEPA）的吸塵器。

例行清潔
足以用於大部分的面表和物體。

工作：殺死廚房和食品表面、餐具和入口玩具的大部分細菌。

正確的工具：
消毒劑

- 清潔廚房和食品表面後使用EPA註冊的消毒劑。
- 使用有消毒循環的洗碗機來清洗餐盤、餐具和入口的玩具。
- 如果您沒有洗碗機，請在清洗餐盤、餐具和入口的玩具後使用EPA註冊的消毒劑。

工作：殺死受到血液或體液沾汙的表面上幾乎全部的細菌。

正確的工具：
殺菌劑

- 使用EPA註冊的殺菌劑：
  - 馬桶和換尿布區域及表面。
  - 任何受到血液、糞便或體液沾汙的表面。
  - 在疾病爆發期間頻繁接觸的表面。

使用消毒劑或殺菌劑之前
總是先清潔表面！

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Step-by-Step Cleaning for Child Care Programs

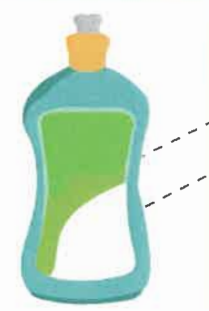
Cleaning means to remove dirt, dust, debris, and sticky substances by washing, wiping, scrubbing, or mopping hard surfaces with soap or detergent and water. Routine cleaning of toys, floors, cribs, cots, mats, play equipment, refrigerators, counters, and shelves is recommended for child care settings.

STEP 1 Gloves may be worn to protect skin. Always follow product label directions for personal protective equipment like gloves.

STEP 2 Spray the cleaning solution onto the surface.

STEP 3 Wipe the surface with a single use paper towel, a microfiber cloth, or a mop.

STEP 4 Rinse according to product label directions.



STEP 5 Allow the surface to air dry, or dry with a fresh paper towel or microfiber cloth.

Important note: Some cleaning products are ready-to-use and some are meant to be diluted with water.

Always follow product label directions!

Paso a paso

Limpieza para programas de cuidado infantil

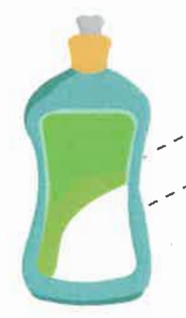
Limpieza significa eliminar la suciedad, el polvo, los escombros y las sustancias pegajosas lavando, limpiando, frotando o fregando las superficies duras con jabón o detergente y agua. Se recomienda la limpieza de rutina de juguetes, pisos, cunas, colchonetas, equipos de juego, refrigeradores, mostradores y estantes para los entornos de cuidado infantil.

PASO 1 Se pueden usar guantes para proteger la piel. Siempre siga las instrucciones de la etiqueta del producto para equipo de protección personal como guantes.

PASO 2 Rocíe la solución de limpieza en la superficie.

PASO 3 Limpie la superficie con una toalla de papel de un solo uso, un paño de microfibra o un trapeador.

PASO 4 Enjuague según las instrucciones de la etiqueta del producto.



DESCRIPCIÓN

Producto de limpieza para todo uso. Seguro de usar en mostradores, pisos, fregaderos y otras superficies duras.

CÓMO UTILIZAR

- Rocíe el producto sobre la superficie y límpielo.
- Para los problemas difíciles, déjelos reposar unos minutos antes de limpiarlos.
- Enjuagar con agua. No deje residuos de producto en la superficie.

PASO 5 Permita que la superficie se seque al aire, o seque con una toalla de papel nueva o un paño de microfibra.

Nota Importante: Algunos productos de limpieza están listos para usar y otros deben diluirse con agua.

¡Siga siempre las instrucciones de la etiqueta del producto!

一步步

對兒童保育設施進行清潔

清潔是指用肥皂、洗滌劑和水清洗、擦拭、擦洗或擦除堅硬的物體表面，以清除污垢、灰塵、碎片和粘性物質。對於兒童保育設施，建議對玩具、地板、嬰兒床、小床、墊子、遊戲設備、冰箱、櫃檯及其架子經常進行清潔。

步驟 1

可以佩戴手套保護皮膚。
始終按照產品標籤說明使用手套等個人防護配備

步驟 2

把清潔液噴灑在物體表面。

步驟 3

用一次性紙巾、超細纖維布或拖把擦拭物體表面。

步驟 4

遵循產品標籤說明漂清。

可在櫃檯、地板、水槽和其它堅硬物體表面安全使用。

如何使用

- 將產品噴灑在物體表面並擦拭乾淨。
- 對於頑固的臟物，可等待幾分鐘再擦拭乾淨。
- 用水沖洗，不要在物體表面留下任何產品殘留。

步驟 5

讓表面風乾，或用清潔紙巾或超細纖維布擦拭乾淨。

重要提示：
有些清潔產品可以直接使用，有些則需要用水稀釋後才能使用。

始終按照產品說明使用產品！

School of Nursing

Step-by-Step
Sanitizing for Child Care Programs

Sanitizing means to kill germs at a level that reduces the risk of becoming ill from contact with germs on the surface. Sanitizing is used on food contact surfaces (dishes, utensils, cutting boards, high chair trays, tables), toys that children may place in their mouths, pacifiers, and mixed use tables. Choose an EPA registered sanitizer that is approved for use on food contact surfaces. DO NOT USE SANITIZERS NEAR CHILDREN!

STEP 1 Put on gloves.

STEP 2 Pre-clean the surface with soap and water. Surfaces should be clean before applying a disinfectant.

STEP 3 Apply the sanitizer. Spray away from people and provide ventilation.

STEP 4 Leave the surface wet for the appropriate contact (dwell) time stated on the product label. Set a timer to keep track of the time.

STEP 5 Allow the surface to air dry, or dry with a fresh paper towel or microfiber cloth.

Important note: Some sanitizers are ready-to-use and some are meant to be diluted with water.

Always follow product label directions!

If sanitizing a food contact surface, you may need to rinse the surface with water after. Check the label. If required, use enough water to remove all of the sanitizer.

www.cdpr.ca.gov

Paso a paso

Sanitizando para programas de cuidado infantil

Sanitizar significa matar gérmenes a un nivel que reduce el riesgo de enfermarse por el contacto con gérmenes en la superficie. El sanitizante se usa en superficies en contacto con alimentos (platos, utensilios, tablas de cortar, bandejas de sillas altas, mesas), juguetes que los niños pueden colocarse en la boca, chupetes y mesas de uso mixto. Elija un sanitizante registrado por la EPA que esté aprobado para su uso en superficies en contacto con alimentos.

¡No use los sanitizantes cerca de los niños!

PASO 1 Ponte los guantes.

PASO 2 Limpie previamente la superficie con agua y jabón. Las superficies deben estar limpias antes de aplicar un sanitizante.

PASO 3 Aplica el sanitizante. Rocíe lejos de las personas y proporcione ventilación.

PASO 4 Deje la superficie húmeda durante el tiempo adecuado de contacto (permanencia) indicado en la etiqueta del producto.

PASO 5 Permita que la superficie se seque al aire, o seque con una toalla de papel nueva o un paño de microfibra.

Nota Importante: Algunos sanitizantes están listos para usar y otros deben diluirse con agua.

¡Siga siempre las instrucciones de la etiqueta del producto!

Si sanitiza una superficie en contacto con alimentos, puede que necesite enjuagar la superficie con agua después. Revisa la etiqueta. Si es necesario, use suficiente agua para eliminar todo el sanitizante.

CALIFORNIA CCHP CHILDCARE HEALTH PROGRAM

一步步

對兒童保育設施進行消毒

消毒指在一定程度上殺死細菌，以減少接觸物體表面細菌而生病的風險。消毒用於食物接觸面（盤子、器皿、砧板、高椅托盤、桌子）、兒童可能放在嘴裡的玩具、奶嘴和多重用途的桌子。選擇一種在美國環境保護署註冊的消毒劑，該消毒劑必須被准許用於食品接觸表面。不要在兒童附近使用消毒劑！

步驟 1 戴上手套。

步驟 2 用肥皂和水預先清洗表面，應確保表面在使用消毒劑之前是乾淨的。

步驟 3 在遠離人群並通風的情況下使用消毒劑噴霧。

步驟 4 在產品標籤上規定的適當接觸（停留）時間內保持表面濕潤，設置計時器來記錄時間。

步驟 5 讓表面風乾，或用乾淨紙巾或超細纖維布擦拭乾淨。

重要提示：
有些消毒劑可以直接使用，有些則需要用水稀釋。

始終按照產品說明使用產品！

如果對食物接觸表面進行消毒，可能需要在消毒後用水沖洗表面。檢查產品說明標籤，如果需要，使用大量清水沖洗殘留的消毒劑。

Step-by-Step Disinfecting for Child Care Programs

Disinfecting means to destroy almost all germs that could make a person sick. Disinfecting is for toileting areas and high-touch areas that collect lots of germs (bathroom faucets and counters, diaper changing tables, toilets, sinks used in toileting routines, drinking fountains, doorknobs). Choose an EPA registered disinfectant, and use the product according to the label directions. DO NOT USE DISINFECTANTS NEAR CHILDREN!

STEP 1 Put on gloves.

STEP 2 Pre-clean the surface with soap and water. Surfaces should be clean before applying a disinfectant.

STEP 3 Apply the disinfectant. Spray away from people and provide ventilation.

STEP 4 Leave the surface wet for the appropriate contact (dwell) time stated on the product label. Set a timer to keep track of the time.

STEP 5 Allow the surface to air dry, or dry with a fresh paper towel or microfiber cloth.

Important note: Some disinfectants are ready-to-use and some are meant to be diluted with water.

Always follow product label directions!

Paso a paso
Desinfección para programas de cuidado infantil

Desinfectar significa destruir casi todos los gérmenes que podrían enfermar a una persona. La desinfección es para áreas de baño y áreas de alto contacto que recolectan muchos gérmenes (grifos y mostradores de baño, cambiadores de pañales, inodoros, lavabos utilizados en rutinas de inodoro, bebederos, picaportes). Elija un desinfectante registrado por la EPA y use el producto de acuerdo con las instrucciones de la etiqueta.

¡No use los desinfectantes cerca de los niños!

PASO 1 Ponte los guantes.

PASO 2 Limpie previamente la superficie con agua y jabón. Las superficies deben estar limpias antes de aplicar un desinfectante.

PASO 3 Aplica el desinfectante. Rocíe lejos de las personas y proporcione ventilación.

PASO 4 Deje la superficie húmeda durante el tiempo adecuado de contacto (permanencia) indicado en la etiqueta del producto.

PASO 5 Permita que la superficie se seque al aire, o seque con una toalla de papel nueva o un paño de microfibra.

Nota Importante: Algunos desinfectantes están listos para usar y otros deben diluirse con agua.

¡Siga siempre las instrucciones de la etiqueta del producto!

一步步

對兒童保育設施進行減菌

減菌意味著消滅幾乎所有可能導致人生病的細菌。減菌適用於廁所區域和細菌聚集較多並經常接觸的區域（浴室水龍頭和櫃檯、嬰兒護理臺、馬桶、如廁的水槽、飲水機、門把手等）。選擇EPA註冊的減菌劑，並按照標籤說明使用產品。

切勿在兒童附近使用減菌劑！

步驟 1

戴上手套。

步驟 2

用肥皂和水預先清潔表面，應確保表面在使用減菌劑之前是乾淨的。

步驟 3

在遠離人群並通風的情況下使用減菌劑噴霧。

步驟 4

在產品標籤上規定的適當接觸（停留）時間內保持表面濕潤，設置計時器來記錄時間。

步驟 5

讓表面風乾，或用乾淨紙巾或超細纖維布擦拭乾淨。

重要提示：
有些減菌劑可以直接使用，
有些則需要用水稀釋。

始終按照產品說明使用產品！

INFECTION CONTROL

Janitorial Guidelines

(THIS IS A PROCEDURE FOR A JANITOR AND THE PERSON SUPERVISING.)

POLICY: The janitorial staff will assure that the level of cleanliness and sanitation will meet the standards that have been adopted.

PURPOSE: To protect the health of children and staff from communicable diseases and allergens.
To assure a constant level of cleanliness and sanitation.
To model health and hygiene habits for the children and families.
To comply with licensing requirements.

PROCEDURE: Daily cleaning: A seven-step method.

1. Remove all trash and litter from all areas of the classroom. Replace plastic liners in all trashcans.

2. "High dusting" - Dust everything above shoulder level with a long-handle mop, sprayed lightly with water to prevent dust from flying.

3. "Dry Dusting" - Mop the floor with the same dust mop as above. Vacuum all carpets and spot clean as necessary.

4. Damp wipe all surfaces with a germicidal solution.
   a. counters
   b. doors
   c. cabinets
   d. furniture: tops, sides, fronts
   e. tables and chairs
   f. desks
   g. lower parts of walls

5. Scrub sinks, toilets, and dividers with a disinfectant cleanser. Clean mirror with glass cleaner.

6. Damp mop smooth floors with a germicidal solution (do bathroom floors last), use a cloth for corners and baseboards.

7. Stand back and look… --- Would you bring your child here?

G. ENVIRONMENT

Daily Environmental Assessment	G-01
Monthly Environmental Assessment	G-02
Smoking and Substance Use	G-03
Weapons Ban	G-04
Ventilation and Air Quality	G-05
Pest Control	G-06
Facility Safety Inspection	G-07
Lead Water Testing Requirement	G-08
Lead Poisoning Prevention	G-09
Lead is Poison Flyer in Multiple Languages	G-10

DAILY ENVIRONMENTAL ASSESSMENT

POLICY: Each childcare will conduct a daily inspection of the facility and grounds prior to being used by children. The assessment will be done by the Director, Health Advocate, or designee.
All potential risk situations will be attended to and corrected immediately.
Safety is the responsibility of every member of the staff.

PURPOSE: To assess the health and safety of the environment.
To have an opportunity to correct problems.
To provide the safest environment possible consistently.
To assure everyone is aware of their responsibility for the safety of children and staff.

PROCEDURE:

1. Assure cleaning, sanitizing, and disinfecting are effective. Look at:
    a. Bathroom floor, toilets, sinks and walls.
    b. Garbage has been emptied.
    c. Carpets and floors for evidence of vacuuming.
        - are dangerously small items or trash lying around?
        - is sand or dirt evident?
    d. Counter tops, sinks and surfaces for dust or dirt.
    e. Kitchen floor, counters, stovetop, and storage.
2. Assess the temperature and ventilation of the area.
    a. Read and record the room temperature.
    b. Read and record the refrigerator and freezer temperatures daily
    c. Run the tap water for 2 minutes if you have old plumbing to minimize lead exposure. Check the water temperature to be less than 120 F.

   d. Hot water temperature at sinks used for handwashing or where the hot water will be in direct contact with children should be at a temperature of at least 60°F and not exceeding 120°F (Caring for our Children, Chapter 5.2.1.14). Licensing regulations state that water temperature should be between 105°F to 120°F.

   e. When windows or doors are open, check that screens are intact and that window guards are installed if applicable for safety.

3. Check that the security systems are working properly.

   a. Close and test the gate security and locks.

   b. Assure that telephones are working and turn on computers.

   c. Check the fire-alarm system and record that it is operational and is trouble free.

   d. Spot-check fire extinguishers to make sure they are holding a charge.

   e. First aid kits and emergency equipment are secure, available, accessible, and fully stocked (no expired antiseptics and emergency supplies).

4. Look at room arrangements.

   a. All exits must be totally clear as well as the path of exit. Each facility must have at least 2 exits.

   b. Traffic patterns must not require passage through "dirty areas" in order to reach "clean areas".

5. Inspect the yard.

   a. Look for and remove debris or animal droppings.

   b. Check for damage to equipment or fencing.

   c. Assure that sandbox is in its proper place and covered when not in used

6. Make sure there are no tools, ladders, standing water, poisonous plants or other dangers left in any child area.

7. Check staff preparation.

    a. Review staff to child ratios.

    b. Orient new or substitute staff to:

        - evacuation routes
        - any children with special needs
        - standards of care for your program
        - specific duties and responsibilities
        - supplies needed and where they are stored.

    c. Personal items are locked and out of reach of the children. (handbags/backpacks).

    d. Follow licensing requirements and regulations. Cal Code Title 22 Section 101239

MONTHLY ENVIRONMENTAL ASSESSMENT FORM

POLICY: Each childcare will conduct a monthly or routine inspection of the facility. The assessment will be done by the Director, Health Advocate or designee.
All potential risk situations will be reported and corrected in a timely manner.

PURPOSE: To assess and provide a healthy and safe environment.
To have an opportunity to correct problems.

PROCEDURE:

Facility: ____

Date: ____________ Inspector: ______________________________

	DEFICIENCY	CORRECTED
Outdoors:		
1. Uncluttered		
2. Bushes trimmed		
3. Uneven surfaces clearly marked		
4. Cement in good repair		
Playgrounds:		
1. Clean and uncluttered (no glass, nails, debris)		
2. Equipment (stable, in good repair, dry)		
3. Sandbox clean, sandbox cover available		
4. Toys and riding equipment in good repair		
5. Drinking fountain clean and working		
6. Stairs blocked off		
7. Review and follow: Title 22 Buildings and Grounds Regulations		

	DEFICIENCY	CORRECTED
Offices:		
1. Uncluttered and dry		
2. Sharp and small objects stored away		
3. No substantial objects on open shelves or cabinets above 3 feet, i.e. where they could fall in an earthquake.		
4. Wires (in good repair, taped to floor)		
5. Outlets (sufficient amount, with plug covers)		
6. Furniture stable with edges protected		
7. Tall furniture (above 3 feet) secured to wall		
Kitchens:		
1. Uncluttered, floor dry, door or barrier in place to prevent children's access.		
2. Stove knobs protected, surface clear		
3. Cleaning supplies locked and stored		
4. Counter tops (clean, uncluttered, equipment away from edges)		
Bathrooms:		
1. Clean, uncluttered, and dry		
2. Fixtures in good repair (toilet, sinks, step stools)		
3. Dispensers filled- soap, toilet paper, paper towels		
Classrooms:		
1. Clean, uncluttered and floor dry		
2. Trash removed		
3. Fire extinguishers present and checked by fire department within the year		

	DEFICIENCY	CORRECTED
4. Fire alarm operational		
5. Smoke detectors and carbon monoxide detectors operational		
6. Protective covers on outlets		
7. Tall furniture secured to floor or wall		
8. No open storage above children's heads		
9. Windows in good repair (no broken glass anywhere)		
10. Sinks clean and operational		
11. Furniture (in good repair, edges protected)		
12. Lighting sufficient and operational		
13. Toys (in good repair, stored neatly, age appropriate). No toys less than 3 cm in diameter for rooms with children under 3 years old.		
14. Flooring secured, flat, non-skid rugs		
15. No decorations hanging from ceiling or lights		
16. Paper on walls covers 30% or less		

Definition: *in good repair*

In the condition it was when new, operational, safe; any and all repairs have restored it to its original level of operation and safety.

Write comments on reverse.

Date submitted to Supervisor: ___________________

Supervisor Signature: ___________________________

SMOKING AND SUBSTANCE USE

POLICY: Smoking and/or the use of tobacco products or smokeless tobacco (e.g. vaping), alcohol, cannabis, or illicit substances in any form is prohibited on the child care facility premises, including outdoors spaces.

Assembly Bill No. 615 Chapter 335 California Health and Safety Code, Section 1596.795 This bill prohibits smoking in day care facilities, including private residences. https://ww2.arb.ca.gov/our-work/programs/environmental-tobacco-smoke/california-tobacco-laws-reduce-ets-exposure)

PURPOSE: To maintain the health and safety of the environment.
To prevent airborne pollutants.
To provide the safest environment possible consistently.
To assure everyone is aware of their responsibility for the safety of children and staff.
To comply with licensing regulations.

PROCEDURE:

1. Do not allow smoking, tobacco products, vaping, or other air pollutants to infect your premises, including indoor air or your outdoor play areas.
2. Post notices to warn all who enter your gate that it is a smoke-free environment.
3. Staff clothing should not smell of smoke. Staff who smoke off premises should wash hands and change clothing prior to contact with children.
4. Institute disciplinary action against any offenders.
5. The use of cannabis, illicit substances, or alcohol by staff on the premises or while caring for children, including use before arrival, during breaks, or during lunch, **is a serious safety and legal concern**.
    a. Institute disciplinary action, consider termination. Notify licensing and complete an incident report. Follow site policies.

   b. The use of alcoholic beverages and legal drugs in family child care homes after children are not in care is not prohibited, but these items should be safely stored at all times.

6. Review Health and Safety Code Section 1596.795:
   https://www.daycare.com/california/state79.html

7. Caring for Our Children, Chapter 3, Tobacco, and Drug Use:
   https://nrckids.org/CFOC/Database/3.4.1.1

WEAPONS BAN

POLICY: There are NO weapons of any sort allowed on the premises of the childcare center.

PURPOSE: To assure the safety of children and staff.
To remove the threat of violence.
To provide the safest environment possible consistently.
To assure everyone is aware of their responsibility for the safety of children and staff.

PROCEDURE:

1. Call 9-1-1 immediately to report any weapon seen or found on the premises.

2. Assist the authorities during investigation if applicable.

3. Post signs declaring the policy where all who enter can see.

4. Toy weapons are to be confiscated and returned to the parent at the end of the day.

5. "Firearms and other weapons are not allowed on the premises of a childcare center. In family childcare homes, guns and ammunition must be locked in a gun safe or other storage unit, or guns must have a trigger lock on, or the firing pin may be removed from the gun and stored separately. Guns and ammunition must be stored apart from one another. There is zero tolerance for failing to keep guns stored and locked as required. Gun and ammunition violations result in a citation and a civil penalty (CDSS, 2016)."

VENTILATION AND AIR QUALITY

POLICY: Each staff member will be alert and aware of the importance of ventilation and air quality to the health, quality of life and the child's experience while at our childcare. The facility will be aired out daily. The mechanical ventilation system will be maintained in a safe and healthy fashion according to manufacturer's recommendations.

PURPOSE: To maintain the health and safety of the environment.
To remove airborne pathogens.
To provide the safest environment possible consistently.
To assure everyone is aware of their responsibility for the safety of children and staff.

PROCEDURE:

1. Open doors or window in classrooms to provide fresh air throughout the day.
   a. Open windows not more than 3.5 inches or per site policy.
   b. Consider outdoor air quality and follow instructions per Bay Area Air Quality Management District at https://www.baaqmd.gov/.
      i. **See section H33 and H34 of this manual for additional information on air quality.**
   c. Windows must be designed in a way that prevents children from falling or climbing out of the window, or have protective barriers installed on them.
2. Assure filters on heating and air conditioning units are changed at least annually and more often if recommended by the service person or contract.
3. During warm months, call the local Bay Area Air Quality Management District at 415-749-5000 for current information on the air quality and recommendations for outdoor play and asthma care, or visit https://www.baaqmd.gov/about-air-quality/current-air-quality
4. Reduce pollutants indoors and prohibit smoking. Follow the bill prohibiting smoking in day care facilities, including private residences. Law section (ca.gov)
5. Review and follow recommendations on ventilation in schools at childcare from CDC Ventilation in Schools and ChildCare Programs (cdc.gov)
6. See Guidance for Building Operations During the COVID-19 Pandemic

PEST CONTROL

POLICY: The childcare facility will be kept free of insects, rodents, and pests.

PURPOSE: To maintain the health and safety of the environment.
To provide the safest environment possible consistently.
To assure everyone is aware of their responsibility to the safety of the children and staff.

PROCEDURE:

1. Screens on doors and windows to the outdoors must be intact and in place at all times.

2. Keep food areas clean and neat at all times. Wipe up spills immediately. Cover and label all foods stored on the premises.

3. Do not use toxic sprays, chemicals, powders, or aerosols to eliminate pests.

4. Maintain a contract with an exterminator who understands the sensitivity of childcare environment and has approved methods of pest control.

5. Arrange for pest control to be done when children are not present and will not be present for at least 24 hours.

6. Review and follow California School & Child Care Integrated Pest Management (IPM). This training must be completed annually. QR Code available on next page.

7. Take a DPR Healthy Schools Act Online Course

    a. *Training will not work in Safari browser. Make sure browser is up to date with the most current version.

8. Classroom Spiders Best Management Practices, PDF | En Español, PDF

9. Schoolyard Spiders Best Management Practices, PDF | En Español, PDF

10. Preventing Termites, PDF | En Español, PDF

11. Ant IPM Managing Ants Inside Schools, PDF | En Español, PDF

12. Classroom Pest Prevention Tips, PDF | En Español, PDF

13. Carbon Monoxide Devices for Managing Burrowing Rodents at Schools, PDF | En Español, PDF

14. Integrated Pest Management for Child Care Programs, PDF | En Español, PDF
15. Reminders for Using Disinfectants at Schools and Child Cares, PDF | En Español, PDF
16. School District Integrated Pest Management Plan Template, PDF
17. 2023-2024 School IPM Recordkeeping Calendar

QR Code to IPM Training:

FACILITY SAFETY INSPECTION

PLEASE INSPECT YOUR SITE FOR THE FOLLOWING CONDITIONS.
NOTIFY YOUR DIRECTOR OF ANY UNSAFE CONDITIONS.

- ❑ All objects stored above shoulder level should be secured to wall surfaces, not to tip, or fall.
- ❑ Store all heavy objects on the lowest shelves.
- ❑ Separate all glass objects in such a manner that they will not be jolted against each other or against other objects which would cause them to break.
- ❑ Store chemicals on low shelves with child safety locks.
- ❑ Inspect all areas for loose items that might tip or fall during an earthquake (including statues, display items, pictures, etc.) and secure them to wall surfaces or relocate them away from child areas.
- ❑ DO NOT allow access to doors or other exits to be blocked or partially blocked at any time.
- ❑ DO NOT leave doors to storage cabinets open and unlatched when the cabinets are not in use.
- ❑ DO NOT let glass containers of materials accumulate on counter tops or other work spaces; put them back into proper storage areas when you have finished using.
- ❑ DO NOT allow electrical cords to extend across walkway or exit ways. Remove them immediately after use and store them properly.
- ❑ DO NOT suspend flammable material or other objects from ceilings or from light fixtures.

LEAD WATER TESTING REQUIREMENT

POLICY: Childcare center facilities built before January 2010 will have their water outlets tested for lead by a certified professional lead assessor every 5 years and submit results to their licensing office. Family childcare homes can test their water for lead through the SFPUC.

PURPOSE: To protect the health of children from lead poisoning. To comply with state laws and licensing regulations.

PROCEDURES FOR CHILD CARE CENTERS (CCC'S)

1. Per Health and Safety Code 1597.16 and Assembly Bill 2370 Statutes of 2018, the new state law requires all Child Care Centers (CCC's) constructed before January 1, 2010, to test their water sources for lead by January 2023, with subsequent testing every 5 years after the date of the first test.

2. For new childcare licenses issued after July 2022, lead water testing is required within 180 days of licensure.

3. This requirement for lead testing does not apply to Family Child Care Homes (FCC's), although FCC's are highly recommended to test their water for lead (see FCC section on next page).

4. For detailed requirements of the lead testing, please carefully review PIN 21-21 CCP

5. A list of certified lead assessors can be found at: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/CertListSF.aspx

6. The center shall direct the External Certified Water Sampler to work with an accredited environmental laboratory (ELAP) who will provide results of lead testing to the State Water Board, the Certified External Water Sampler, and the Child Care Center.

7. The certified lead assessor must complete form LIC 9275.

8. A result of **5.0 ppb** or higher will indicate the water is unsafe for drinking and immediate action is required.

9. There is some limited availability of State and Federal Funding to test drinking

water for lead contamination in childcare centers and for remediation (correction). PIN 21-04-CCP contains links to both the state and the federal options for funding assistance. **This funding is subject to availability and may be discontinued at any time.**

10. Application for state funding assistance to determine your eligibility for funding: https://ab2370assistance.owp.csus.edu/

11. A vast amount of detailed information on the lead testing requirements can be found at: Water Testing Information (ca.gov)

PROCEDURES FOR FAMILY CHILD CARE HOMES (FCC'S)

12. Lead testing by a certified lead assessor can be expensive and is not required for FCC's. However, San Francisco homes are usually old buildings which pose risks of lead in old water pipes, in old paint on walls, in the soil, and other sources. FCC's are highly recommended to do their own assessment for risks and water testing - $25 through SFPUC.
13. Call 3-1-1 or call the SFDPH Childhood Lead Poisoning Prevention Program (CLPP) at **415-252-3800** to request a **free** lead assessment and determine your home's risk of lead contamination. CLLP website for more information: https://www.sfdph.org/dph/eh/cehp/lead/default.asp

14. To test lead in your tap water, you can collect samples yourself and submit them to the San Francisco Public Utilities Commission (SFPUC) Water Quality Division. The cost is $25 per sample.

    a. Complete this application and call 415-551-3000 to schedule the testing. Water Quality Division (sfpuc.org)

LEAD POISONING PREVENTION

POLICY: Our childcare program will make every effort to protect children from lead exposure.

PURPOSE: To comply with state law.
To protect the health of children because:

- The presence of lead hazards on a property with children under 6 years old is a violation of the San Francisco Health Code. Remediation will be mandatory by state law and a childcare licensing citation may be issued.

- Lead poisoning has no early symptoms in children. Lead poisoning can cause permanent brain damage including developmental delays, learning problems, intellectual disability, aggression, and anti-social behavior problems, as well as hearing loss, organ damage, dental cavities, and more. Even low levels of lead can cause lasting neurological harm.

- "Exposure to lead in the preschool years significantly increases the chance that children will be suspended or incarcerated during their school careers.... Among boys, a one-unit increase in blood lead levels raised the probability of incarceration by 27 to 74 percent" Source and Article: https://spia.princeton.edu/news/decrease-lead-exposure-early-childhood-may-be-responsible-drop-crime-rate

- Children under 6 years old and unborn babies are at the greatest risk of serious lead poisoning from to low levels of lead exposure, compared to older children or adults. Children ages 0-6 and pregnant people should avoid any potential lead exposure.

- It is a licensing requirement to provide the Risks and Effects of Lead Poisoning brochure (PUB 515 – available in section N) to each family upon enrollment in licensed childcare, for centers and childcare homes.

PROCEDURE:
Children are exposed to lead through eating the lead because they put lead-contaminated hands, or food, or other objects into their mouths. The childcare site should eliminate potential sources of lead in the childcare environment. Common sources of lead and prevention strategies include:

1. Water

a. See section G-8 on testing drinking water for lead.

b. For older plumbing: Flush the tap for 30 seconds to 2 minutes before using the water for drinking or cooking. Water in pipes and faucets may become contaminated with lead from brass faucets or lead solder when water has not been taken from the tap for more than 6 hours.

c. Use only cold tap water to drink, cook food, or prepare baby formula. If you need hot water, take it from the cold water tap and heat it.

d. Many water filters do not take lead out. If you buy a water filter, be sure that is says that it removes lead or be sure to test your faucets for lead.

e. Do not store drinking water in a clay pottery pitcher.

2. Chipping paint or any remodeling work done on buildings built before 1979

a. Any amount of chipping paint should be immediately blocked off from access to children and remediated as soon as possible.

b. Before starting any repair, remodeling, or construction projects that could disrupt the paint on the walls, seek detailed guidance from the SFDPH Childhood Lead Poisoning Prevention Program (415-252-3800) on how to minimize the spread of lead during the construction.

   i. If renovation and repair work on a pre-1979 building is not properly contained and all dust and debris is not subsequently cleaned up, it is considered a violation of the San Francisco Building Code.

c. Some younger children will mouth/bite on windowsills within reach, especially while teething. Do not allow biting/mouthing/teething on painted windowsills.

3. Soil and dirt

a. Before gasoline fuel was "unleaded" in 1995, cars driving around the city released lead in the air which has settled into the soil around us. Lead in soil does **not** go away over time. Some areas of soil have much higher lead levels than other areas, but all soil and dirt should be treated as potentially containing lead. You can reduce exposure risk by:

b. Removing outdoor shoes inside the center or home.

c. Washing hands well after playing in dirt or gardening.

d. Regularly washing of floors with water.

e. Using new soil to grow food in a garden.

f. Covering bare or uncovered dirt/soil in your yard.

4. **Ceramic glaze on pottery**
   a. Do not serve water or food stored in clay pottery and do not cook food in clay pottery unless a lead test has been done on the pottery. Especially if the pottery was made outside of the U.S.

5. **Metals in jewelry, keys, toys, etc.**
   a. Be aware that lead is often found in metals and some plastics. Avoid metal objects or test each potential object that children regularly play with or put in their mouth using a home test kit.

   b. If families have placed metal jewelry, cultural amulets, etc on their children, speak to the parents about them testing the item for lead as well as risks of jewelry being a choking hazard.

6. **Plastic coating on cables and cords**
   a. Keep all electric cables and cord out of reach of children, especially young children prone to mouthing/chewing on cords.

7. **Toys and art supplies**
   a. Lead is found in plastic parts or metal parts of some toys, some children's products like baby bottles, sunglasses, and every day items, especially if the item was manufactured outside of the U.S. It can be impossible to predict that some common toys or items have high lead levels! It is recommended to sign up for email updates on recalled items by the Consumer Product Safety Commission to find out if lead has been found in commonly sold children's products. Link to sign up for email alerts on recalls: Recalls | CPSC.gov

   b. You can also try to avoid purchasing toys and products manufactured outside of the U.S. because many other countries do not enforce or even require safety testing of manufactured items for lead levels.

8. **Dust**
   a. Dust can sometimes contain lead, therefore, clean floors and surfaces regularly and wipe down dusty surfaces with a wet disposable cloth.

9. **Make up**
   a. Some traditional or cultural make up products like Surma, Kohl, Kajal, etc. can have high levels of lead. If a parent is using eye liner or similar product

on their child for cultural reasons, talk to the parent about testing the make up for lead. The use of eye liner on infants and children is sometimes practiced by some families from India or Pakistan, in both Muslim and Hindu cultures.

10. **Occupational exposure** to facilities working with metals like fishing weights, bullets, recycling facilities, construction, and remodeling work, etc.

    a. Adults exposed to lead at work can transfer lead particles from their clothing or shoes to children. Workers should change their clothes and bathe before coming into contact with children.

11. Some **candy** manufactured in other countries (e.g. Miguelito chili powder and Rockaleta Junior lollipops from Mexico, etc).

12. Some **traditional spices and herbal remedies** that are imported from outside of the U.S (e.g. Arazcon and others).

13. Children who are **deficient in vitamins**/nutrients will absorb higher levels of lead from lead exposure compared to children with healthy nutrition. Eating enough Vitamin C, calcium, and iron reduces the risk of lead poisoning if exposed.

14. Children with Medi-Cal or publicly funded programs are required to have their blood levels tested by their healthcare provider at age 1 and at age 2. Children with private insurance or who are not receiving subsidized services may not always be offered a lead test. Parents may ask their healthcare provider for a lead test at any time, and **every child should have at least 1 lead test before age 6.**

15. For any questions regarding lead poisoning, and lead related resources, please contact the SFDPH Childhood Lead Poisoning Prevention Program at 415-252-3800 or visit SFDPH - Lead Prevention Info for Child Care Providers

16. For Home Lead Hazard Investigation, please **call 311** to reach out to SFDPH Childhood Lead Prevention Program. Scan QR code below to access their program website:

LEAD is a Poison!

Most common sources of childhood lead poisoning

Damaged paint in homes built before 1979

Cracked or peeling lead-based paint creates paint chips and lead dust that can be accessible to children in the home and through contact with bare soil. Fix damaged paint with lead-safe practices and replace or cover bare soil.

Unsafe work practices create lead dust

Pre-**1979** homes can become contaminated with lead due to improper remodeling. Always hire a lead-certified contactor to do home repairs and renovations. Requiring lead-safe work practices in your home will protect children, pets and the environment.

Lead dust from work and hobbies

Construction, painting, gardening or recycling centers; as well as, activities like fishing, or making jewelry, pottery or stained glass can track lead dust back to the house. Change clothes and shoes before leaving work and wash your hands and face; shower immediately when you get home.

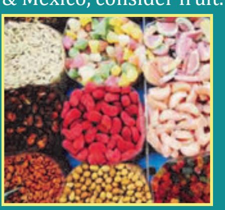
Other potential sources of lead

Some...

Imported products

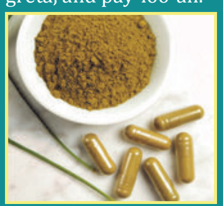
Some consumer products have been found to contain lead, such as:

Candies
Instead of candy from Asia & México, consider fruit.



Spices
Avoid bright powdered spices from Asia.

Home Remedies
Don't use azarcon, greta, and pay-loo-ah.



and...

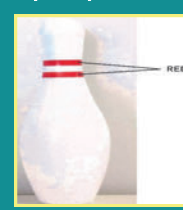
Art Supplies
Some children's arts and crafts products are recalled due to violation of paint standard. Unless labeled "Meets ASTM D-4236".

Ceramic Ware
Paint and glaze in tableware may have lead. Do not purchase items with Prop. 65 Warning.

Jewelry & Keys
Metal parts in jewelry and brass keys may contain high levels of lead. Swallowing an item can be fatal.

Makeup
Some lipsticks and traditional makeup have lead. Avoid kohl, surma, kajal, & sindoor.

Toys
Lead has been found in the paint, glaze and metal parts of various toys. Buy US made toys.



Cables & Cords
Lead in the plastic coatings may be swallowed. Prevent children from sucking or chewing.

To learn more, visit the Consumer Product Safety Commission: www.cpsc.gov

Lead Poisoning

- Affects learning & behavior
- Decreases intelligence
- Causes dental cavities
- Decreases hearing ability
- Damages organs

Take Action!

- Ask your child's doctor to test for lead at the ages of 1&2, or once before the age of 6
- Wash hands with soap and water before and after meals and play
- Give your child food rich in vitamin C, calcium and iron
- Ask your landlord to fix damaged paint and cover bare soil
- Call us for a free home inspection, we'll work with the landlord to fix lead hazards

It's your child's health–protect it!

For more information, contact: Children's Environmental Health Promotion Program | San Francisco Department of Public Health
1390 Market Street, Suite 210, San Francisco, CA 94102 | www.sfdph.org/dph/eh/cehp/lead 311

Blood Lead Levels

What Do They Mean?

A blood lead test gives an idea of how much lead your child has been recently exposed to in the environment. Children with lead in their blood may not look or act sick, but learning and behavior problems may show up years later when they go to school.

Blood Lead Test Result	What Does It Mean?	When To Get Another Blood Test?	What Can You Do?
0	**Your child has no detectable lead in their body.**	Ask your doctor to test your child for lead at 1 & 2 years of age or once before the age of 6.	› Avoid sources of lead › Give your child iron, calcium, & vitamin C rich food › Wash hands and face before eating and after play › Keep home paint intact and dust free › Use a wet sponge or mop to clean floors and windows
1-9	**No amount of lead in the body is normal or safe.** Your child has been exposed to some amounts of lead.	Retest if your child's risk of lead exposure changes. For example: If you move to an older home with chipped or peeling paint, if someone in your home works in construction, gardening, etc., or have travelled outside of the US.	All of the above, and... › See back of this form for information on lead hazards around your home (Lead is a Poison) › Follow best practices if someone in your household works in construction, landscaping, etc. › Our program will provide information and offer a home visit to help look for lead hazards at home
10-14	Your child has been exposed to some amount of lead in their environment.	**1-3 months** Call your doctor to have your child re-tested for lead	All of the above, and... › At a Blood Lead Level of 10 and above a Public Health Nurse will make a home visit to provide follow-up care within two weeks of test result › An inspector will join the home visit to find sources of lead in the home
15-19	Your child has been exposed to moderate amounts of lead in their environment.	**1-3 months** Call your doctor to have your child re-tested for lead	All of the above, and... › Home visit done within one week of test result
20-44	Your child has been exposed to large amounts of lead in their environment.	**1 week then 1 month** Call your doctor to have your child re-tested for lead	All of the above
45-69	Your child has been exposed to very large amounts of lead in their environment.	**As Soon As Possible, within 48 hours** Call your doctor to have your child re-tested for lead	All of the above, and... › Your child may require specialized medical treatment in the hospital. Call your doctor ASAP for a confirming blood test and lead poisoning checkup › Home visit done within 48 hours of test result
Above 70	**Medical Emergency:** Your child has been exposed to dangerously high amounts of lead in their environment.	**Seek IMMEDIATE medical attention**	All of the above, and... › Your child requires specialized treatment in the hospital **NOW!** › Home visit done within 24 hours of test result

鉛是有毒的物質！

鉛毒的普遍來源

源自1979 年以前建造樓房的破爛油漆

破裂或剝落的油漆導致兒童接觸含鉛的油漆碎片、塵埃及泥土

不安全的施工方法會產生鉛塵

在 1979 年以前建造的樓房進行翻修時若採取不適當的工序會導致鉛塵的產生，從而污染家居和環境。僱用具處理鉛認可資格的承辦商，及使用安全施工方法來保護你的孩子、寵物、及環境。

來自一些工作行業和活動

以下的工作及活動可能將鉛塵帶回家裡 ： 建築、髹漆、園藝種植、回收、釣魚、和珠寶、陶器、或彩色玻璃製造。回家後，需盡快洗澡或淋浴。

鉛的其它潛在來源

其它... 進口產品

進口糖果
以吃水果來取代糖果

香料
避免使用來自亞洲的鮮艷粉末香料

坊間草、成藥
避免使用，並請教醫生

以及 ..

美術產品
一些兒童美術產品因含超標的鉛而被回收。印有 “Meets DSTM-4236” 的產品可安全使用

陶瓷器皿
可能有鉛釉。不要買 65 議案警告（黃色三角標誌）的產品

金屬首飾和鑰匙
一些項鍊、戒指、手鐲、飾物、及鑰匙被測試出含鉛。吞下這些物品會可能致命

化妝品
一些唇膏、以及來自中東的眼線曾被驗出含鉛

玩具
鉛存在於一些玩具的油漆、彩料及金屬

電視及電腦膠纜
膠纜外層含鉛。兒童可能觸摸、咀嚼或吮這些含鉛產品

有關產品含鉛的資訊，瀏覽消費者產品安全委員會網址：

www.cpsc.gov

鉛對健康構成的風險

- 影響學習及行為
- 降低智商
- 引致蛀牙
- 減低聽覺
- 損害身體器官

採取行動！

- 請醫生為孩子在一歲及兩歲或六歲前至少一次做鉛毒檢測
- 用餐前後或玩耍後，使用肥皂和水為孩子洗手
- 給孩子吃含豐富維生素 C、鈣質及鐵質的食物
- 請求業主維修破爛油漆及覆蓋光禿的泥土
- 聯絡我們的辦公室，安排免費家居環境檢查。我們會與您的業主協作解決

這是你孩子的健康 — 請保護它！

查詢更多資料，聯絡：兒童環境衛生促進計劃 | 三藩市公共衛生署
1390 Market Street, Suite 210, San Francisco, CA 94102 | www.sfdph.org/dph/eh/cehp/lead

311

血含鉛量程度

程度數字代表甚麼意思？

血含鉛量檢測可讓您了解你的孩子近期接觸了多少存在環境裡的鉛。即使孩子的血內含鉛，但外貌和行為上看起來可能不像生病，可是在日後求學階段時或許因受鉛影響而出現學習和行為問題

血含鉛量檢測結果 每百毫升血液含鉛量（微克）	數字代表甚麼意思？	何時接受另一次血含鉛量檢測？	你能做些甚麼？
0	你孩子的體內沒有被檢測到存有鉛	請醫生為你的孩子在他/她一歲及兩歲、或六歲以前至少一次做鉛毒檢測	› 避免接觸含鉛的物件 › 給孩子吃含豐富維生素C、鈣及鐵質的食物 › 進食前，先洗手及臉 › 保持家居油漆完整和潔淨無塵 › 經常用濕海綿及拖把分別清潔窗和地板
1-9	體內即使只有微量的鉛都是非正常和可能危害健康 你的孩子曾接觸一些鉛	假若你的孩子暴露於環境裡的鉛危害情況有變，他/她應接受複檢，例如：如果你搬到一所有油漆剝落的老舊房子、或你的家人是從事建築行業或園藝等活動、或最近曾離開美國到外地旅遊	做上述的事項，並且… › 參巧後頁「鉛是有毒的物質」的教育資料，讓你認識你樓房周圍的鉛危害 › 如果的家人有從事建築行業或園藝活動，叮囑他們採取最佳的施工方法 › 聯絡我們的辦公室索取預防鉛中毒的教育資料及要求免費家居環境鉛危害的檢查
10-14	您的孩子已經在環境中接觸到一些鉛	**一至三個月內** 打電話給醫生為孩子安排另一次血含鉛量檢測	做上述的事項，並且… › 當血含鉛量達致10 或以上，公共衛生護士會進行家訪，提供相關的跟進護理 › 環境衛生檢查員參與家訪，尋找鉛的來源
15-19	您的孩子已經在環境中接觸到一些鉛	**一至三個月內** 打電話給醫生為孩子安排另一次血含鉛量檢測	做上述的事項，並且… › 家訪需於血含鉛檢測後一星期內進行
20-44	您的孩子已經在環境中接觸到大量鉛	**一星期內，然後一個月內** 打電話給醫生為孩子安排另一次血含鉛量檢測	做上述的事項
45-69	您的孩子已經在環境中接觸到非常大量的鉛	**盡快，在 48 小時內** 打電話給醫生為孩子安排另一次血含鉛量檢測	做上述的事項，並且… › 您的孩子可能需要到醫院接受專門的鉛中毒治療。盡快打電話給醫生安排另一次確診鉛毒的抽血檢驗和鉛中毒的檢查 › 家訪需於血含鉛檢測後 48 小時內進行
70 以上	**緊急醫療狀況：** 您的孩子已經在環境中接觸到高危險程度的鉛	**立即** 求醫	做上述的事項，並且… › 您的孩子**現在**需要馬上到醫院接受專門治療！ › 家訪需於血含鉛檢測後 24 小時內進行

¡El Plomo es un Veneno!

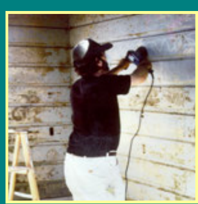
Fuentes más comunes de envenenamiento de plomo

Pintura dañada en viviendas construidas antes de 1979

Grietas o pintura pelada crea pedacitos de pintura y polvo con plomo que pueden ser accesibles a los niños en el hogar y por el contacto con la tierra. Corrija la pintura dañada con prácticas seguras de plomo y reemplace o cubra la tierra.

Practicas de trabajo inseguras crean polvo de plomo

Casas construidas antes de 1979 pueden contaminarse con plomo debido a una remodelación inadecuada. Siempre contrate a un contratista certificado para trabajar con plomo para hacer reparaciones del hogar. Exija prácticas de trabajo seguras con plomo en su casa así protegerá a los niños, mascotas y el medio ambiente.



Polvo de plomo del trabajo y pasatiempos

Trabajar en construcción, pintura, jardinería o centros de reciclaje, así como realizar actividades de pesca o fabricación de vidriería, joyería, o cerámica puede llevar polvo de plomo a casa. Cambie su ropa y zapatos antes de dejar el trabajo y lave sus manos y cara; bañarse en cuanto llegue a casa.

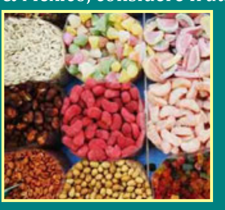
Otras fuentes potenciales de plomo

Algunos...

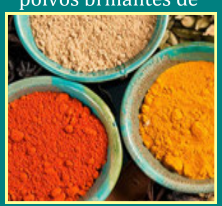
Productos importados

Se ha encontrado plomo en algunos productos de consumo, tales

Dulces
En lugar de dulces de Asia & México, considere fruta.



Especias
Evite especias en polvos brillantes de



Remedios Caseros
No use azarcon, greta, y pay-loo-ah.

y...

Artículos de arte
Algunos artículos de arte y artesanías son retirados por excesos de plomo. Al menos que se etiqueten, "Meets ASTM D-4236".

Cerámica
La pintura y el esmalte en cerámicas pueden tener plomo. No compre artículos con la advertencia de la proposición 65

Joyería y llaves
Las piezas metálicas en joyas y llaves de latón pueden contener altos niveles de plomo. Puede ser fatal tragar una pieza.

Maquillaje
Algunos lápices labiales y maquillaje tradicional tienen plomo. Evite kohl, surma, kajal, & sindoor.

Juguetes
La pintura, el esmalte y metal de varios juguetes contienen plomo. Use los que están hechos en US.

Cables suaves
El plomo en las capas de plástico puede tragarse. Evitar que los niños chupen o mastiquen.

Para obtener más información, visite la Comisión de Seguridad de Productos para el Consumidor: www.cpsc.gov

Envenenamiento por plomo

- Afecta aprendizaje y conducta
- Disminuye la inteligencia
- Causa caries dentales
- Disminuye la capacidad auditiva
- Daña los órganos

¡Tome Acción!

- Pídale al medico de su hijo que le haga la prueba de plomo a la edad de 1 & 2 años, o una vez antes de los 6 años
- Lavar las manos con agua y jabón antes y después de comer, jugar y dormir
- Dele a su hijo alimentos ricos en vitamina C, calcio y hierro
- Pídale al propietario de la casa que arregle la pintura dañada y cubra la tierra
- Llámenos para una inspección gratuita de casa, trabajaremos con el propietario para arreglar los peligros de plomo

Es la salud de su hijo — ¡Protéjala!

Para más información, contacte a: Programa de Salud Ambiental de los Niños | Departamento de Salud Publica de San Francisco
1390 Market Street, # 210, San Francisco, CA 94102 | www.sfdph.org/dph/eh/cehp/lead
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Niveles de Plomo en la Sangre

¿Que Significan?

La prueba de detección de plomo en la sangre da una idea de la cantidad de plomo a la que su hijo ha estado expuesto en su medioambiente recientemente. Los niños con plomo en la sangre podrían no verse o parecer enfermos, pero los problemas de comportamiento pueden presentarse mucho tiempo después, cuando vayan a la escuela.

Resultados de la prueba de sangre	¿Qué significan?	¿Cuándo hay que recibir otra prueba de detección de plomo?	¿Qué puede hacer usted?
0	**Su hijo no tiene plomo detectable en su cuerpo.**	Pídale a su doctor que le haga la prueba de plomo a su hijo al año y 2 años de edad o una vez antes de los 6 años.	› Evite las fuentes comunes de plomo › Dele a su hijo alimentos ricos en hierro, calcio y vitamina C › Lavar las manos y cara antes y después de comer y jugar › Mantenga la pintura intacta y la casa libre de polvo › Use una esponja o un trapeador húmedo para limpiar los pisos y los bordes de ventanas
1-9	**Ninguna cantidad de plomo en la sangre es normal o segura.** Su hijo ha estado expuesto a una pequeña cantidad de plomo.	Haga otra prueba si el riesgo de exposición al plomo de su hijo cambia. Por ejemplo, si se muda a una vivienda más vieja con pintura dañada o descascarada, si alguien en su casa trabaja en la construcción, jardinería, etc., o a viajado al extranjero.	Todo lo anterior y... › Consulte atrás de esta forma para información sobre algunas fuentes de plomo (El Plomo es un Veneno) › Siga las prácticas recomendadas si alguien en su casa trabaja en construcción, jardinería, mecánica, etc. › Nuestro programa le proporcionará información y le ofrecerá una visita gratuita a su hogar para ayudarle a detectar los riesgos de plomo en su hogar
10-14	Su hijo ha estado expuesto a una cantidad de plomo en su medioambiente.	**1-3 meses** Llame al médico de su hijo para obtener otra prueba de plomo	Todo lo anterior y... › Si su hijo tiene un nivel mayor de 10 una enfermera de salud pública visitará su hogar para dar atención y seguimiento dentro de dos semanas de los resultados de la prueba de plomo › Un inspector se unirá a la visita de casa para encontrar fuentes de plomo en el hogar
15-19	Su hijo ha estado expuesto a cantidades moderadas de plomo en su medioambiente.	**1-3 meses** Llame al médico de su hijo para obtener otra prueba de plomo	Todo lo anterior y... › La visita a casa será realizada dentro de una semana de los resultados de la prueba de plomo
20-44	Su hijo ha estado expuesto a grandes cantidades de plomo en su medioambiente.	**A la semana y al mes** Llame al médico de su hijo para obtener otra prueba de plomo	Todo lo anterior
45-69	Su hijo ha estado expuesto a muy grandes cantidades de plomo en su medioambiente.	**Tan pronto como sea posible, dentro de 48 horas** Llame al médico de su hijo para obtener otra prueba de plomo	Todo lo anterior y... › Su hijo podría necesitar tratamiento médico especializado en el hospital. Llame a su médico CUANTO ANTES para una prueba de sangre de confirmación y una revisión médica de envenenamiento de plomo › La visita a casa será realizada dentro de 48 horas de los resultados de la prueba de plomo
Más de 70	**Emergencia médica:** Su hijo ha estado expuesto a cantidades peligrosamente altas de plomo en su medioambiente.	**Busque atención médica INMEDIATAMENTE**	Todo lo anterior y... › Su hijo requiere tratamiento especializado en el hospital **¡AHORA!** › La visita a casa será realizada dentro de 24 horas de los resultados de la prueba de plomo

Ang TINGGA ay lason!

Karaniwang sanhi ng pagkalason sa tingga sa mga bata

Sirang pintura sa mga bahay na itinayo bago 1979

Maaaring mahantad ang mga bata sa mga piraso ng pintura o alikabok na may tingga mula sa nagpipingas na pintura sa tahanan at lupa. Ayusin ang pintura sa pamamagitan ng pamamaraang ligtas sa tingga, at takpan o palitan ang lupa.

Mapanganib na pamamaraan sa trabaho

Ang tahanang itinayo bago ang taong 1979 ay maaaring magkarooon ng tingga dahil sa hindi mabuting pag-ayos o remodel ng tahanan. Laging umupa ng kontratistang sertipikado sa tingga. Gumamit ng ligtas sa tingga na pamamaraan upang protektahan ang inyong mga anak, alagang hayop at ang kapaligiran.

Alikabok ng tingga mula sa trabaho at libangan

Trabaho sa konstruksyon, pamimintura, paghahardin o *recycling center* at libangan tulad ng pangingisda o paggawa ng alahas, palayok o *stained glass* ay maaaring mag-uwi ng alikabok na may tingga sa bahay. Magpalit ng damit at sapatos bago iwanan ang trabaho at hugasan ang mga kamay at mukha; maligo kaagad pagdating sa bahay.

Ibang posibleng sanhi ng tingga

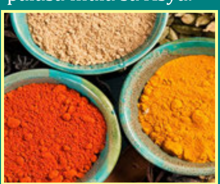
Ang ilang...

Angkat na produkto

Ang ilang produktong pang mamimili ay natagpuang naglalaman ng tingga, katulad ng:

Kendi
Sa halip ng kendi mula sa Asya at Meksiko, subukan ang prutas.

Pampalasa
Iwasan ang matitingkad na pulbong pampalasa mula sa Asya.



Lunas sa Bahay
Huwag gumamit ng *azarcon, greta*, at *pay-loo-ah.*

at...

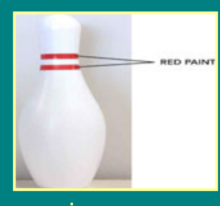
Gamit Pang-Sining
Ang ilang produktong pang-sining ay binawi dahil sa paglabag sa pamantayan ng pintura. Piliin ang may tatak na "*Meets ASTM D-4236*".

Seramik
Ang pintura o pangkinang sa mga pinggan ay maaaring may tingga. Iwasan ang mga bagay na may *Prop. 65 Warning.*

Alahas at Susi
Ang mga metal na bahagi ng alahas at susi na *brass* ay maaaring maglaman ng tingga. Ang paglunok ng alinman ay maaaring makamatay.

Makeup
May mga lipistik at tradisyonal na makeup na may tingga. Iwasan ang *kohl, surma, kajal, at sindoor.*

Laruan
May natagpuang tingga sa pintura, pangkinang at mga bahaging metal sa iba't-ibang mga laruan. Bumili ng gawa sa US.



Kable at Kurdon
Maaaring malunok ang tingga sa takip na plastik pag ito ay sinipsip o nginuya.

Para sa higit pang impormasyon, bumisita sa:
Consumer Product Safety Commission:
www.cpsc.gov

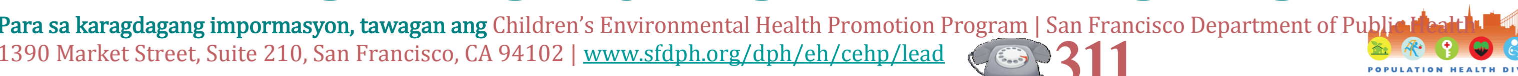
Pagkalason sa Tingga

- Nakaaapekto ng pagkatuto at pag-uugali
- Nakabababa ng talino
- Nakasisira ng ngipin
- Nakapanghihina ng pandinig
- Nakapipinsala ng katawan

Kumilos!

- Hilingin sa inyong doktor na suriin ang inyong anak para sa tingga sa edad 1 at 2, o minsan bago mag edad 6 na taon
- Hugasan ang mga kamay gamit ang sabon at tubig bago at pagkatapos kumain at maglaro
- Bigyan ang inyong anak ng pagkaing mayaman sa bitamina C, kaltsyum (*calcium*), at bakal (*iron*)
- Hilingin sa may-ari ng inyong bahay na ayusin ang sirang pintura at takpan ang lupa
- Tawagan kami para sa isang libreng inspeksyon ng inyong tahanan, kami ay makikipag-ugnayan sa may-ari ng tahanan upang ayusin ang mga panganib ng

Kalusugan ng inyong anak, pangalagaan!



Para sa karagdagang impormasyon, tawagan ang Children's Environmental Health Promotion Program | San Francisco Department of Public Health
1390 Market Street, Suite 210, San Francisco, CA 94102 | www.sfdph.org/dph/eh/cehp/lead

Antas ng Tingga sa Dugo

Anung Ibig Sabihin Nito?

Ang pagsusuri ng dugo para sa tingga ay nagbibigay ng ideya ukol sa kung gaano karaming tingga nahantad ang inyong anak. Ang mga batang may tingga sa kanilang dugo ay maaaring magmukha o kumilos nang tila walang sakit, ngunit maaaring lumitaw ang mga problema sa pagkatuto at pag-uugali matapos ang ilang taon kapag sila ay pumasok sa paaralan.

Resulta ng pagsusuri ng dugo para sa tingga	Anong ibig sabihin nito?	Kailan dapat muling magpasuri?	Anong maaaring ninyong gawin?
0	**Walang makitang tingga sa katawan ng inyong anak.**	Tanungin ang inyong doctor na suriin ang inyong anak sa edad na 1 at 2 o minsan bago mag-6 na taong gulang.	› Iwasan ang mga pinangmumulan ng tingga › Bigyan ang inyong anak ng pagkaing mayaman sa kaltsyum (*calcium*), bakal (*iron*) at bitamina C › Hugasan ang kamay at mukha bago at pagkatapos maglaro › Panatilihing maayos ang pintura at linisin ang alikabok sa bahay › Gumamit ng basang espongha o panlampaso upang linisin ang mga sahig at bintana
1-9	**Walang halaga ng tingga sa katawan ang normal o ligtas.** Ang inyong anak ay nahantad sa ilang halaga ng tingga.	Ipasuring muli ang inyong anak kung may pagbabago sa kapaligiran o panganib ng tingga. Halimbawa: Kung kayo ay lumipat sa mas lumang bahay na mayroong natatapyas o natutuklap na pintura, kung may kasama sa bahay na nagtatrabaho sa konstruksiyon, paghahardin, at iba pa, o naglakbay sa labas ng Estados Unidos	Lahat ng nasa itaas, at... › Basahin ang kabilang pahina para sa impormasyon ukol sa panganib ng tingga sa paligid ng inyong bahay (Ang Tingga ay Lason) › Sundin ang mga pinakamabuting gawi kung mayroong kasama sa bahay na nagtatrabaho sa konstruksiyon, paghahardin o *landscaping,* at iba pa › Magbibigay ang aming programa ng impormasyon at mag-aalok na dalawin ang inyong bahay upang hanapin ang mga pin agmumulan ng panganib ng tingga
10-14	Ang inyong anak ay nahantad sa ilang halaga ng tingga sa kaniyang kapaligiran.	**1-3 buwan** Tawagan ang inyong doktor upang ipasuri muli ang dugo ng inyong anak para sa tingga.	Lahat ng nasa itaas, at... › Sa antas ng tingga sa dugo na 10 at higit pa, isang nars ng Pampub-likong Kalusugan ang dadalaw sa inyong bahay upang magbigay ng pangangalaga sa loob ng dalawang linggo mula sa petsa ng resulta › Isang inspektor ang sasama sa pagbisita sa bahay upang hanapin ang mga pinagmumulan ng tingga sa tahanan
15-19	Ang inyong anak ay nahantad sa katamtamang halaga ng tingga sa kaniyang kapaligiran.	**1-3 buwan** Tawagan ang inyong doktor upang ipasuri muli ang dugo ng inyong anak para sa tingga.	Lahat ng nasa itaas, at... › Isang pagdalaw sa tahanan sa loob ng isang linggo mula sa petsa ng resulta
20-44	Ang inyong anak ay nahantad sa malaking halaga ng tingga sa kaniyang kapaligiran.	**1 linggo, pagkatapos 1 buwan** Tawagan ang inyong doktor upang ipasuri muli ang dugo ng inyong anak para sa tingga.	Lahat ng nasa itaas
45-69	Ang inyong anak ay nahantad sa napakalaking halaga ng tingga sa kaniyang kapaligiran.	**Sa lalong madaling panahon, Sa loob ng 48 oras** Tawagan ang inyong doktor upang ipasuri muli ang dugo ng inyong anak para sa tingga.	Lahat ng nasa itaas, at... › Maaaring mangailangan ng dalubhasang medikal na paggamot ang inyong anak sa ospital. Tawagan ang inyong doktor sa lalong madaling panahon upang tiyakin ang halaga ng tingga sa dugo ng inyong anak, at magtakda ng susunod na pagsusuri sa inyong anak. › Isang pagdalaw ng nars at inspektor sa inyong tahanan sa loob ng 48 oras mula sa resulta ng pagsusuri
Above 70	**Medikal na Emerhensya:** Ang inyong anak ay nahantad sa delikadong mataas na halaga ng tingga sa kaniyang kapaligiran.	**Magtamo KAAGAD ng medikal na tulong**	Lahat ng nasa itaas, at... › Ang inyong anak ay nangangailangan ng dalubhasang paggamot sa ospital **NGAYON DIN!** › Isang pagdalaw ng nars at inspektor sa inyong tahanan sa loob ng 24 oras mula sa resulta ng pagsusuri

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MEDICAL RELEASE AND AUTHORIZATION FOR TREATMENT FORM

I, the parent or legal guardian of ___________________, give my permission to administer first aid in the event my child becomes ill or sustains any injury at the childcare program.

If it is the opinion of the childcare provider that emergency medical care is required, and I am unable to be reached for instruction, consent is hereby given to transport my child to the nearest Emergency Room, and consent is given to the physician on duty at the Emergency Room to administer treatment deemed necessary for the relief of pain and the preservation of life and health.

I further agree to release the Child Care Center/Family Child Care Home from any liability, financial or legal in connection with the transportation and treatment.

Signature: ____ Date: _____________

Home address: ____

Phone Number: ____

Insurance: _________________________________ Group number: ________________

Child's date of birth: ____________ Last tetanus shot: _________________________

Allergies:____

Other pertinent information: ____

____

Business telephone: Mother_____________________________

Father ____________________________

Child's Primary Care Provider: _________________________ Phone: ______________

Address: ____

Others to call in case of an emergency:

These should be people who can pick the child up (have transportation), be readily available, and whom you would trust to authorize treatment or care for the child in your absence].

Name: _____________________________________ Phone: ______________________

Business Phone: ______________________

Name: _____________________________________ Phone: ______________________

Business Phone: ______________________

Please also complete CCL form: LIC627

EMERGENCY MEDICAL TREATMENT

POLICY: In the event of illness or injury requiring emergency medical treatment, an attempt will be made to reach the parent/legal guardian at the telephone numbers provided. The parent/legal guardian and staff member will decide on a course of action to provide appropriate care for the child.

If the parent/legal guardian cannot be reached, the child care staff will follow the directions on the emergency card and obtain the necessary treatment for the child.

The parent will agree to be financially responsible for costs incurred for transportation and/or treatment and will have signed a statement to that effect upon enrollment.

PURPOSE: To assure that an ill or injured child receives appropriate medical care.
To avoid complications due to delay.
To assure that the parent's wishes are carried out.

PROCEDURE:

1. **See section E-19 on medical emergencies.**

2. The Director and Site Manager or designee will assess the situation and attempt to contact the parent.

3. The Director and the Site Manager/Health Advocate or designee will agree with the parent on the plan of action, document it, and proceed to carry it out OR:

    a. Arrange to transport and accompany the child by walking or by ambulance to the Emergency Medical Facility designated by the parent/legal guardian, or to the nearest one.

4. Assure copies of necessary release forms accompany the child.

5. Document the incident, transport, care provided, names of emergency medical caregivers, treatments discussed and approved, timing and outcome.

6. Document continuing efforts to contact the parent.

7. Continue to act as the child's advocate until the parent can be reached or the court intervenes.

Emergency Response Card from EMSA can be found here: Emergency First Aid Guidelines for California Schools

Resources: https://emsa.ca.gov/childcare_provider/

FIRST AID GUIDELINES

POLICY: A child has the right to a safe environment and deserves to have caregivers who will take every reasonable precaution to prevent accidents and injury. In the case of accidental injury, the child will receive appropriate first aid immediately.

PURPOSE: To ensure every child's safety.
To ensure the child appropriate care under all circumstances.

PROCEDURE:

1. Teacher will assure that there is a fully stocked first aid kit and disposable gloves available anywhere the children may go.

2. Caregivers will wear disposable gloves every time they touch bodily fluids such as blood, feces, vomit or urine.

   i. Handling of human milk without gloves has **not** been shown to transmit HIV nor Hepatitis B, so it does not fall under the CDC's list of bodily fluids that require universal precautions such as gloves. Professionals who frequently handle human milk may choose to wear gloves if they wish, or if site policy requires it. (Source: CDC, 2022).

3. Teacher will assure that children sustaining an injury will receive first aid.

   a. **Cut, Scrape or Abrasion:**

      i. Clean the wound with soap and water.

      ii. Decide on appropriate size and shape of covering.

      iii. Attach to wound with adhesive.

      iv. Apply ice pack if there is swelling and/or pain.

   b. **Burn:**

      i. Flush all burns with cool running water immediately until burning stops.

      ii. Cover large burns with a clean dry cloth. Cover smaller burns loosely with a clean, cool, damp cloth to cool the burn and relieve pain.

      iii. **DO NOT BREAK BLISTERS!**

c. **Bee Sting:**

  i. Remove stinger by brushing over the top of the sting -do not use tweezers or pinch the stinger.
  ii. Wash with soap and water.
  iii. Apply ice to reduce swelling and/or pain.
  iv. Check the child's health folder for bee sting allergy.
  v. Ask the child if he/she is having difficulty breathing or swallowing
  vi. Notify parents immediately if there is allergic reaction
  vii. **Dial 9-1-1 if the child has any difficulty breathing.**

d. **Sand in eyes**

  i. Flush cool water into eye
  ii. Do not allow child to rub the eyes.
  iii. If there are a few grains left under the eyelid, use a moist cotton tipped applicator and gently touch the grain to lift it out of the eye

e. **Head injury:**

  i. Do NOT move a severely injured or ill person unless absolutely necessary for immediate safety. If moving is necessary, protect the neck by keeping it straight to prevent further injury
  ii. Check for breathing - Start CPR if needed
  iii. Assess consciousness and awareness of surroundings
  iv. Call 9-1-1 if unconscious (for any length of time), severe headache, vomiting, or change in behavior or loss of coordination. Arrange for transportation of the ill or injured person, if necessary.
  v. If alert and moving; apply ice to bump.
  vi. Observe for lethargy, vomiting, severe headache, or change in behavior.

vii. The responsible school nurse, administrator, or a designated employee should notify the parent/legal guardian of the emergency as soon as possible to determine the appropriate course of action.

f. Fracture, Sprain, or Strain

i. Immobilize with towel, cardboard, or sling.

ii. Gently support and elevate injured part and adjacent joint, with pillow or folded towel, if possible

iii. Use ice for swelling and/or pain.

iv. Dial 9-1-1 if: bone or joint is deformed or bent in an unusual way; skin broken over possible fracture; bone sticking through skin; skin of the injured extremity pale/cool when compared with opposite extremity

For more emergency response and first aid info from EMSA, please visit: Emergency First Aid Guidelines for California Schools

Resource: https://emsa.ca.gov/childcare_provider/

San Francisco Department of Public Health: Child Care Health Program

FIRST AID KIT SUPPLIES CHECKLIST

It is recommended to replace a first aid kit every 3-5 years.

Remove all OTC medication from children's First Aid kit.

The first aid kit should contain at least the following items:

Title 22 Regulations (revised 2015) required items are in **BOLD**

ITEM The numbers listed next to the items are the minimum quantity recommended.	COMMENTS	DATE CHECKED (Restock after each use and inventory monthly)			
1. Disposable nonporous, latex-free (recommended) or non-powdered latex gloves x 5 pairs					
2. Scissors x 1					
3. Tweezers x 1					
4. **Thermometer** (non-glass/non-mercury) x 1					
5. Bandage x 10					
6. Sterile gauze pads (2x2) x 10					
7. Large sterile gauze pads (4x4) x 4					
8. Flexible roller gauze x 2					
9. Triangular bandages x 2					
10. Safety pins x 6					
11. Eye patch or dressing x 2					
12. Cold pack x 2					
13. Current addition of First Aid Manual within last 5 years x 1					
14. Alcohol Pads x 10 (Discard if pad is dry or damaged)					
15. Normal Saline Eyewash x 1. (Check Expiration Date)					
16. First Aid adhesive tape x 2					
17. CPR masks (child and adult size) x 1					
18. Additional items for emergency backpack:					
19. Facility Emergency Plan					
20. Children's emergency contacts					
21. Children's medication					
22. Name tags					
23. Pencil and note pad x 1					
24. Bottled water to rinse wound x 1					
25. Liquid soap x 1					
26. Hand sanitizer x 1					
27. Tissues x 1 packet					
28. Wipes x 1 packet					
29. Plastic bags for handling biohazard material x 2					
30. Plastic bags to contain waste material.					
31. Flashlight x 1					
32. Whistle x 1					
33. Battery-powered radio x 1					
INITIALS OF PERSON WHO CHECKED					

SERIOUS ILLNESS, HOSPITALIZATION, OR DEATH

POLICY: The childcare program will have a plan for handling a child serious illness, injury, or death occurring at the childcare facility.

PURPOSE: To respond appropriately to a serious illness, injury, hospitalization, or death occurring at the childcare facility.

PROCEDURE:

1. In the event of a serious illness, injury or death in the childcare facility;

    a. Perform CPR per protocol and call 9-1-1

    b. Contact parents to inform them of the situation.

    c. Remove the other children from the immediate area.

    d. Answer the children's questions as honestly as you can and reassure them the ill or injured child is being cared for.

2. When the paramedics arrive, they will take charge of the ill / injured person.

3. Notify Licensing of the incident for further instructions and complete required documentation (e.g. LIC 624/624B, and if applicable, LIC 9187 Death Report).

4. Conduct an internal review to determine if the environment or the staff contributed to the injury or death, and if any action needs to be taken.

5. Assist the children in understanding and coping with the situation:

    a. Ask victim's family what information/update you can provide to families and children who are worried. **Respect privacy** and relay appropriate information to the families and children.

    b. Consult a professional grief counselor or therapist to assist with the next few days and the tasks at hand.

    c. Locate appropriate children's books that deal with the situation.

    d. Validate children's feelings. Answer questions honestly but keep it age appropriate.

THE EMERGENCY PLAN

POLICY: The childcare program will have a contingency plan in the event of an emergency, disaster, or mass casualty event.

PURPOSE: To assure the safety of our children in ALL situations.
To enable staff to handle emergencies which may arise.
To protect the health and safety of each child and staff member.
To satisfy Licensing requirements and Health and Safety Code Regulations

PROCEDURE:

1. An Emergency Plan must be developed. It is strongly recommended to obtain input from staff, parents, and community leaders.
2. Use LIC 610 form for child care centers, or 610A for family child care homes.
3. The Director is responsible for updating, validating, testing, and administering the Plan, and for ensuring staff are trained on their responsibilities.
4. The Plan will be updated at least annually. Any changes in the key staff listed in the Plan will be updated immediately.
5. **A copy of the Plan will be**:
   a. Submitted to Licensing.
   b. Posted in each classroom with an evacuation route map specific to that area. It should be posted in a prominent location, ideally next to a telephone.
   c. Posted in the main office.
   d. Be placed in the disaster kit.
6. There will be a disaster kit centrally and safely stored that contains the supplies necessary to care for the children during the length of the emergency.
7. Newly hired staff, or staff reassigned to new roles, will be trained on the Plan and their responsibilities during emergencies within 1 week of hire.
8. The Plan will be tested at minimum 2 times per year, but more frequent drills are highly recommended. The type of drill will alternate i.e., fire drill, earthquake drill, etc.
9. Required skills will be taught and practiced with all the staff and children.

10. The facility will have regular safety inspections.

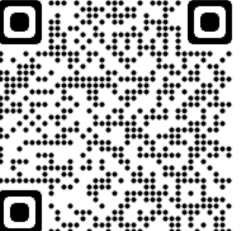
11. Identify hazards in your community. The minimum requirement is to have a Plan for fires, floods, and earthquakes. As a best practice, it is also recommended to have a Disaster Plan for:

    - Extreme weather (hot and cold)
    - Tsunamis
    - Power Outages
    - Medical Emergencies
    - Hazardous Materials Incident
    - Bomb Threat
    - Violence, guns, active shooter inside the childcare facility
    - Violence, guns, active shooter outside the childcare facility
    - Disgruntled or impaired adult
    - Civil unrest in the area
    - Terrorism
    - Pandemics / Epidemics

For a Step-by-Step Guide to developing a Disaster Plan for Child Care Centers, see:

https://cchp.ucsf.edu/sites/g/files/tkssra181/f/Step-by-Step-Guide-Emergency-Disaster.pdf

And additional information and resources can be found at:
https://cchp.ucsf.edu/resources/disaster-preparedness



EMERGENCY ORGANIZATION

The Director has the primary responsibility. In his/her absence, the Site Manager or designee will take charge.

Emergency Charge Succession List

1. Director
2. Site Manager
3. Health Advocate
4. Designee

General Instructions

1. The first person to become aware of an emergency or potential emergency situation, shall notify the person in charge and begin steps appropriate to that situation.

2. The appropriate person shall take charge. The Charge will direct all actions to be taken while in an emergency mode, without question.

3. To order evacuation for any reason, the fire alert system will be activated or follow your agency's protocol.

EMERGENCY CHARGE PERSONNEL

The next part of the manual deals specifically with the duties and responsibilities of the Emergency Charge.

In the event of a disaster, assume your leadership role according to the line of succession. During a disaster there must be only one Emergency In- Charge. If another person is taking the lead, assist him/her until you are asked to take over.

1. Assess the type of disaster and determine the plan to be followed. Refer to this manual.

2. Assess the extent and amount of damage/danger and decide what needs to be done.

3. Take control! Take action!

Your concerns by priority are:

1. Life
2. Health
3. Safety
4. Water
5. Food
6. Waste Disposal (Biohazard materials and other waste)
7. Recreation for children
8. Notification of families (social media platforms, etc)
9. Reunification planning

Your line of succession to follow order is:

1. _e.g The Director______________________
2. _e.g Site Manager______________________
3. _e.g Lead Teacher______________________

Job Action Sheets: Staff Roles and Responsibilities

During an emergency it is important that staff members know what to do to keep everyone safe. The following are key emergency roles and duties:

Incident Leader: Directs evacuations and disaster response activities. Oversees the other positions and the person count. This role is usually filled by the director, site supervisor, lead teacher, or owner.

First Aid Coordinator: Provides first aid to children and staff. Assesses and documents injuries and treatments. Determines the need for outside medical assistance.

Communication Coordinator: Provides status updates to families and local emergency services before, during, and after an emergency. Monitors emergency alerts, warnings, and public safety updates. Distributes resources and materials to help families recover and cope with the emergency. If staffing allows, consider assigning multiple people to this role as it may consist of communication with many people.

Transportation Coordinator: Oversees the movement of staff and children in the case of an evacuation or relocation. The Transportation Coordinator also tracks road conditions and road closures that may affect evacuation routes.

Security, Attendance, and Reunification Coordinator: Keeps track of attendance and person count for children and staff. Reports missing persons to the Incident Leader. Secures entrances and monitors sign-out procedures for reunification of children and families.

Supervision and Care Coordinator: Ensures that children (including children with special needs and infants and toddlers) are well cared for while other staff members are busy with emergency roles.

Facility Safety Coordinator: Protects the building and grounds from further damage and children and staff from injury. Takes charge of utilities, for example, gas, water, electricity, and sanitation. Conducts search and rescue operations. Reports unsafe situations to the Incident Leader.

Supplies Coordinator: Assembles emergency supplies, equipment, and other essential materials (for example, food, water, comfort items) needed in an emergency. Distributes resources and reports additional needs to the Incident Leader. Monitors and updates supplies before, during, and after an emergency.

An individual teacher might fill more than one of these jobs, or the jobs might be filled by a team of staff members, depending on the size of the program. When assigning jobs be mindful of staff members' strengths and skills. Provide ongoing training to ensure staff members understand their roles in an emergency. Cross-train in multiple positions in case someone is absent or is unable to perform their emergency job.

Use the following JOB ACTION SHEETS to assign roles and responsibilities. The Job Action Sheets may be customized to fit the needs of your child care program and staff. For example, specific duties can be shared or reassigned.

THE EMERGENCY DRILL

<u>POLICY</u>: The childcare program will conduct emergency drills at least 2 times per year, but more frequent drills are highly recommended.

<u>PURPOSE</u>: To test the facility and alarm system for reliability.
To allow children to learn and recognize by repetition the key words and sounds that will keep them safe.
To satisfy the Fire Safety Standards and Licensing regulations requiring drills.

<u>PROCEDURE</u>:

1. Create a scenario for a disaster and alert all staff members.
2. Assure everyone "This Is Only a Drill" but that they must treat it as a real emergency.
3. Sound the actual alarm that would be heard in the event of a fire.
4. Staff and children evacuate according to procedure.
5. Staff are responsible for knowing the correct procedure for each type of emergency. The director is responsible for ensuring all staff are trained on the procedures.
6. Each drill should end in an evacuation. Although you would not evacuate in all situations, evacuation practice is required, and children must practice this most important life-saving skill frequently. By carefully setting up your drill, you can work it into all disaster drills. i.e., after an earthquake, one room has falling light fixtures.
7. Drills should be held on different days and times of day. Practice using different exits and include scenarios where key site leadership may be unavailable.
8. Drills will be logged and evaluated.
9. Consider participating in interagency, community emergency drills, such as those planned by the Office of Emergency Services, the Fire Dept, etc.

POSSIBLE DISATER DRILL SCENARIOS

Announce "THIS IS A DRILL…………IT IS ONLY A DRILL"

We are having a 6.3 earthquake. The epicenter is in San Mateo. The shaking inside your room is tremendous. It will last for one full minute and then stop. Please do exactly as you would in a real earthquake. **BEGIN NOW.**

After the shaking stops:

The shaking has stopped. There is a fire on the street outside. You hear sirens from everywhere. There is a fire in the storage area. The play yard appears undamaged. The _________________ Classroom has a fire in the wall with the washing machine. When you try to evacuate, the fire exit door is blocked by lots of clutter that was being stored there.

Please do exactly as you would in a real earthquake and fire. **BEGIN NOW.**

An unbolted tall bookshelf in the _______ Classroom has fallen. There is one child trapped under it; the child is crying.

The Office roof has collapsed. The director and site coordinator are unconscious and seem to be badly injured. Then, a child with asthma begins having trouble breathing due to the dust from the collapsed roof. Their inhaler is found to be expired.

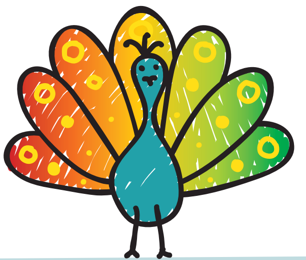
"THIS IS A DRILL…………IT IS ONLY A DRILL"

While children are playing outside, there is violence or gun shots on the street in front of the childcare facility. Please do exactly as you would in a real threat. **BEGIN NOW**

Soon, a police officer enters the childcare and instructs you to lock down until they clear the threat. It's almost pickup time and parents will be arriving soon. *(Try practicing a test of notifying all parents of time sensitive emergency information and instructions. Be clear it is only a practice test of the emergency notification system).*

Sample Emergency Disaster Drills

Conduct emergency disaster drills at least every six months. Include different types of drills, in a variety of locations, at different times of the day. Log the date, time, and type of drill. Make a yearly schedule for the different drills you will practice. Keep documentation of your drills on site for at least one year.



Fun ideas to build skills and knowledge for emergency disaster drills

- Play games like follow-the-leader so that children can learn to move together in an orderly way.
- Plan a field trip to the fire station or have your local fire fighters visit your program.
- Provide for dress up and dramatic play with costumes for fire fighters, first responders and emergency workers.
- Develop a science theme with books and activities about earthquakes, tornados, floods, blizzards, etc.
- Play "turtle" and have children pretend to be turtles by crouching down, covering their heads, and holding still.
- Play "lizards under rocks" and have children pretend to be lizards seeking shelter under a sturdy table.
- Practice using a walking rope for children to hold onto when walking as a group.

Sample of an Announced Earthquake Drill: Drop, Cover, and Hold On

- Use songs, rhymes, books, or scripted stories to teach children the basics of what happens in an earthquake, how to Drop, Cover, and Hold On, and how to assume the "turtle pose." Teach the turtle pose, by showing how to kneel on the ground and cover your head with your hands. Bend at the waist so your face is close to your knees and protected from falling objects.
- Tell the children that during an earthquake, the Earth might move beneath their feet like a boat in the waves. Explain that earthquakes may be noisy, with loud banging, crashing, or rumbling sounds and ringing alarm bells.

Stage	Actions
NOTIFICATION	▪ Tell the children that an earthquake drill is about to happen. Then say "Earthquake—Drop, Cover, and Hold On," or use a bell or alarm to signal the drill.
INDOOR ACTION	▪ Drop to the ground with the children, take cover under a sturdy piece of furniture such as a heavy desk or table (if available), and hold on. Try using role-play imagery like: "I am a mama chicken and you are my little chicks, get under my wings! Now let's all be turtles, get in your turtle pose!" ▪ Huddle together facing away from windows while you assume a turtle pose. Pretend that the table is a log or a rock. ▪ Demonstrate how to cover your eyes with your free hand (the one you're not holding on with). ▪ If there are no sturdy pieces of furniture to get under, huddle together and assume the turtle pose next to an interior wall but away from windows, overhead light fixtures, and tall pieces of furniture that might fall over. ▪ *For infants:* Carefully pick up the baby in your arms, holding the child against your chest, and carry them as you Drop, Cover and Hold On. The adult will provide additional protection above and on either side of the child. Alternatively, place infants in an evacuation crib (or other infant evacuation equipment) and roll it next to an interior wall. Lock the wheels and shield the infants from falling objects.
OUTDOOR ACTION	▪ Move the children into the open, away from buildings, fences, trees, tall playground equipment, utility wires, and streetlights. ▪ Have the children face away from windows and assume a turtle pose.
CONCLUSION	▪ Stay under cover until the drill is over. Work up to staying under cover for one minute or longer after seeking cover. ▪ Take attendance and ensure all children are present and safe.

Sample Announced Fire / Evacuation Drill

NOTIFICATION	■ Tell the children that a fire drill is about to happen. A smoke detector test button or other designated noise, such as a recording of the fire alarm, may be used as your practice alarm. Tell children that when they hear that sound it means there is a fire drill. ■ Explain to the children that when they hear the fire alarm or designated noise, they must get up quickly and leave everything behind. ■ Point out all the exits to the children. Tell the children that you will leave the building through the closest exit. Test alternate escape routes and windows that can be used as exits. Practice with ladders if they are part of your evacuation plan.
ACTION	■ Evacuate children as follows: ■ *Infants and Toddlers:* Practice using evacuation equipment for infants and toddlers. For example, use an evacuation crib, a stroller with multiple seats, a wagon, or an infant rescue vest/apron/carrier. ■ *Preschoolers:* Gather children in a group and supervise an orderly evacuation to the designated assembly area. Practice using a walking rope for children to hold on to during evacuation. ■ *Children with Special Needs:* These children will be assisted by specific staff members who have been trained in their role to evacuate children with special needs. ■ Grab the daily attendance list and the “Ready-to-Go Kit” backpack, including the Ready-to-Go File on the way out. ■ Check bathrooms and the classroom, and shut the door behind you after you are sure everyone has exited. ■ Gather outside at the agreed upon place. ■ Take attendance to ensure everyone has made it out safely.
COMMUNICATION	■ Practice using a portable battery or hand-assisted radio to listen for announcements from local officials.
CARE AND SUPERVISION	■ Follow established procedures for assisting children and/or staff with special health care needs. Bring medications, care plans, and assistive devices for communication and mobility. ■ Follow established procedures for addressing children’s (especially infants and toddlers) nutrition and hygiene needs during the period of time they are evacuated.
CONCLUSION	■ Remain at the meeting spot until the child care director or designee announces the end of the drill.

Sample Announced Tsunami / Flood Drill

- Both tsunami and flood drills will be the same as an evacuation drill, except that you will need to seek higher ground.
- Tsunamis come after earthquakes, and they can come on suddenly.
- For most floods, you would have time to follow flood updates and call families to pick up their children before evacuating. Flash floods can come on quickly and you will have to leave the building right away.

NOTIFICATION	▪ Tell the children that an emergency drill is about to happen and they will leave the building. ▪ Explain to the children that when they hear "tsunami drill" or "flood drill," you will all evacuate the building. ▪ Tell the children that they must get up quickly and leave everything behind, just like in a fire drill. ▪ Point out all the exits to the children. Tell the children that you will leave the building through the closest exit.

ACTION	▪ Evacuate children as follows:
	  ▪ *Infants and Toddlers:* Practice using evacuation equipment for infants and toddlers. For example, use an evacuation crib, a stroller with multiple seats, a wagon, or an infant rescue vest/apron/carrier.
	  ▪ *Preschoolers:* Gather children in a group and supervise an orderly evacuation to the designated assembly area. Practice using a walking rope for children to hold on to during evacuation.
	  ▪ *Children with Special Needs:* These children will be assisted by specific staff members who have been trained in their role to evacuate children with special needs.
	▪ Grab the daily attendance sheet and the "Ready-to-Go" Kit including the "Ready-to-Go" File on the way out.
	▪ Check bathrooms and other classrooms, and shut the door behind you after everyone has exited.
	▪ Gather outside at the agreed upon place.
	▪ Take attendance to ensure everyone has made it out safely.

COMMUNICATION	▪ Practice using a portable battery or hand-assisted radio to listen for announcements from local officials.
CARE AND SUPERVISION	▪ Follow established procedures for assisting children and/or staff with special health care needs. Bring medications, care plans, and assistive devices for communication and mobility. ▪ Follow established procedures for addressing children's (especially infants and toddlers) nutrition and hygiene needs during the period of time they are evacuated.
CONCLUSION	▪ Tell the children that in a real event you would be going to a relocation site at higher ground. You may want to practice walking on the sidewalk through the neighborhood as if you were actually going to this location. If appropriate, tell the children the name or location of the higher ground relocation site.

Sample Announced Lockdown Drill

NOTIFICATION	■ Tell the children that a lockdown drill is about to happen. ■ Director or designee will announce “Lockdown” or other code word.
ACTION	■ If there are children playing outside, bring them inside. ■ Go to the nearest room or the designated location away from danger. ■ Bring disaster supplies to the designated safe place location. ■ Tell staff and families outside the building that they cannot enter the building and to find a safe location. ■ Lock the classroom doors and windows, cover the windows, and turn off lights and audio equipment. ■ Keep all children sitting on the floor, away from doors and windows. Use tables, cabinets, or other heavy furniture as a shield, if present. ■ Take attendance of children and ensure all children remain in room as quietly as possible. ■ Ignore any fire alarm activation.
COMMUNICATION	■ Turn cell phones on silent or vibrate. ■ Role-play: “Call 9-1-1” (just pretend!) and explain the situation. * note: in a real emergency it might not be safe to talk on the phone, but you can still call 9-1-1 and leave the phone on. Do not make phone calls unless there is an emergency situation (for example, an injured child or adult in need of immediate medical attention).
CARE AND SUPERVISION	■ Follow established procedures to help children stay quiet, for example, holding hands, gently rocking back and forth, and making eye contact with each child, or offering pacifiers to infants. ■ Follow established procedures for assisting children and/or staff with special health care needs. Bring medications, care plans, and assistive devices for communication and mobility. ■ Follow established procedures for addressing children’s (especially infants and toddlers) nutrition and hygiene needs during the period of time they are in lockdown.
CONCLUSION	■ Remain in the room until the child care director or designee announces the end of the lockdown.

Sample Announced Shelter-in-Place Drill

NOTIFICATION	■ Tell the children that a shelter-in-place drill is about to happen. ■ Director or designee will announce "Shelter-in-Place."
ACTION	■ Bring children and staff to the pre-determined areas within the facility or home. Choose an interior room without windows or vents that has adequate space to accommodate children and staff. ■ Close and lock all windows and doors. ■ Shut off the building's heating systems, air conditioners, exhaust fans, and switch intakes to the closed position. ■ Seal all cracks around the doors and any vents into the room with duct tape or plastic sheeting. ■ Conduct a roll call to ensure everyone is present and accounted for in the area. ■ No outside access is permitted, but activity within the facility may continue.
COMMUNICATION	■ Role play: providing status updates for families (just pretend!). ■ Practice using a portable battery or hand-assisted radio to listen for announcements from local officials. ■ Keep cell phone within reach at all times.
CARE AND SUPERVISION	■ Bring disaster supplies to the designated safe place location. ■ Follow established procedures for assisting children and/or staff with special health care needs. Bring medications, special health care plans, and assistive devices for communication and mobility. ■ Follow established procedures for addressing children's (especially infants and toddlers) nutrition and hygiene needs. ■ Provide developmentally appropriate activities.
CONCLUSION	■ Continue the shelter-in-place drill until the child care director or designee announces the end of the shelter-in-place drill.

Sample Announced Tornado Drill

NOTIFICATION	■ Tell the children that a tornado drill is about to happen. ■ Director or designee will announce "Tornado" or other code word.
ACTION	■ If children are playing outside, bring them inside. ■ Secure or store outdoor toys, furniture, and equipment that may act as missiles. ■ Seek shelter in an interior, protected area of the building on the lowest level possible or in a designated tornado shelter. ■ Keep children away from windows. ■ Take attendance. ■ Bring disaster supplies to the designated safe location.
COMMUNICATION	■ Role play: Provide status updates for families (just pretend!). ■ Practice using a portable battery or hand-assisted radio to listen for announcements from local officials. ■ Keep cell phone within reach at all times.
CARE AND SUPERVISION	■ Follow established procedures for assisting children and/or staff with special health care needs. Bring medications, special health care plans, and assistive devices for communication and mobility. ■ Follow established procedures for addressing children's (especially infants and toddlers) nutrition and hygiene needs. ■ Provide developmentally appropriate activities.
CONCLUSION	■ Continue the tornado drill until the child care director or designee announces the end of the drill.

Sample Impaired Adult Role-Play

No children are involved in this drill. Including children in an impaired adult drill may cause confusion or fear.

Conduct this role-play exercise as part of a staff meeting.

Assign someone to play the impaired adult, two people to play staff members and one person to play the director.

- Role-play a situation involving an adult who has come to the child care facility to pick up a child. The adult is stumbling, slurring their speech, and smells strongly of alcohol.
- The staff person identifies the adult as intoxicated, and immediately looks for a space away from the children to have a conversation with her/him.
- At the same time, the staff member uses a code word to signal another staff member to assist.

  Example of script:

  "Hello, (name of family member). How are you doing this afternoon?"

  "Fine"

  "I know you are here to pick up (name of child). Unfortunately, we are going to have to find someone else to take (name of child) home today."

  "What? Why? We have to be somewhere at 6 o'clock!"

  "I am concerned because I smell alcohol on you and we cannot let (name of child) go home with you alone."

  "I'm fine; it was just a few beers, what's your problem?"

  "It's our policy that if someone seems impaired, that we can't send the child home alone with him or her."

  "I don't have my phone."

  "We have an emergency contact list and we'll call for you. Let's go to the office and make that call."

- Alternatively, if the impaired adult becomes combative, then one staff member goes to get the director. The director continues the conversation with the impaired adult and determines if a call to the police or social services (Child Protective Services) is needed.

Other situations you might role-play: Adults who are emotionally impaired (for example, severely depressed or manic); using drugs; overly tired; or violent. You might also practice how to respond to a disgruntled staff member or former employee.

Debrief with staff.

Bonus Drill: Relocation/Reunification

NOTIFICATION	■ Make arrangements with one of your relocation sites to conduct a relocation and reunification drill. ■ Collect a Relocation/Reunfication Drill Permission Form for each child. ■ Using the emergency numbers listed on each Child Emergency Information Form, notify families of where and when they can pick up their child that day.
ACTION	■ Conduct an evacuation drill with the children (see drill above). ■ Walk or transport children to the relocation site and check in with the primary contact of the site. ■ Take attendance. ■ Set up an area to release children and secure against unauthorized access (use caution tape or signs).
CARE AND SUPERVISION	■ Follow established procedures for assisting children and/or staff with special health care needs. Bring medications, care plans, and assistive devices for communication and mobility. ■ Follow established procedures for addressing children's (especially infants and toddlers) nutrition and hygiene needs during the period of time they are evacuated. ■ Set up developmentally appropriate activities for the children. ■ Ensure children stay within designated boundaries.
REUNIFICATION	■ Check Child Emergency Information Form for the name of person(s) authorized to pick up child. ■ Check identification of person(s) picking up children. ■ Document child releases and have adult sign before releasing child to adult. ■ Report any unauthorized individuals to the director. ■ Use alternate modes of communication as needed to reach families of children who have not been picked up by a pre-determined time. Ensure that these families update their emergency contact information immediately following the conclusion of the reunification drill.
CONCLUSION	■ End drill when all children have been picked up. ■ Pack up all materials and thank your reunification site host. ■ Debrief with staff. ■ Debrief with families.

SAMPLE SCENARIOS FOR INDIVIDUAL STAFF

NAME TAGS FOR DRILL LEADERS

(Instructions: Cut on dotted line and tape on appropriate person – some should be children.)

I'M DEAD..........
DON'T ASK ME!!!!

I'M UNCONSCIOUS.......
DON'T ASK ME!!!

I'M NOT EVEN HERE.......
DON'T ASK ME!!!

I HAVE A BROKEN LEG.......
I'M IN SHOCK!!!

I'M REALLY SCARED.......
WHAT DO I DO????

I'VE FORGOTTEN EVERYTHING I PRACTICED FOR A DISASTER, WHAT DO I DO???

RECORDING AND EVALUATING AN EMERGENCY DRILL

POLICY: Each emergency drill will be documented and evaluated for efficiency and effectiveness.

PURPOSE: To recognize where improvement is needed.
To have a record of past history.
To satisfy the Health and Safety Code Regulations and Licensing requirements.

PROCEDURE:

1. Assign one uninvolved, trained adult to monitor the drill in one room.

2. Assign that individual to fill out the Emergency Drill Evaluation Form.

3. Assign another uninvolved, trained adult to watch and time the entire site's performance and the evacuation. Complete an Emergency Drill Evaluation Report form (see H-15).

4. Initiate the drill.

5. After the "all clear" and when the children are safe in their rooms, all pertinent parties meet with the two monitors to discuss the successes and the weaknesses of the drill.

6. A plan for improvement is decided upon.

7. Share the successes and weaknesses of the drill and the plans for improvements with all staff, e.g. during a staff meeting.

8. Maintain a log of all drills. Drill logs are required by Licensing Regulations to be kept onsite for a minimum of 1 year.

EMERGENCY DRILL EVALUATION REPORT

Type of Emergency Drill: ______________________ Room Observed: ____________

Date: ________________ Day of Week: _____________ Time: _________________

Number of staff: ______________ Number of children: ____________

1. What was done first? — Was this an appropriate response?

- #___ Evacuated immediately? ___ yes ___ no
- #___ Duck and cover? ___ yes ___ no
- #___ Waited for instructions? ___ yes ___ no

2. Did everyone respond to the evacuation signal? ___ yes ___ no
3. Were children following directions? ___ yes ___ no
4. Does everyone know skills required for correct action? ___ yes ___ no
5. Did everyone know who was in charge? ___ yes ___ no
6. Which skills did the children or staff demonstrate? (May add comments)

- ❑ duck and cover ____
- ❑ stop drop and roll ____
- ❑ crawling out of smoke ____
- ❑ evacuation siren / fire alarm ____
- ❑ attendance sheets ____
- ❑ took all required items for evacuation ________________________________
- ❑ correct evacuation route ____
- ❑ command post ____
- ❑ utility shut-off ____
- ❑ first aid ____
- ❑ name tags ____

- ☐ disaster kit ______________________________________

Evacuation time lapse: ___________

Additional Comments:

____

____

____

____

____

____

____

____

____

Name & Signature: ____

Emergency Disaster Drill Log

California Community Care Licensing (CCL) Requirements

Licensed child care programs must conduct emergency drills at least once every 6 months. Practice "duck, cover, and hold" earthquake drills under tables or desks no less than four times per year. Programs are required to keep written documentation with the date and time of the drills at your facility.

Types of Drills

Schedule drills based on your hazard analysis. In California, the four most common natural disasters are earthquakes, fires, floods, and tsunamis. It is also helpful to conduct drills for human-caused emergencies such as a gas leak, a chemical spill, an active shooter, and/or an impaired or disgruntled adult.

MONTH	TYPE OF DRILL	DATE HELD	TIME OF DRILL	NOTES FOR IMPROVEMENT	SIGNATURE / INITIALS
January					
February					
March					
April					
May					
June					
July					
August					
September					
October					
November					
December					

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EVACUATION PROCEDURE

POLICY: In the event that our facility becomes a risk to the health and safety of the children or staff, we will evacuate to a pre-arranged location at least 50 feet from the building.

PURPOSE: To maintain the safest environment possible for all.
To protect the health and safety of all children and staff.

PROCEDURE:

1. All ambulatory children will immediately line up in two lines at the designated door. During drills, teach children which word or phrase will indicate an emergency and the need to get in line as quickly as possible.

2. Non-ambulatory children will be placed in rolling cribs and/or multiple child strollers and wheeled to the door.

3. The following items must be taken outside with you during an evacuation:
   - Attendance sheet / roster
   - First aid kit
   - Emergency contact information for all children
   - All children's medications and emergency care plans
   - Walking ropes
   - You may include other optional items in your Go-Bag, such as toys, books, diapers, water, etc.

4. A teacher will check nap room, bathrooms, closets, and other spaces for children who may be frightened, hiding, or unsure of what to do. Make sure all children are present and no child is left behind.

5. The walking ropes will be passed to all ambulatory children to hold.

6. The teacher will then lead the children by the ropes along the designated or the alternative evacuation route.

7. The children will be seated at the designated evacuation area.

8. The teacher will take roll and account for every child.

9. The teacher will be responsible for involving the children in activities until further instructions are received.

FACILITY EVACUATION ALERT SYSTEM

(Adapt this procedure for your facility)

During an emergency, the site or facility will initiate evacuation alert by performing the following actions. The one circled is applicable to our facility:

- The facility or home is equipped with smoke detection or sprinkler system, that will trigger the alarm to sound for evacuation.
- The staff will manually operate the alarm by pulling one of the nearest Fire Alarm Boxes located at: ______________________. See Evacuation Maps for locations of all pull boxes.
- Our facility uses an alternative sound device for a fire alert. The staff will perform the following to initiate evacuation alert: _______________________________

ALL STAFF WILL REMAIN ON DUTY WITH THE CHILDREN UNTIL THEY ARE RELIEVED.

EVACUATION TRANSPORTATION

If we are to go to an alternate location as an evacuation site, the one circled is our transportation plan:

1. Local authorities will arrive and make arrangements.

2. Call the local van service at:________________________ and order the number of seats you need.

3. Use your own personal vehicle.

OUR LOCAL VAN SERVICE IS:

(Fill in the appropriate name and number)

NAME: ____

TELEPHONE #: ____________________________________

Wallet Cards

Make copies of the page as needed. Fill out the cards, cut them out and fold them in half. Laminate the cards or have a store laminate them for you.

Child care provider: ______________	Relocation site #1: ______________
Phone: ______________	Address: ______________
Alternate: ______________	Phone: ______________
Out of area contact: ______________	Relocation site #2: ______________
Phone: ______________	Address: ______________
Alternate: ______________	Phone: ______________
Status update location: ______________	Code word: ______________

Child care provider: ______________	Relocation site #1: ______________
Phone: ______________	Address: ______________
Alternate: ______________	Phone: ______________
Out of area contact: ______________	Relocation site #2: ______________
Phone: ______________	Address: ______________
Alternate: ______________	Phone: ______________
Status update location: ______________	Code word: ______________

Child care provider: ______________	Relocation site #1: ______________
Phone: ______________	Address: ______________
Alternate: ______________	Phone: ______________
Out of area contact: ______________	Relocation site #2: ______________
Phone: ______________	Address: ______________
Alternate: ______________	Phone: ______________
Status update location: ______________	Code word: ______________

Child care provider: ______________	Relocation site #1: ______________
Phone: ______________	Address: ______________
Alternate: ______________	Phone: ______________
Out of area contact: ______________	Relocation site #2: ______________
Phone: ______________	Address: ______________
Alternate: ______________	Phone: ______________
Status update location: ______________	Code word: ______________

RELOCATION PLANNING AND PROCEDURE

Relocation Sites:
Choose two off-site places where you could go in an emergency. Write the addresses and phone numbers on form LIC 610-Section IV (centers) and LIC 610A-Section 4 (family child care homes). Consider Hazard Analysis when choosing relocation sites. For example, if you are in a flood zone, at least one relocation site should be on higher ground; in areas at risk for earthquakes, one relocation site might be within walking distance and the other a mile or more away.

Letter of Agreement with Relocation Site:
Ask the owner of your relocation sites to sign a letter of agreement/permission (see template in H-22). Attach the Letters of Agreement with Relocation Site to form LIC 610/610A.

Transportation Needs:
Staff and children may need to be transported by automobile, van, or bus for relocation to another site. Consider your transportation needs and resources in advance. Do you have access to a van or other automobile? In some emergencies you may need to call local law enforcement or the fire department to assist with transporting staff and children.

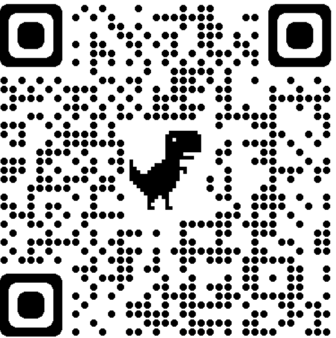
* Mass shelters, such as Red Cross Shelters, cannot accept responsibility for children without an adult who has legal authority for a child. Shelter volunteers make referrals to social services and law enforcement to reunite children with their families as soon as possible after a disaster. It is usually better for children to stay with someone who the parents have entrusted with their care (e.g. a child care provider or people who are authorized to take them from the facility), in a familiar location (e.g. the child care center, family child care home, a relocation site in the neighborhood) rather than go to a mass shelter.

To relocate to another area:

1. Initiate name tag procedure (see page H-23).
2. Arrange route and means of transportation.
3. Inform everyone where they are going and how to get there.
4. Have teachers take necessary equipment.
5. Leave a sign to inform parents where you will be.

6. Keep everyone together.
7. Call parents/legal guardian (if possible) after relocating.
8. Notify Community Care Licensing.

Sample Relocation Letter and other useful disaster preparedness documents (from UCSF) can be found here: [Emergency Plan Documents]()



Resource: UCSF California Childcare Health Program

https://cchp.ucsf.edu/resources/disaster-preparedness

Letter of Agreement with Relocation Site

I hereby give permission for ____ child care provider to use the below listed site as an emergency relocation site for child care staff and children during a drill or actual emergency event.

This agreement will remain in effect until Month, Date, Year:____

The agreement may be terminated before this date by either party, but only with written notification.

Relocation Site Name:____

Relocation Site Address:____

Relocation Site Contact Person:____

Relocation Site Contact Number:____

Alternate Contact Number:____

Is site accessible at all times the child care program is open? ☐ Yes ☐ No

Include any information needed to access and enter the site:

Maximum Number of Children and Staff/Capacity:____

Check off items that the relocation site will provide in an emergency:

☐ Water

☐ Food

☐ Transportation

☐ Telephone

☐ People to assist

☐ Other:

Include any special considerations (storage room, restrooms, wheelchair accessible, back-up equipment, supplies, etc.):

Relocation Site Representative Printed Name:____

Signature:____________________________________ Date:____

Child Care Program Representative Printed Name: ____

Signature:____________________________________ Date:____

Adapted from: Child Care Resource Center, *Emergency Preparedness Toolkit for Child Care Programs,*
funded by the Los Angeles County Department of Public Health

NAME TAG PROCEDURE

POLICY: The child care staff will assume responsibility for identifying and determining attendance during a disaster.

PURPOSE: To make sure no child is left behind.
To easily identify children in an emergency situation.
To serve as a back-up system to daily attendance roster.
To provide information about the child for disaster workers.

PROCEDURE:

1. Once relocated to the evacuation site, a name tag (e.g. name tag stickers) will be put on each child.

2. Blank name tags and a marker will be kept in first aid kits.

3. Make a name tag for each child on your roll sheet.

    a. Child's Name

    b. Parent's or legal guardian's name and phone number

    c. Childcare program name, address, and phone number

    d. Classroom name and teacher's name

4. All missing children's name tags will be given to the Emergency Charge.

5. As children are picked up, take their tag off. Have the person taking the child sign the tag and note where they are going on the tag. (Leave tag on if going to new location or hospital and make a note of location).

6. Name tags will be kept as reference, and therefore should be legible and safeguarded.

Emergency Supplies Checklist

Keeping Track of Your Supplies

- ☐ Date supplies, keep a record, and review every six months.
- ☐ Rotate food and water before they expire.
- ☐ Check that supplies are in good condition and that important documents are up-to-date every six months.
- ☐ Check batteries for damage and refresh as need. Do not store batteries inside of the device. (Store in a baggie).
- ☐ Update sizes of children's clothing and age appropriateness of activities as needed.
- ☐ Remind parents to update contact information at least every six months.
- ☐ Considering picking a date that is easy to remember to check your supplies, such as the beginning and end of Daylight Savings Time.
- ☐ Consider printing and laminating a copy of your supplies list to store with your supplies. You can use it to check off items as they are used and request replacements as needed.

Documents

Attendance Records — Keep the daily attendance sheet where you can easily grab it in an emergency.

- ☐ Daily attendance sheet

"Ready-to-Go" File — Store these emergency documents in a binder, folder, or envelope inside (or near) your "Ready-to-Go" Kit.

- ☐ Child Emergency Information Forms (includes medical release and emergency transportation permission)
- ☐ Emergency plan
- ☐ Emergency contact information of local agencies, services, and facilities
- ☐ Relocation site agreements with maps and written directions
- ☐ Special Health Care Plans
- ☐ Parent Consent for Administration of Medication and Medication Chart (LIC 9221)

Back-up Business Documents — Back up your business records on a thumb drive, cloud service, or have hard copies.

- ☐ Children's records
- ☐ Employee records
- ☐ Food program records
- ☐ Accounts receivable
- ☐ Insurance policies
- ☐ Rental agreements
- ☐ Floor plans
- ☐ Bank records
- ☐ Other business documents

Supplies

	"READY-TO-GO" KIT	72 HOUR EMERGENCY SUPPLIES
	Use a waterproof backpack (or wheeled duffle bag or bin) that holds enough supplies for an evacuation lasting up to 6 hours.	**Use a sturdy waterproof container with a tight-fitting lid that holds enough supplies for lockdown or shelter-in-place lasting up to 72 hours.**
Food & Water	☐ One gallon of water for every four people (this may not fit in a backpack, store so that it can be taken in an evacuation) ☐ Non-perishable snacks such as granola bars and crackers ☐ Formula / appropriate food for infants and toddlers (consider liquid formula or store enough water to mix powdered formula) ☐ Infant bottles ☐ Disposable cups, plates, bowls, and utensils	☐ One gallon of water per person per day ☐ Water purification filter or tablets ☐ Non-perishable food items such as canned fruit and protein sources (e.g. beans, tuna, chicken) ☐ Formula/appropriate food for infants and toddlers (consider liquid formula or store enough water to mix powdered formula) ☐ Infant bottles ☐ Disposable cups, plates, bowls, and utensils ☐ Manual can opener
First Aid	**Small first-aid kit to include:** ☐ A current edition of a pediatric first-aid manual (for example, American Academy of Pediatrics, Red Cross, National Safety Council) ☐ Sterile first-aid gauze pads ☐ Bandages or roller bandages ☐ Liquid soap (plain) ☐ Adhesive tape ☐ Scissors ☐ Tweezers ☐ Disposable gloves ☐ Chemical ice pack	**Large first-aid kit to include:** ☐ A current edition of a pediatric first-aid manual (for example, American Academy of Pediatrics, Red Cross, National Safety Council) ☐ Sterile first-aid gauze pads ☐ Bandages or roller bandages ☐ Adhesive tape ☐ Scissors ☐ Tweezers ☐ Thermometer ☐ Liquid soap (plain) ☐ Cotton balls ☐ Disposable gloves ☐ Thick gauze pads or sanitary napkins ☐ Chemical ice pack ☐ Heat pack ☐ Safety pins ☐ Triangle type sling

	"READY-TO-GO" KIT	72 HOUR EMERGENCY SUPPLIES
Safety	☐ Walking Rope ☐ Whistle ☐ Flashlight with batteries ☐ Glow sticks ☐ Duct tape ☐ Masking tape/painter's tape ☐ Caution tape for marking boundaries ☐ Work gloves ☐ Utility knife/multi-tool ☐ Extra keys	☐ Walking Rope ☐ Whistle ☐ Flashlight ☐ Extra batteries ☐ Glow sticks ☐ Duct tape ☐ Masking tape/painter's tape ☐ Caution tape for marking boundaries ☐ Work gloves ☐ Permanent marker ☐ Plastic sheeting (to seal windows, doors, and vents in shelter-in-place situation) ☐ Dust/filter mask (1 per person) ☐ Goggles ☐ Utility knife/multi-tool ☐ Extra keys
Personal Care & Hygiene	☐ Diapers ☐ Wet wipes ☐ Alcohol-based hand sanitizer ☐ Toilet paper ☐ Paper towels ☐ Sunscreen	☐ Diapers ☐ Wet wipes ☐ Toilet paper ☐ Menstrual products ☐ Paper towels ☐ Plastic bags (varied sizes) ☐ 5 gallon plastic bucket with toilet seat ☐ Toothbrushes and toothpaste ☐ Sunscreen
Comfort, Clothing & Bedding	☐ Emergency blankets ☐ Activity items such as card games, crayons, paper, small toys, and books ☐ Clean teething rings and pacifiers ☐ Emergency cash (small bills)	☐ Emergency blankets (1 per person) ☐ Extra blankets ☐ Rain ponchos ☐ Several pairs of clean socks and underwear in a variety sizes ☐ Extra children's clothes in a variety of sizes, including jackets, hats, and closed-toe shoes ☐ Several children's activity items ☐ Clean teething rings and pacifiers ☐ Personalized comfort kits for each child to include a favorite activity, toy, or book, photo of the child's family, and comfort note from the parent ☐ Emergency clothing, supplies, medication and comfort items (for example, reading material, music) for staff members ☐ Emergency cash (small bills)
Communication	☐ Radio with extra batteries or crank radio (emergency stations identified)	☐ Radio with extra batteries or crank radio (emergency stations identified) ☐ Portable cell phone charger and cords ☐ Signal/flare ☐ Walkie-talkie

EARTHQUAKE

1. As soon as you feel the movement, the lead teacher calls out "Duck and Cover!!!".

   a. Drop to the ground.

   b. Take cover by getting under a sturdy table or other piece of furniture.

   c. Hold on until the shaking stops.

   d. Do not stand in doorway or run outside (new research shows that a doorway does not offer adequate protection FEMA Article).

   NOTE: Infant-toddler caregivers cover children with body if possible.

2. Do not run outside or evacuate while the building is shaking.

3. After the quake, the Emergency Charge will instruct on further action.

Until then:

   a. Check for injured children or staff.

   b. Evacuate everyone when the order is given by Emergency Charge.

   c. Stay with your group until you are relieved of your duties.

REMEMBER!! Panic action kills and injures more people than the direct results of an earthquake!!

After the earthquake:

4. Look around for possible hazards to determine if it is safe for you to move before getting up and helping others.

5. Emergency Charge decides whether to evacuate or stay put.

6. Any of the following require immediate evacuation: fire, damage to structure, a gas leak, or hazardous materials spill. In some situations, you may choose not to evacuate or to delay evacuation. For example, if there is a slight shaking with no apparent damage and another hazard such as severe weather, it may be more dangerous to move children outside.

7. If you smell gas or hear a blowing or hissing noise, open a window, and then quickly leave with the children, and shut the gas off outside. Be aware that if you shut off the gas meter for any reason, a professional must turn it back on. It may take days or weeks before they are able to do so.

8. Unless you must evacuate immediately (fire, severe damage to structure, gas leak, or hazardous materials spill), check all children and adults for injuries and give first aid for injuries before evacuating.

9. Do not move seriously injured persons unless they are in immediate danger of further injury (fire and flooding). Instead, cover them with a sturdy table or whatever is available and send someone for medical help after the earthquake shaking stops.

10. As time permits, you may need to turn off utilities such as gas, electricity, and water. If electrical wires are crackling inside, shut off the gas first, then turn off the master electrical switch.

11. If you must evacuate, get out of the building, gather at your designated safe place, and take the emergency kit (first aid bag and medications) along with your list of children and their emergency contacts.

12. When possible, to reduce the chances of both physical and emotional harm, move children who are able to walk away from danger, away from collapsed buildings, and away from severely injured survivors. If you must leave the area, place a note for the parents outside the door, telling them where you are going.

13. Call 9-1-1 if there is a fire or medical emergency. If the phone doesn't work, send someone for help.

14. Treat minor injuries.

15. Reassure the children. Tell them that their parents will come for them as soon as they can, that their parents know everyone will be safe with you, and that you are all together.

16. Listen to a battery-operated radio for instructions and the latest emergency information.

    - KQED 88.5 FM
    - KFBK 1530 AM
    - Check **alertsf.org**

EARTHQUAKE EMERGENCY CHARGE RESPONSIBILITY

1. **Duck and cover. Protect yourself.**
2. When shaking stops, check evacuation area for safety. (wires down? trees tipping?)
    a. If area is safe, alert staff to evacuate.
    b. If unsafe, check alternate evacuation areas.
    c. Assign a staff person to tell others where to evacuate.
3. Check for damage and gas leaks to the buildings (Concern depends upon severity of the quake.)
4. Turn off gas, water, and electricity (location of turn-offs should be noted in your emergency plan).
5. Account for all children and personnel.
6. Make sure disaster kit is available.
7. Determine injuries.
8. Set up First Aid Station and staff it.
9. Send injured children and staff to First Aid Station.
10. Appoint a search and rescue team and lead it.
11. Put triage into effect (see H-44).
12. Monitor First Aid efforts. Identify those with special health needs.
13. Monitor radio. Attempt to get help.
14. Assign temporary spaces for classes.
15. Determine each group's needs (blankets, diapers, etc.).
16. Ascertain what food, water and supplies are available.
17. Ration all supplies.
18. Make a plan for survival until help arrives.

19. Assign an alternate for relief for yourself.

20. Keep communications open and flowing.

21. Keep a night watch for strangers and animals.

Source: https://www.ready.gov/earthquakes

FIRE

1. If you discover a fire, alert the entire building or site, and call 911.
2. Tell your supervisor:
    a. Where the fire is
    b. How extensive it is
    c. Type of fire if known (electrical, paper, chemical)
3. If you hear the fire alarm.
    a. Immediately follow evacuation procedure.
    b. Test closed doors with your hand. If they are hot, there is likely a fire on the other side of the door. If door or doorhandle is hot, use the alternate evacuation route.
4. After evacuation, and if fire is small and contained, one staff member should try to put the fire out with the extinguisher.
5. Stay in the evacuation area until the Emergency Charge instructs you to return.

NO ONE WILL RE-ENTER A BURNING BUILDING

NOTE: This section should be filled out for each classroom.

The closest pull box is:

The closest telephone is:

The closest fire extinguisher is:

The fire extinguisher must be recharged every year:

The closest exit is: ____

FIRE EMERGENCY CHARGE RESPONSIBILITY

1. Evacuation procedure!
2. Call Fire Department.
3. Check all areas (that you can check safely) to assure evacuation is complete.
4. Close doors and windows as you check if it can be done quickly.
5. Assure that the disaster kit is taken out.
6. Turn off gas.
7. Account for all children and personnel. (Teachers will have taken roll).
8. Determine if there are injuries.
9. Give instructions for First Aid. Assign someone to set up a station and treat the injured.
10. Direct firefighters to engulfed areas.
11. Have facility information ready for Fire Chief.
12. Direct paramedics to injured people.
13. If damage is extensive, initiate name tag procedure.
14. Dispatch someone to a phone to start calling parents/guardians of injured children and families of injured staff.
15. Determine if relocation is appropriate - follow procedure.
16. Advise everyone of what is going on.
17. Work closely with Fire Chief to coordinate efforts.

FLOOD

1. If instructed by local authorities to evacuate because of flood dangers, the Emergency Charge shall give instructions to classrooms and then set evacuation procedure in motion.

2. Parents should be called to pick children up immediately, if there is time.

3. Turn off electricity.

4. Evacuate to nearest high ground.

Our evacuation location is: ____
(Fill in your designated area.)

FLOOD EMERGENCY CHARGE RESPONSIBILITY

1. Important points to impart to all:

   a. Stay out of contaminated water.

   b. Drinking water supply will be contaminated. Don't drink tap water, not even if purified. You may use unopened bottled water.

2. If no help or instructions arrive, try to get everyone to the highest ground available - safely. (Be careful of too much weight on the roof!).

For more info on flood prevention, visit [American Red Cross Flood Safety]

Be **Red Cross** Ready

Tsunami

Preparedness Checklist

A tsunami is a series of ocean waves caused by earthquakes, landslides, or volcanic eruptions. These waves can kill and injure people and destroy entire communities. Tsunamis strike as fast-moving walls of water that flood, drain, and re-flood the land for hours. Tsunamis can flood more than a mile inland. But we can take action to prepare. Prepare now to protect yourself and your loved ones.

What to Do: Before

Know your Risk

- Tsunamis can strike any U.S. coast, but the risk is greatest for communities with Pacific and Caribbean coastlines. Coastal areas such as beaches, bays, lagoons, harbors and river mouths and areas along rivers and streams that lead to the ocean are the most vulnerable.
- If you live on or near a coast, find out if you are in a tsunami hazard zone.

Make Plans to Stay Safe

- Learn about your community's tsunami evacuation plan. Some communities have maps with evacuation zones and routes. Know and practice these routes in the places where you spend time.
- If your community does not have a tsunami evacuation plan, identify a safe place at least 100 feet (30 meters) above sea level or at least 1 mile (1.6 km) inland.
- Be ready to move quickly to higher ground or inland. Don't wait for an official alert.
- If you are near the coast, a tsunami could follow an earthquake. As soon as the shaking stops, move quickly to higher ground or inland away from the coast. Don't wait for an official alert.

Understand Tsunami Alerts and Natural Signs of a Tsunami

- There are two ways that you may be warned: an official tsunami alert or a natural sign of a tsunami. Both are equally important. You may not get both.
- A natural sign of a tsunami may be your first, best, or only warning that a tsunami is on its way. Natural signs include an earthquake, a loud roar from the ocean, or unusual ocean behavior, such as a sudden rise or wall of water or a sudden retreat of the water, showing the ocean floor. If you experience any of these signs, a tsunami could be coming. Immediately move to higher ground or inland away from the coast. Don't wait for an official alert.
- Tsunami alerts are shared on local radio, television, weather radios, and other emergency alert systems. Understand the different alerts and what to do when you receive them.

Alert	What it means	What to do
Tsunami Information Statement	An earthquake has occurred, but there is no threat, or it was very far away, and the threat has not been determined.	Monitor local emergency information.
Tsunami Watch	A distant earthquake has occurred. A tsunami is possible.	**Be Aware.** Monitor local emergency information. Be prepared to take action if necessary.
Tsunami Advisory	A tsunami with dangerous currents or waves is expected or occurring.	**Take Action.** Stay out of the water and away from beaches and waterways. Follow instructions from local officials.
Tsunami Warning	A tsunami that may cause widespread flooding is expected or occurring! Dangerous coastal flooding and powerful currents are possible and may continue for several hours or days after initial arrival.	**DANGER-TAKE IMMEDIATE ACTION! MOVE TO HIGH GROUND OR INLAND (AWAY FROM THE WATER).**

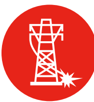
What to Do: During

Move to High Ground or Inland

If your community is under a Tsunami Warning or you see natural signs of a tsunami:

- **DANGER-TAKE IMMEDIATE ACTION! MOVE TO HIGH GROUND OR INLAND (AWAY FROM THE WATER).**
- If you are near the coast and experience shaking from an earthquake: **DROP, COVER,** and **HOLD ON** to protect yourself. As soon as the shaking stops, **MOVE TO HIGH GROUND OR INLAND (AWAY FROM THE WATER).**
- Once you have evacuated, stay there until officials say it is safe to return home or direct you to evacuate further inland.

What to Do: After



Stay Safe

- Understand the dangers you may face after a tsunami. Many injuries happen during cleanup.
- If you have evacuated, listen to local officials to learn if it is safe to return home. If there is a lot of damage, it may be days before it is safe to return to your community.
- Avoid roads that were flooded, they may be damaged and could collapse.
- Do not touch floodwaters. They may contain sewage, bacteria, and chemicals that can make you sick.
- Avoid damaged or fallen power lines. Assume all wires are live and dangerous.
- When officials allow, inspect the outside of your home for damage before reentering.
- If your home is damaged, it may be safer to wait for a professional.
- Be aware of carbon monoxide poisoning. Do not use gasoline, propane, natural gas or charcoal-burning devices inside a home, basement, garage, tent, or camper — or even outside near an open window. Carbon monoxide can't be seen or smelled, but it can kill you fast. If you start to feel sick, dizzy or weak, **get to fresh air right away — do not delay.**
- Avoid using candles because of the fire risk. Use battery-powered lights and flashlights instead.

Stay Healthy

- Monitor your local health department for information about drinking water safety. Tsunamis can contaminate water supplies.
- **When in doubt, throw it out.** Throw away food that got wet or warm.
- Clean and disinfect everything that got wet. Mud left from floodwaters can contain sewage, bacteria, and chemicals. Mold can become a problem if a building is flooded and not completely dried out within 24-48 hours. Mold exposure can lead to asthma attacks, eye and skin irritation, and allergic reactions.

Clean Up Safely

- Follow all specific recommendations from your local public health officials. Use the right safety gear including gloves, goggles, rubber boots, and N95 masks. Know how to safely operate any needed equipment.
- Pace yourself. Cleaning up is a big job. Rest when you need to. Work with other people and get help lifting heavy objects. Decide which cleanup tasks are most important and focus on those first.
- Avoid heat-related illness. If you are without air conditioning in hot weather, be aware of risk for heat stroke, heat exhaustion, heat cramps, and fainting.

Take Care of Yourself

- It's normal to have a lot of bad feelings, stress, or anxiety after a disaster or other emergency.
- Eat healthy food and get enough sleep to help you deal with stress.
- You can contact the Disaster Distress Helpline for free if you need to talk to someone. Call or text **1-800-985-5990**.

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Hazard and Protective Actions Icons are used courtesy of FEMA and are available at community.fema.gov/ProtectiveActions/s/protective-actions-icons

FoodSafety.gov

Refrigerated Food and Power Outages: When to Save It and When to Throw It Out

Type of Food	Held above 40 °F for more than 2 hours
Meat, poultry, seafood	
Raw or leftover cooked meat, poultry, fish, or seafood; soy meat substitutes	Discard
Thawing meat or poultry	Discard
Salads: Meat, tuna, shrimp, chicken, or egg salad	Discard
Gravy, stuffing, broth	Discard
Lunchmeats, hot dogs, bacon, sausage, dried beef	Discard
Pizza with any topping	Discard
Canned hams labeled "Keep Refrigerated"	Discard
Canned meats and fish, opened	Discard
Casseroles, soups, stews	Discard
Cheese	
Soft cheeses: blue/bleu, Roquefort, Brie, Camembert, cottage, cream, Edam, Monterey Jack, ricotta, mozzarella, Muenster, Neufchatel, queso blanco, queso fresco	Discard
Hard cheeses: Cheddar, Colby, Swiss, Parmesan, provolone, Romano	Keep
Processed cheeses	Keep
Shredded cheeses	Discard
Low-fat cheeses	Discard
Grated Parmesan, Romano, or combination (in can or jar)	Keep
Dairy	

Type of Food	Held above 40 °F for more than 2 hours
Milk, cream, sour cream, buttermilk, evaporated milk, yogurt, eggnog, soy milk	Discard
Butter, margarine	Keep
Baby formula, opened	Discard
Eggs	
Fresh shell eggs, eggs hard-cooked in shell, egg dishes, egg products	Discard
Custards and puddings, quiche	Discard
Fruits	
Fresh fruits, cut	Discard
Fresh fruits, uncut	Keep
Fruit juices, opened	Keep
Canned fruits, opened	Keep
Dried fruits, raisins, candied fruits, dates	Keep
Sliced or shredded coconut	Discard
Sauces, Spreads, Jams	
Opened mayonnaise, tartar sauce, horseradish	Discard (if above 50 °F for more than 8 hrs)
Peanut butter	Keep
Jelly, relish, taco sauce, mustard, catsup, olives, pickles	Keep
Worcestershire, soy, barbecue, hoisin sauces	Keep
Fish sauces, oyster sauce	Discard
Opened vinegar-based dressings	Keep
Opened creamy-based dressings	Discard
Spaghetti sauce, opened	Discard
Bread, cakes, cookies, pasta, grains	
Bread, rolls, cakes, muffins, quick breads, tortillas	Keep
Refrigerator biscuits, rolls, cookie dough	Discard

Type of Food	Held above 40 °F for more than 2 hours
Cooked pasta, rice, potatoes	Discard
Pasta salads with mayonnaise or vinaigrette	Discard
Fresh pasta	Discard
Cheesecake	Discard
Breakfast foods: waffles, pancakes, bagels	Keep
Pies and pastry	
Cream filled pastries	Discard
Pies: Any with filling containing eggs or milk, e.g., custard, cheese-filled, or chiffon; quiche.	Discard
Fruit pies	Keep
Vegetables	
Fresh vegetables, cut	Discard
Fresh vegetables, uncut	Keep
Fresh mushrooms, herbs, spices	Keep
Greens, pre-cut, pre-washed, packaged	Discard
Vegetables, cooked	Discard
Tofu, cooked	Discard
Vegetable juice, opened	Discard
Baked potatoes	Discard
Commercial garlic in oil	Discard
Potato salad	Discard
Casseroles, soups, stews	Discard

Date Last Reviewed January 28, 2021

Frozen Food and Power Outages: When to Save It and When to Throw It Out

Type of food	Contains ice crystals and feels cold as if refrigerated	Thawed and held above 40°F for more than 2 hours
Meat, poultry, seafood		
Meat, poultry, seafood – all types of cuts	Refreeze	Discard
stews, soups	Refreeze	Discard
Dairy		
Milk	Refreeze (some loss of texture)	Discard
Eggs (out of shell) and egg products	Refreeze	Discard
Ice cream, frozen yogurt	Discard	Discard
Cheese (soft and semi-soft)	Refreeze (some loss of texture)	Discard
Hard cheeses	Refreeze	Refreeze
Shredded cheeses	Refreeze	Discard
Cheesecake	Refreeze	Discard
Fruits		
Juices	Refreeze	Refreeze. (discard if mold, yeasty smell, or sliminess develops)
Home or commercially packaged	Refreeze (will change texture and flavor)	Refreeze (discard if mold, yeasty smell, or sliminess develops)
Vegetables		
Juices	Refreeze	Discard after held above 40°F for 6 hours
Home or commercially packaged or blanched	Refreeze (may suffer texture and flavor loss)	Discard after held above 40°F for 6 hours

Type of food	Contains ice crystals and feels cold as if refrigerated	Thawed and held above 40°F for more than 2 hours
Breads and pastries		
Breads, rolls, muffins, cakes (without custard fillings)	Refreeze	Refreeze
Cakes, pies, pastries with custard or cheese filling	Refreeze	Discard
Pie crusts, commercial and homemade bread dough	Refreeze (some quality loss may occur)	Refreeze (quality loss is considerable)
Other Foods		
Casseroles: pasta, rice-based	Refreeze	Discard
Flour, cornmeal, nuts	Refreeze	Refreeze
Breakfast items: waffles, pancakes, bagels	Refreeze	Refreeze
Frozen meal, entree, specialty item (pizza, sausage and biscuit, meat pie, convenience foods)	Refreeze	Discard

Date Last Reviewed January 28, 2021

FEMA

FEMA P-2149/March 2018

BE PREPARED FOR A NUCLEAR EXPLOSION

Nuclear explosions can cause significant damage and casualties from blast, heat, and radiation but you can keep your family safe by knowing what to do and being prepared if it occurs.

A nuclear weapon is a device that uses a nuclear reaction to create an explosion.

Nuclear devices range from a small portable device carried by an individual to a weapon carried by a missile.

A nuclear explosion may occur with a few minutes warning or without warning.

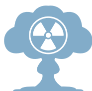
Bright FLASH can cause temporary blindness for less than a minute.

BLAST WAVE can cause death, injury, and damage to structures several miles out from the blast.

RADIATION can damage cells of the body. Large exposures can cause radiation sickness.

FIRE AND HEAT can cause death, burn injuries, and damage to structures several miles out.

ELECTROMAGNETIC PULSE (EMP) can damage electronics several miles out from the detonation and cause temporary disruptions further out.



FALLOUT is radioactive, visible dirt and debris raining down that can cause sickness to those who are outside.

Fallout is most dangerous in the first few hours after the detonation when it is giving off the highest levels of radiation. It takes time for fallout to arrive back to ground level, often more than 15 minutes for areas outside of the immediate blast damage zones. This is enough time for you to be able to prevent significant radiation exposure by following these simple steps:

GET INSIDE

Get inside the nearest building to avoid radiation. Brick or concrete are best.

Remove contaminated clothing and wipe off or wash unprotected skin if you were outside after the fallout arrived.

Go to the basement or middle of the building. Stay away from the outer walls and roof.

STAY INSIDE

Stay inside for 24 hours unless local authorities provide other instructions.

Family should stay where they are inside. Reunite later to avoid exposure to dangerous radiation.

Keep your pets inside.

STAY TUNED

Tune into any media available for official information such as when it is safe to exit and where you should go.

Battery operated and hand crank radios will function after a nuclear detonation.

Cell phone, text messaging, television, and internet services may be disrupted or unavailable.

HOW TO STAY SAFE

IN THE EVENT OF A NUCLEAR EXPLOSION

Identify shelter locations. Identify the best shelter location near where you spend a lot of time, such as home, work, and school. The best locations are underground and in the middle of larger buildings.

While commuting, identify appropriate shelters to seek in the event of a detonation.

Outdoor areas, vehicles and mobile homes do NOT provide adequate shelter. Look for basements or the center of large multi-story buildings.

Make sure you have an **Emergency Supply Kit** for places you frequent and might have to stay for 24 hours. It should include bottled water, packaged foods, emergency medicines, **a hand-crank or battery-powered radio** to get information in case power is out, a flashlight, and extra batteries for essential items. If possible, store supplies for three or more days.

FEMA

FEMA P-2149
Catalog No. 17233-16

If warned of an imminent attack, immediately get inside the nearest building and move away from windows. This will help provide protection from the blast, heat, and radiation of the detonation.

If you are outdoors when a detonation occurs take cover from the blast behind anything that might offer protection. Lie face down to protect exposed skin from the heat and flying debris. If you are in a vehicle, stop safely, and duck down within the vehicle.

After the shock wave passes, **get inside the nearest, best shelter location** for protection from potential fallout. You will have 10 minutes or more to find an adequate shelter.

Be inside before the fallout arrives. The highest outdoor radiation levels from fallout occur immediately after the fallout arrives and then decrease with time.

Stay tuned for updated instructions from emergency response officials. If advised to evacuate, listen for information about routes, shelters, and procedures.

If you have evacuated, do not return until you are told it is safe to do so by local officials.

Immediately after you are inside shelter, if you may have been outside after the fallout arrived:

Remove your outer layer of contaminated clothing to remove fallout and radiation from your body.

Take a shower or wash with soap and water to remove fallout from any skin or hair that was not covered. If you cannot wash or shower, use a wipe or clean wet cloth to wipe any skin or hair that was not covered.

Clean any pets that were outside after the fallout arrived. Gently brush your pet's coat to remove any fallout particles and wash your pet with soap and water, if available.

It is safe to eat or drink packaged food items or items that were inside a building. Do not consume food or liquids that were outdoors uncovered and may be contaminated by fallout.

If you are sick or injured, listen for instructions on how and where to get medical attention when authorities tell you it is safe to exit.

Take an Active Role in Your Safety

Download the **FEMA app** to get more information about preparing for a nuclear explosion.

Go to **Ready.gov**: https://www.ready.gov/nuclear-blast

Go to the **Centers for Disease Control**: https://emergency.cdc.gov/radiation

Go to **Health & Human Services**: https://www.remm.nlm.gov/nuclearexplosion.htm

CHEMICAL EMERGENCY

- A chemical emergency occurs when a hazardous or poisonous chemical is released into the environment and has the potential to harm people's health. Chemical releases can be unintentional, such as the release of toxic gas from an industrial accident, or intentional, such as in a terrorist attack. Some hazardous chemicals are found in household cleaners. A truck carrying hazardous materials could crash into your building. Children are at greater risk than adults during a chemical emergency. Learn more about the types of hazardous chemicals.

- Each chemical emergency is different and may require different actions to keep people safe. During an emergency, you may have to evacuate or to shelter in place, depending on how close you are to the incident. **In most cases, emergency authorities (local police, emergency coordinators, or government on the radio and on the television emergency broadcast system) will let you know where to go to protect yourself.**

- In some chemical emergencies, emergency authorities decide when it is safe to evacuate the immediate area and give instructions to go to an emergency shelter, if necessary. **Parents/legal guardians should be advised NOT TO GO to the child care** facility during the emergency but wait for pickup instructions, location, and clearance from emergency authorities.

1. In the event of relocation, proceed with evacuation procedure and name tag procedure. Try to contact parents/legal guardians to advise of current location.

- Some chemical emergencies make going outdoors or leaving the immediate area too dangerous. When this happens, emergency authorities will tell you to shelter in place. **Parents/legal guardians should be advised NOT TO GO to the child care** facility during the emergency but to wait for pickup instructions and clearance from emergency authorities.

- Instructions from authorities will be provided to classrooms by the Emergency Charge.

- In the event of a potential hazardous materials emergency or other life-threatening environmental hazard within your facility, staff should **call 9-1-1.** Try to determine type of chemical or hazardous material if possible.

- Report the incident to Community Care Licensing, complete LIC624.

What if a Chemical Gets on Me or the Children?

- Many chemicals can go through clothing and be absorbed through the skin. If exposed to hazardous chemicals, you will need to quickly decontaminate (reduce or remove the chemical so it is no longer dangerous to you).
- You can decontaminate by removing your clothing, disposing of it properly, and washing your body. Learn more about decontamination.
- Use gloves when helping to decontaminate children and wash your hands with soap and water after decontaminating another person to ensure that you do not contaminate yourself or anyone else.
- If you don't know what chemical spilled on you or your clothing, you can contact 1-800-232-4636 or email cdcinfo@cdc.gov for more information about personal cleaning and disposal of contaminated clothing.

Reference: https://www.cdc.gov/childrenindisasters/chemical-threats.html

Additional Resources:

CDC: Chemical Emergencies

Chemical Agents: Facts About Personal Cleaning and Disposal of Contaminated Clothing

Fact-sheets on specific chemical agents

Chemical Terrorism and Agents from the American Academy of Pediatrics

SFDPH - Hazardous Materials and Waste Program

SMOG ALERT

1. Identify "at risk" children with asthma and other respiratory allergies.

2. Check the daily air quality at https://www.baaqmd.gov/about-air-quality/current-air-quality

3. Air Quality Index (AQI) tells you how clean or polluted your air is and what associated health effects might be a concern. It rates air quality from 0 to 500. The greater the AQI value, the greater the level of air pollution, and the greater the health concern. For example, an AQI value over 300 represents hazardous air quality. To make it easier to understand, AQI is divided into six categories, each assigned a specific color:

COLOR	Air Quality Index Levels of Health Concern	Numerical Value	Meaning
GREEN	Good	0 to 50	Air quality is considered satisfactory, and air pollution poses little or no risk
YELLOW	Moderate	51 to 100	Air quality is acceptable; however, for some pollutants there may be a moderate health concern for a very small number of people who are unusually sensitive to air pollution.
ORANGE	Unhealthy for Sensitive Groups	101 to 150	Members of sensitive groups may experience health effects. The general public is not likely to be affected.
RED	Unhealthy	151 to 200	Everyone may begin to experience health effects; members of sensitive groups may experience more serious health effects.

PURPLE	**Very Unhealthy**	**201 to 300**	Health warnings of emergency conditions. The entire population is more likely to be affected.
MAROON	Hazardous	301 to 500	Health alert: everyone may experience more serious health effects

4. Modify outdoor activity plans based on AQI. See H-34 for guidance.

Reference: https://www.airnow.gov/

Air Quality and Outdoor Activity Guidance for Schools

Regular physical activity — at least 60 minutes each day — promotes health and fitness. The table below shows when and how to modify outdoor physical activity based on the Air Quality Index. This guidance can help protect the health of all children, including teenagers, who are more sensitive than adults to air pollution. Check the air quality daily at www.airnow.gov.

Air Quality Index	Outdoor Activity Guidance
green GOOD	Great day to be active outside!
yellow MODERATE	Good day to be active outside! Students who are unusually sensitive to air pollution could have symptoms.*
orange UNHEALTHY FOR SENSITIVE GROUPS	It's OK to be active outside, especially for **short activities** such as recess and physical education (PE). For **longer activities** such as athletic practice, take more breaks and do less intense activities. Watch for symptoms and take action as needed.* Students with asthma should follow their asthma action plans and keep their quick-relief medicine handy.
red UNHEALTHY	For **all outdoor activities**, take more breaks and do less intense activities. Consider moving **longer or more intense activities** indoors or rescheduling them to another day or time. Watch for symptoms and take action as needed.* Students with asthma should follow their asthma action plans and keep their quick-relief medicine handy.
purple VERY UNHEALTHY	Move **all activities** indoors or reschedule them to another day.

* Watch for Symptoms

Air pollution can make asthma symptoms worse and trigger attacks. Symptoms of asthma include coughing, wheezing, difficulty breathing, and chest tightness. Even students who do not have asthma could experience these symptoms.

If symptoms occur:
The student might need to take a break, do a less intense activity, stop all activity, go indoors, or use quick-relief medicine as prescribed. If symptoms don't improve, get medical help.

Go for 60!

CDC recommends that children get 60 or more minutes of physical activity each day. www.cdc.gov/healthyyouth/physicalactivity/guidelines.htm

Plan Ahead for Ozone

There is less ozone in the morning. On days when ozone is expected to be at unhealthy levels, plan outdoor activities in the morning.

Questions and Answers

How long can students stay outside when the air quality is unhealthy?

There is no exact amount of time. The worse the air quality, the more important it is to take breaks, do less intense activities, and watch for symptoms. Remember that students with asthma will be more sensitive to unhealthy air.

Why should students take breaks and do less intense activities when air quality is unhealthy?

Students breathe harder when they are active for a longer period of time or when they do more intense activities. More pollution enters the lungs when a person is breathing harder. It helps to:

- ✔ reduce the amount of time students are breathing hard (e.g., take breaks; rotate players frequently)
- ✔ reduce the intensity of activities so students are not breathing so hard (e.g., walk instead of run)

Are there times when air pollution is expected to be worse?

Ozone pollution is often worse on hot sunny days, especially during the afternoon and early evening. Plan outdoor activities in the morning, when air quality is better and it is not as hot.

Particle pollution can be high any time of day. Since vehicle exhaust contains particle pollution, limit activity near idling cars and buses and near busy roads, especially during rush hours. Also, limit outdoor activity when there is smoke in the air.

How can I find out the daily air quality?

Go to www.airnow.gov. Many cities have an Air Quality Index (AQI) *forecast* that tells you what the local air quality will be later today or tomorrow, and a *current* AQI that tells you what the local air quality is now. The AirNow website also tells you whether the pollutant of concern is ozone or particle pollution. Sign up for emails, download the free AirNow app, or install the free AirNow widget on your website. You can also find out how to participate (and register your school) in the School Flag Program (www.airnow.gov/schoolflag).

If students stay inside because of unhealthy outdoor air quality, can they still be active?

It depends on which pollutant is causing the problem:

Ozone pollution: If windows are closed, the amount of ozone should be much lower indoors, so it is OK to keep students moving.

Particle pollution: If the building has a forced air heating or cooling system that filters out particles then the amount of particle pollution should be lower indoors, and it is OK to keep students moving. It is important that the particle filtration system is installed properly and well maintained.

What physical activities can students do inside?

Encourage indoor activities that keep all students moving. Plan activities that include aerobic exercise as well as muscle and bone strengthening components (e.g., jumping, skipping, sit-ups, pushups). If a gymnasium or open space is accessible, promote activities that use equipment, such as cones, hula hoops, and sports balls. If restricted to the classroom, encourage students to come up with fun ways to get everyone moving (e.g., act out action words from a story). Teachers and recess supervisors can work with PE teachers to identify additional indoor activities.

What is an asthma action plan?

An asthma action plan is a written plan developed with a student's doctor for daily management of asthma. It includes medication plans, control of triggers, and how to recognize and manage worsening asthma symptoms. See www.cdc.gov/asthma/actionplan.html for a link to sample asthma action plans. When asthma is well managed and well controlled, students should be able to participate fully in all activities. For a booklet on "Asthma and Physical Activity in the School," see http://www.nhlbi.nih.gov/health/resources/lung/asthma-physical-activity.htm.

EPA-456/F-14-003
August 2014

Guidance for Schools During Wildfire Smoke Events

California Environmental Protection Agency
Office of Environmental Health Hazard Assessment

Wildfires in California can create smoke conditions that lead to unhealthy or hazardous air quality for extended periods. This factsheet provides guidance for school officials regarding the closure of schools and managing poor air-quality days due to a prolonged wildfire smoke event.

Reducing Outdoor Activity

- Encourage parents to arrange alternate transportation for students who usually walk or bike to school.
- Encourage using indoor waiting areas for students before and after school, if available.

Consider the following recommended actions for activity modifications based on the Air Quality Index (AQI):

AQI above 100
Air quality is “unhealthy for sensitive groups”.
Move recess and lunch indoors.
Excuse children with sensitivity to air pollution (e.g., asthma) from outdoor physical education activities.

AQI above 150
Air quality is “unhealthy”.
Exercise indoors or limit vigorous outdoor activities to a maximum of 15 minutes.
Move longer and more intense activities indoors.

AQI above 200
Air quality is “very unhealthy”.
Move all activities indoors or re-schedule outdoor events. If appropriate, close school.

AQI above 300
Air quality is "hazardous".
If appropriate, close school.

Improving Indoor Air Quality

- Before fire season, determine optimal settings for the Heating, Ventilation and Air Conditioning system (HVAC) to keep smoke from coming indoors. If possible, install high-efficiency filters that are MERV 13 or greater (see Washington Dept. of Health link below). During smoke events, keep doors and windows closed.
- Do not add to indoor air pollution. Do not use odor-masking sprays or burn candles in classrooms. Postpone science labs and art class activities that use volatile chemicals, as well as any cleaning activities that use solvents.
- Use portable HEPA air cleaners in classrooms if feasible when the AQI is over 100. For a list of air-cleaning devices that comply with California’s ozone emissions limits, school officials should refer to the California Air Resources Board’s list of California Certified Air Cleaning Devices.
- As an alternative to outdoor lunch or recess, create a cleaner air space in a large room with as few doors and windows as possible, such as a gym or cafeteria. To the extent possible, prevent smoke from entering the room and maintain the best air quality possible. Ensure that the room has adequate heating/cooling for the expected occupancy.
- Move students from portable classrooms into permanent buildings, if possible.
- Wearing N95 or similar masks may NOT always be beneficial to children to reduce exposure.

Sensitive Students
Students with existing respiratory and cardiovascular disease, especially those with asthma, are more sensitive to unhealthy air. They may begin experiencing symptoms such as coughing, wheezing, difficulty breathing, and chest tightness when air quality is “moderate” or worse (AQI above 51). Students should follow their asthma action plans and keep medication close. If individuals show adverse signs of smoke exposure, appropriate medical attention should be sought. Teachers, school nurses, and other adult staff should be instructed to pay especially close attention to sensitive students during wildfire events.

Updated December 12, 2019

Considerations for School Closure

Consider the following risks and benefits when making decisions regarding school closure during a wildfire smoke event:

Benefits of Keeping Schools Open:

- School closures often require a working adult parent or guardian to stay home. Not all families have the same ability to meet this need. Unsupervised students may not adhere to health recommendations at home.
- Air quality may be worse at a student's home, particularly if the school is in a modern building with good filtration.
- Schools can provide a safe place with clean indoor air where health recommendations for students can be enforced.

Benefits of School Closure:

- Some schools do not have air conditioning. For these schools, keeping students indoors at school with doors and windows closed may be unhealthy, especially during hot days.
- Transportation to and from school may expose students to unhealthy air, especially for students who walk or bike to school.
- Students on large campuses that require walking long distances between classes may not be able to avoid exposures to unhealthy air.

Preparing for School Reopening

After an extended wildfire smoke event, the main concern is ash that may have settled on school grounds. Ash should be removed before students return to campus. If structures have burned, it is possible that ashes may contain metals, asbestos, burned plastics, and other toxic substances that may pose health risks. If possible, request professional help with clean-up.

Cleaning Ash Indoors

- Use N95 or P100 respirators, gloves, and protective clothing when cleaning indoor areas.
- If ash has settled indoors around doors and windows, it should be swept gently and disposed of. If ash has settled on hard surfaces, such as desks, counters, shelves, or non-carpeted floors, remove it using a damp microfiber cloth with water and mild detergent. Shampoo carpets. **Settled ash should not be vacuumed.**
- Have the ventilation ducts inspected and cleaned if needed.

Cleaning Ash Outdoors

- If ash has settled on a school garden, replace the soil if in a garden box or raised bed, and throw away affected crops.
- Thoroughly clean outdoor areas where children will be present, including playgrounds, lunch areas, and outdoor drinking fountains before children are allowed to return.

For more information:

- Get current air quality information: https://airnow.gov/ or your local air quality agency webpage
- Learn more about outdoor activity guidance for schools: https://www3.epa.gov/airnow/flag/school-chart-2014.pdf
- Learn more about indoor air filtration options: https://www3.epa.gov/airnow/smoke_fires/indoor-air-filtration-factsheet-508.pdf
- Learn more about Washington State Department of Health, "Improving Ventilation and Indoor Air Quality During Wildfire Smoke Events": https://www.doh.wa.gov/Portals/1/Documents/Pubs/333-208.pdf
- Learn more about ash clean-up: https://www3.epa.gov/airnow/smoke_fires/protect-yourself-from-ash-factsheet.pdf
- Get Smart about Wildfire Smoke - Another example of School Air Quality Activity template: https://www.cde.ca.gov/ls/ep/documents/airqualityguidance.pdf
- California Air Resource's Board (CARB) Wildfire resources: https://ww2.arb.ca.gov/our-work/programs/wildfires
- California Environmental Protection Agency (CalEPA) wildfire resources: www.calepa.ca.gov/disaster/fire
- Protecting Children from smoke and ash: https://www3.epa.gov/airnow/smoke_fires/protecting-children-from-wildfire-smoke-and-ash.pdf

Updated December 12, 2019

UTILITIES FAILURE

In case of equipment failure due to a power outage, the childcare program will attempt to remain open if possible and safe to do so. The cause of the failure must be considered in the decision making. The Emergency Charge will determine the course of action.

If you are experiencing a water, power, sewer emergency, or service problem call the 24-hour hotline at 3-1-1, or (415) 701-2311 from outside SF, or log on at https://sf311.org/.

Electricity Failure

1. Use lanterns for light in rooms, small flashlights for mobility.
2. Determine if any doors that rely on electricity have been affected (e.g. automatically locking doors that are opened by a buzzer, etc.) so parents and staff can access the building.
3. Put jackets on for warmth.
4. Do not open refrigerators or freezers except when absolutely necessary. Each time you open it, it will lose its cold temperature significantly.
    a. A refrigerator will hold a safe temperature for about 4 hours. Temperature should not exceed 40° for over 2 hours or all perishable food must be replaced (meat, poultry, fish, eggs, leftovers). See H-29 for details. **Never** taste food to determine its safety.
    b. A full freezer will hold a safe temperature for approximately 48 hours (24 hours if it is half full and the door remains closed). Food may be safely refrozen if it still contains ice crystals or is at 40°F or below, however, its quality may suffer. See H-30 for details.
    c. Meal plan for the day may need to be adjusted if cooking/heating is not possible.
    d. Formula or human milk can be served room temperature or cold. Once the power is back on, check on frozen human milk: if it has started to thaw but still contains ice crystals, it can be refrozen. If human milk has completely thawed but still feels cold, put it in the refrigerator and use it within 24 hours or throw it away.
5. Laundry should be kept in a covered hamper until it can be laundered.

Gas Failure

1. If you smell gas or hear hissing sounds, evacuate immediately, and call 9-1-1.

2. Then Call PG&E at 1-800-743-5000.

Water Failure

1. Call the San Francisco Public Utilities Commission if you are experiencing a water, power, or sewer emergency or service problem call the 24-hour hotline at 3-1-1 or (415) 701-2311 from outside SF or log on at https://sf311.org/.

2. Immediately secure a supply of potable (drinkable) water by:

    a. Using commercially bottled water.

    b. Hauling water from another unaffected approved public water supply in a covered sanitized container.

    c. Arranging for the use of a licensed drinking water hauling truck.

3. Restrict food menu to items that need little or no water to prepare.

4. **Important:** All water used to wash and prepare fruits and vegetables, and any water used as an ingredient in a ready-to-eat food product (coffee, juice, jello, ice etc.), or water used to prepare infant formula, must be from one of the potable water sources described above.

5. For handwashing: Use soap and clean bottled water whenever possible to wash your hands, especially before and after handling food. If you do not have soap and water on hand, use moist towelettes or hand sanitizer.

6. Use alcohol-based sanitizer – CDC recommends that hand sanitizer should contain at least 60% alcohol. You can tell if your sanitizer contains at least 60% alcohol by looking at the product label.

Telephone Failure

1. Determine if any alternate lines work: pay phone, private lines, cell phones.

2. Notify parents/legal guardian of the telephone failure and provide the alternative contact number.

3. One person must attend the alternate phone line.

4. Use radios for internal communication, if applicable

BOMB THREAT

Bomb threats are most commonly received via phone, but are also made in person, via email, written note, or other means. Every bomb threat is unique and should be handled in the context of the facility or environment in which it occurs. Facility supervisors and law enforcement will be in the best position to determine the credibility of the threat.

If a bomb is discovered or a threat received, the staff should notify law enforcement and the Director immediately. Follow authorities' instructions. Director and/or law enforcement will assess the situation and provide guidance regarding facility lock-down, search, and/or evacuation.

Person receiving call:

1. Remain calm. Keep the caller on the line for as long as possible.
2. DO NOT HANG UP, even if the caller does.
3. If possible, write a note to a colleague to call the authorities or, as soon as the caller hangs up, immediately notify them yourself.
4. Listen carefully. Be polite and show interest.
5. Try to keep the caller talking to learn more information.
6. If your phone has a display, copy the number and/or letters on the window display.
7. Complete the Bomb Threat Checklist (see H-38) immediately. Write down as much detail as you can remember. Try to get exact words.
8. Immediately upon termination of call, DO NOT HANG UP, but from a different phone, contact authorities immediately with information and await instructions.

Emergency Charge Responsibility

1. Communicate with law enforcement and serve as liaison.
2. Ensure staff following instructions from law enforcement.
3. Perform documentation of incident.

Resource: [CISA - What to Do in a Bomb Threat]

BOMB THREAT PROCEDURES

This quick reference checklist is designed to help employees and decision makers of commercial facilities, schools, etc. respond to a bomb threat in an orderly and controlled manner with the first responders and other stakeholders.

Most bomb threats are received by phone. Bomb threats are serious until proven otherwise. Act quickly, but remain calm and obtain information with the checklist on the reverse of this card.

If a bomb threat is received by phone:

1. Remain calm. Keep the caller on the line for as long as possible. DO NOT HANG UP, even if the caller does.
2. Listen carefully. Be polite and show interest.
3. Try to keep the caller talking to learn more information.
4. If possible, write a note to a colleague to call the authorities or, as soon as the caller hangs up, immediately notify them yourself.
5. If your phone has a display, copy the number and/or letters on the window display.
6. Complete the Bomb Threat Checklist immediately. Write down as much detail as you can remember. Try to get exact words.
7. Immediately upon termination of call, DO NOT HANG UP, but from a different phone, contact authorities immediately with information and await instructions.

If a bomb threat is received by handwritten note:

- Call ______________________________________
- Handle note as minimally as possible.

If a bomb threat is received by e-mail:

- Call ______________________________________
- Do not delete the message.

Signs of a suspicious package:

- No return address
- Excessive postage
- Stains
- Strange odor
- Strange sounds
- Unexpected delivery
- Poorly handwritten
- Misspelled words
- Incorrect titles
- Foreign postage
- Restrictive notes

**** Refer to your local bomb threat emergency response plan for evacuation criteria***

DO NOT:

- Use two-way radios or cellular phone. Radio signals have the potential to detonate a bomb.
- Touch or move a suspicious package.

WHO TO CONTACT (Select One)

- **911**
- **Follow your local guidelines**

For more information about this form contact the Office for Bombing Prevention at: OBP@cisa.dhs.gov

V2

BOMB THREAT CHECKLIST

DATE:

TIME:

TIME CALLER HUNG UP:

PHONE NUMBER WHERE CALL RECEIVED:

Ask Caller:

- Where is the bomb located? (building, floor, room, etc.)
- When will it go off?
- What does it look like?
- What kind of bomb is it?
- What will make it explode?
- Did you place the bomb? Yes No
- Why?
- What is your name?

Exact Words of Threat:

____

____

____

Information About Caller:

- Where is the caller located? (background/level of noise)
- Estimated age:
- Is voice familiar? If so, who does it sound like?
- Other points:

Caller's Voice

- ☐ **Female**
- ☐ **Male**
- ☐ Accent
- ☐ Angry
- ☐ Calm
- ☐ Clearing throat
- ☐ Coughing
- ☐ Cracking Voice
- ☐ Crying
- ☐ Deep
- ☐ Deep breathing
- ☐ Disguised
- ☐ Distinct
- ☐ Excited
- ☐ Laughter
- ☐ Lisp
- ☐ Loud
- ☐ Nasal
- ☐ Normal
- ☐ Ragged
- ☐ Rapid
- ☐ Raspy
- ☐ Slow
- ☐ Slurred
- ☐ Soft
- ☐ Stutter

Background Sounds

- ☐ Animal noises
- ☐ House noises
- ☐ Kitchen noises
- ☐ Street noises
- ☐ Booth
- ☐ PA system
- ☐ Conversation
- ☐ Music
- ☐ Motor
- ☐ Clear
- ☐ Static
- ☐ Office machinery
- ☐ Factory machinery
- ☐ Local
- ☐ Long distance

Threat Language

- ☐ Incoherent
- ☐ Message read
- ☐ Taped message
- ☐ Irrational
- ☐ Profane
- ☐ Well-spoken

Other Information:

____

____

____

____

Emergency Action Plan Guide
Active Shooter Preparedness

Purpose

The Active Shooter Emergency Action Plan Video is a virtual learning tool that describes the fundamental concepts of developing an Emergency Action Plan (EAP) for an active shooter scenario. This instructive video guides organizations through important considerations of EAP development utilizing the first-hand perspectives of active shooter survivors, first responders, and other subject matter experts who share their unique insights.

Organizations are encouraged to use this guide as a medium to document the ***initial steps*** toward creating an Active Shooter preparedness plan. This guide *is not* meant to replace your organization's Emergency Action Plan. Rather, it is a tool that begins the EAP development process.

Pre-Planning Recommendations and Suggested Training

- ✓ Does your organization have an emergency action plan? If so, review your organization's policy or process for creating the plan. Determine if an active shooter preparedness plan can fit into your organization's overarching plan which may already include a plan for fire evacuation, severe weather, and bomb threats.
- ✓ Obtain a copy of the Federal Emergency Management Agency's (FEMA) Comprehensive Preparedness Guide (CPG) 101 *"Developing and Maintaining Emergency Operations Plan"* and review the six step planning process.
- ✓ Explore the Department of Homeland Security's Active Shooter Preparedness Website to better understand the active shooter threat.
- ✓ View the Options for Consideration Video to recognize possible actions to take if confronted with an active shooter scenario.
- ✓ Download and review the Active Shooter Preparedness Workshop Series presentations. This six module series contains additional information, instructor notes, and videos that supports the Active Shooter Emergency Action Plan process. The *Planning Steps (1-6)* below will correlate to the Training Modules (1-6) in the presentation slides. *Example: Module 2 will assist with completing Planning Step 2a and 2b.*

How to Use This Guide

Step 1 – Review the pre-planning recommendations and suggested training.

Step 2 – Allot *at least* **2-hours** to complete the Active Shooter Emergency Action Plan video.

Step 3 – Watch the EAP video.

Step 4 – Complete ***Planning Steps 1-6***. Use the fillable space to document the initial steps required to begin developing the organization's Emergency Action Plan. Note: *The Planning Steps contain information derived from the EAP video and other online resources to help inform the planning process.*

Step 5 – Begin drafting the organization's Active Shooter Emergency Action Plan. Refer to the EAP Guide and resources listed in *Pre-Planning Recommendations and Suggested Training* as required.

Need Help? Contact the DHS Active Shooter Preparedness team at ASworkshop@hq.dhs.gov

HOW TO RESPOND
WHEN AN ACTIVE SHOOTER IS IN YOUR VICINITY

QUICKLY DETERMINE THE MOST REASONABLE WAY TO PROTECT YOUR OWN LIFE. CUSTOMERS AND CLIENTS ARE LIKELY TO FOLLOW THE LEAD OF EMPLOYEES AND MANAGERS DURING AN ACTIVE SHOOTER SITUATION.

1. Run

- Have an escape route and plan in mind
- Leave your belongings behind
- Keep your hands visible

2. Hide

- Hide in an area out of the active shooter's view.
- Block entry to your hiding place and lock the doors

CALL 911 WHEN IT IS SAFE TO DO SO

3. Fight

- As a last resort and only when your life is in imminent danger.
- Attempt to incapacitate the active shooter
- Act with physical aggression and throw items at the active shooter

HOW TO RESPOND WHEN LAW ENFORCEMENT ARRIVES ON THE SCENE

1. How you should react when law enforcement arrives:

- Remain calm, and follow officers' instructions
- Immediately raise hands and spread fingers
- Keep hands visible at all times
- Avoid making quick movements toward officers such as attempting to hold on to them for safety
- Avoid pointing, screaming and/or yelling
- Do not stop to ask officers for help or direction when evacuating, just proceed in the direction from which officers are entering the premises

2. Information you should provide to law enforcement or 911 operator:

- Location of the victims and the active shooter
- Number of shooters, if more than one
- Physical description of shooter/s
- Number and type of weapons held by the shooter/s
- Number of potential victims at the location

RECOGNIZING SIGNS OF POTENTIAL WORKPLACE VIOLENCE

AN ACTIVE SHOOTER MAY BE A CURRENT OR FORMER EMPLOYEE. ALERT YOUR HUMAN RESOURCES DEPARTMENT IF YOU BELIEVE AN EMPLOYEE EXHIBITS POTENTIALLY VIOLENT BEHAVIOR. INDICATORS OF POTENTIALLY VIOLENT BEHAVIOR MAY INCLUDE ONE OR MORE OF THE FOLLOWING:

- Increased use of alcohol and/or illegal drugs
- Unexplained increase in absenteeism, and/or vague physical complaints
- Depression/Withdrawal
- Increased severe mood swings, and noticeably unstable or emotional responses
- Increasingly talks of problems at home
- Increase in unsolicited comments about violence, firearms, and other dangerous weapons and violent crimes

Contact your building management or human resources department for more information and training on active shooter response in your workplace.

Active Shooter Attacks

Security Awareness for Soft Targets and Crowded Places

An active shooter is an individual actively engaged in killing or attempting to kill people in a confined and populated area. In most cases, active shooters use firearm(s) and have no pattern or method to their selection of victims, which creates an unpredictable and quickly evolving situation that can result in loss of life and injury. Other active shooter attack methods may also include bladed weapons, vehicles, and improvised explosive devices. While law enforcement is usually required to end an active shooter situation, individuals can take steps to prepare mentally and physically for the possibility of this type of event occurring in order to save lives.

Be Alert to Signs of Trouble

While active shooter situations are often unpredictable, paying careful attention to warning signs could go a long way in mitigating a potential incident. Some shooters demonstrate progressively escalating risk factors in their mindsets and behaviors that characterize them as violent prior to an attack. Recognizing these warning signs and reaching out for help could bring at-risk individuals to the attention of law enforcement sooner and prevent a future attack.

Potential warning signs include:

- Increasingly erratic, unsafe, or aggressive behaviors.
- Hostile behavior based on claims of injustice or perceived wrongdoing.
- Drug and alcohol abuse.
- Claims of marginalization or distancing from friends and colleagues.
- Changes in performance at work.
- Sudden and dramatic changes in home life or in personality.
- Financial difficulties.
- Pending civil or criminal litigation.
- Observable grievances and making statements of retribution.

You can help ensure the safety of those around you.

- Be aware of drastic changes in attitude toward others.
- Take note of any escalations in behaviorand report to supervisor.
- Provide any information that may help facilitate intervention and mitigate potential risks.

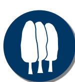
FACTS & EVENTS

- In March 2018, three people were killed by an armed gunman during a hostage situation at Yountville Veterans Home in Napa County, California.
- In February 2018, 17 people including students and teachers were killed and 17 more were wounded when a gunman opened fire inside Marjory Stoneman Douglas High School in Parkland, Florida.
- In October 2017, 58 people were killed and 851 were injured when a gunman opened fire from the window of a hotel room on a crowd of concert goers at the Route 91 Harvest Music Festival on the Las Vegas Strip in Nevada.
- In June 2016, 49 people were killed and 58 were injured when a gunman opened fire inside Pulse nightclub in Orlando, Florida.
- In December 2012, 20 children between six and seven years old as well as six adult staff members were killed when an armed gunman opened fire in Sandy Hook Elementary School in Newtown, Connecticut.
- In July 2012, an armed gunman opened fire at a Century movie theater in Aurora, Colorado, killing 12 people and injuring 70 others.

What Should People Do In Case Of An Active Shooter Attack?

"Run" to the nearest exits, making use of available concealment while moving away from the source of hazard.

If unable to safely evacuate, **"hide"** in a secure area where access can be blocked or entryways can be locked, and, as appropriate, **"fight"**.



If no rapid escape is possible, seek cover behind any available natural or artificial objects that eliminate direct line of sight from the source of hazard.

Call 9-1-1 and remain alert for potential secondary attacks.

Render first aid when safe to do so.

Maintain situational awareness while providing assistance to others.

When help arrives, follow instructions given by law enforcement and first responders.

Protective Measures

Physical Security

- Post signage relating to emergency entry and exit points, first-aid stations, and shelter locations.
- Define the perimeter and areas that require access control, and identify especially sensitive or critical areas that require special access controls.
    - Establish surveillance plan to complement perimeter controls.

Access, Planning, and Personnel

- Conduct periodic background checks on all staff assigned to critical or sensitive areas.
- Review personnel files of recently terminated employees to determine whether they pose a security risk and ensure they are removed from systems.
- Devise credential systems that indicate areas of access and purpose of activity on the premises.
    - Issue special identification badges to contractors, cleaning crews, vendors, and temporary employees.
    - Require that badges be displayed at all times and verified to gain access to the building.
    - Collect all badges when visits are complete.

Additional Resources

- Hometown Security Initiative: https://www.dhs.gov/hometown-security
- Active Shooter Preparedness Program: https://www.dhs.gov/active-shooter-preparedness
- "If You See Something, Say Something® ": https://www.dhs.gov/see-something-say-something
- Nationwide Suspicious Activity Reporting Initiative: https://nsi.ncirc.gov/

Protective Security Advisors (PSAs) proactively engage with government partners and the private sector to protect critical infrastructure. For more information or to contact your local PSA, e-mail NICC@hq.dhs.gov.

LOCAL RADIO STATION DIRECTORY FOR EMERGENCY ALERTS

LISTOS CALIFORNIA — CALIFORNIA FOR ALL

COUNTY	STATION & FREQUENCY	AM/FM
ALAMEDA	KFRC 106.9	FM
ALPINE	KEBR 88.1	FM
AMADOR	KEBR 88.1	FM
BUTTE	KTHU 100.7	FM
CALAVERAS	KOSO 93.1	FM
COLUSA	KXCL 103.9	FM
CONTRA COSTA	KQED 88.3	FM
DEL NORTE	KPOD 97.9	FM
FRESNO	580 KMJ	AM
GLENN	KTHU 100.7	FM
HUMBOLDT	KCRE 94.3	FM
IMPERIAL	KNX 1070	AM
INYO	KINS 106.3	FM
KERN COUNTY	KUZZ 550/107.9	AM/FM
KINGS	KMJ 580	AM
LAKE	KXBX 1270	AM
	KXBX 98.3	FM
LASSEN	KJDX 93.3	FM
LOS ANGELES	KNX 1070	AM
MADERA	KMJ 580	AM
MARIN	KFRC 106.9	FM
MARIPOSA	KMJ 580	AM
MENDOCINO	KOZT 95.3	FM
	KUKI 1400/103.3	AM/FM
MERCED	KMJ 580	AM
MODOC	KILN 99.1	FM
MONO	KINS 106.3	FM

COUNTY	STATION & FREQUENCY	AM/FM
MONTEREY	KPIG 107.5	FM
NAPA	KFRC 106.9	FM
NEVADA	KINS 106.3	FM
ORANGE	KFI 640	AM
	KBIG 104.3	FM
	KNX 1070	AM
PLACER	KEBR 88.1	FM
PLUMAS	KTHU 100.7	FM
RIVERSIDE	KFRG 95.1	FM
	KNX 1070	AM
SACRAMENTO	KQED 89.3	FM
	KFBK 1530	AM
SAN BENITO	KTOM 92.7	FM
SAN BERNARDINO	KFRG 95.1	FM
	KZXY 102.3	FM
SAN DIEGO	KOGO 600	AM
	KWVE 107.9	FM
	KLSD 1360	AM
SAN FRANCISCO	KQED 88.5	FM
	KFBK 1530	AM
SAN JOAQUIN	KVIN 920	AM
SAN LUIS OBISPO	KKJG 98.1	FM
SAN MATEO	KFRC 106.9	FM
SANTA BARBARA	KTMS 1250	AM
SANTA CLARA	KSJO 92.3	FM
	KFRC 106.9	FM
SANTA CRUZ	KTOM 92.7	FM

LOCAL RADIO STATION DIRECTORY FOR EMERGENCY ALERTS

LISTOS CALIFORNIA
CALIFORNIA FOR ALL

COUNTY	STATION & FREQUENCY	AM/FM
SHASTA	KQMS 105.7	FM
	KNRO 1670	AM
	KRRX 106.1	FM
SIERRA	KTHU 100.7	FM
SISKIYOU	KSYC 103.9	FM
	KSIZ 102.3	FM
SOLANO	KEBR 88.1	FM
	KQED 89.3	FM
SONOMA	KQED 88.3	FM
	KZST 100.1	FM
STANISLAUS	KMJ 580	AM

COUNTY	STATION & FREQUENCY	AM/FM
SUTTER	KXCL 103.9	FM
TEHAMA	KQMS 105.7	FM
	KRRX 106.1	FM
	KTHU 100.7	FM
TRINITY	KRRX 106.1	FM
	KQMS1400	AM
TULARE	KMJ 580	AM
TUOLUMNE	KOSO 93.7	FM
VENTURA	KNX 1070	AM
YOLO	KEBR 88.1	FM
YUBA	KEBR 88.1	FM

SEARCH AND RESCUE TEAM PROCEDURE

1. During every emergency and disaster, every child and adult on the premises must be accounted for, including volunteers and visitors.

2. If anyone is discovered to be missing, the Emergency Charge will assign people to assist in search and rescue.

3. Assess the safety of the environment.

4. The group will go to every room and office searching for missing persons. Be sure to check in places where frightened children may be hiding.

5. When a person is found, the situation is assessed.

    1. First Aid may be started at the location, if safe to do so.

    2. The Emergency Charge will either:

        a. Assign one person to stay with the injured.

        b. Transport them to the first aid station.

        c. Leave the deceased person (Do not move the dead. Cover and leave them. Write a note indicating name and location.)

6. See H-44 for information on triaging the injured.

7. The decision will be based on the amount of danger in the area, the severity of the injury and the number of available helpers. Any decision may be temporary or reversed, but the Emergency Charge decides.

TRIAGE PROCEDURE

POLICY: In the event of a serious emergency, the Emergency Charge will make life-saving decisions until relieved by a superior or a rescue team.

PURPOSE: To effectively care for the injured who can be saved, with the most efficient use of time, personnel, and supplies.

PROCEDURE:

In the event of a major disaster, you may be faced with life or death decisions. Remember, decisions may be temporary or changed later, but only one person decides - The Emergency Charge. This will be your most difficult and distasteful responsibility.

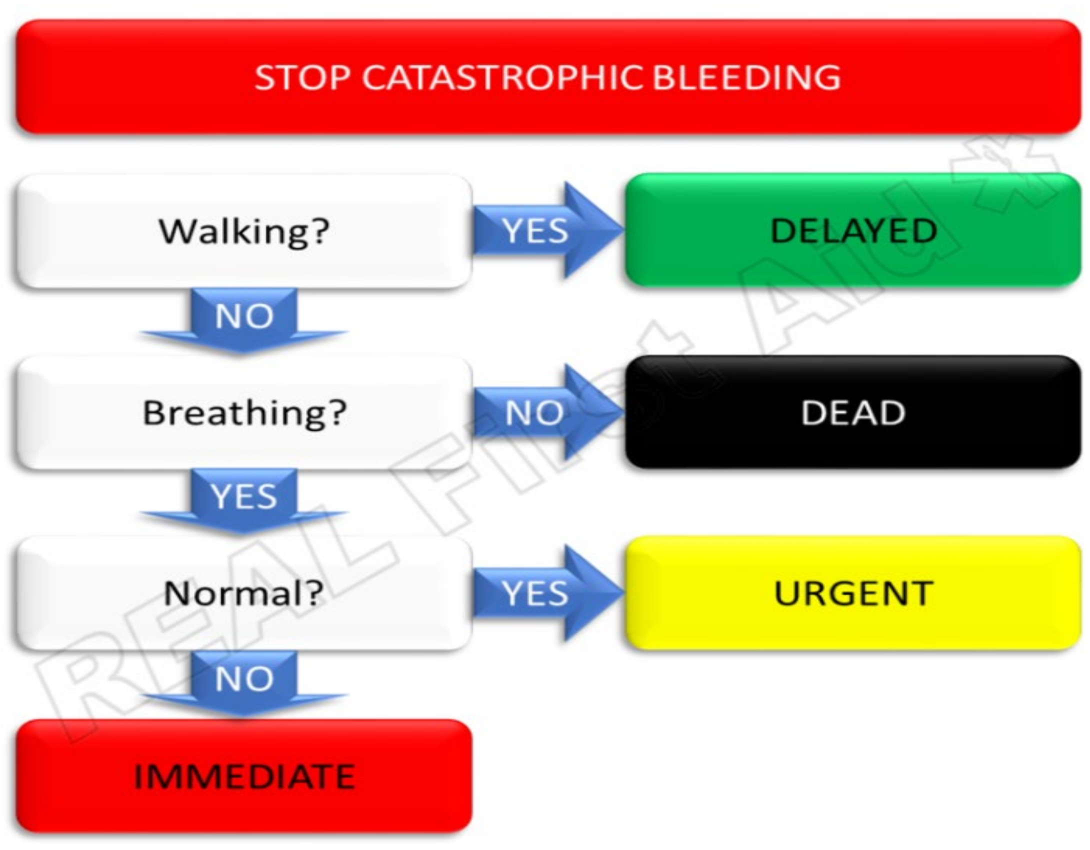
When you have many people injured or several seriously injured, the priorities in order are:

1. Care for the surviving children.
2. Gather as many able-bodied adults as possible.
3. Time management is key. Use resources efficiently.

The purpose of "triage" is to assign the injured into different categories to be treated in the order listed below:

1. **Immediate** - If they are not breathing normally.
2. **Urgent** - If they are breathing normally but unable to walk.
3. **Delayed** - Anyone who is walking around has either the mental capacity or physical ability to mobilize themselves. They are by the nature of their abilities less serious than some who is not able to do so.
4. **Dead** - If the person appears unconscious, properly check the mouth and clear it if necessary, then open they airway by tilting the head. If you are confident that they are not breathing, they are dead.

Use the following flowchart for decision making:



Resource: [Triage — REAL First Aid]

Young Children and Disasters

Disasters and trauma

After experiencing a disaster—whether it is a flood, earthquake, fire, or human caused event, children may react in ways that are difficult to understand. Even if children are not physically injured, the emotional response can be strong. They may act clingy, irritable or distant, and although they are very young and do not seem to understand what is going on, they are affected as much as adults. Adult fears and anxieties are communi- cated to children in many ways. The experience is more difficult for them, as they do not understand the connec- tion between the disaster and all the upheaval that follows. They need reassurance that everything is all right.

There is a wide range of "normal" reactions for children following a disaster, most of which can be handled with extra support at home, child care and school. In some cases, professional intervention may be needed, despite everyone's best efforts. Early intervention can help a child avoid more severe problems.

Message to parents

Some ways to provide reassurance after a disaster are:

- Try to remain calm.
- Remember the effect and anxiety produced by watching television coverage or listening to the radio. Keep TV/radio/adult conversations about the disaster at a minimum around young children.
- Spend extra time being close to your child(ren).
- Answer all questions as honestly and simply as possible. Be prepared to answer the same questions over and over. Children need reassurance.
- Spend extra time with your child at bedtime—soothing and relaxing time—talking, reading or singing quietly.
- Spend extra time with your child when bringing them to child care—they may be afraid you will not come back.
- Try to return to a normal routine as soon as possible to restore a sense of normalcy and security.
- Don't promise there won't be another disaster. Instead, encourage children to talk about their fears and what they can do to help in case of disaster. Tell them you will do everything you can to keep them safe.
- Be patient and understanding if your child is having difficulties.
- Never use threats. Saying, "If you don't behave an earthquake will swallow you up," will only add to the fear and not help your child behave more acceptably.
- Consider how you and your child can help. Children are better able to regain their sense of security if they can help in some way.
- Share your concerns with your child's teacher or child care provider. Consider assistance from professionals trained to work with disaster victims.

Message to child care providers

You can be a support and resource to parents by helping them understand behavioral and emotional responses. Be sensitive to how parents feel when they are separated from their children in a disaster. It may be very helpful for parents, children and you to take some extra time when dropping off children in the morning. A group meeting to reassure parents, discuss your response to their children's reactions, and review your emergency plan will help everyone feel more secure.

Help children cope by talking about their fears. Talk about feeling afraid, and practice what you could do the next time a disaster strikes. Because young children think the world revolves around them, children may need reassurance that they did not cause the disaster.

Consider referring a family for professional help if any of the behaviors on the following page persists two to four weeks after the disaster. Children who have lost family members or friends, or who were physically injured or felt they were in life-threatening danger, are at special risk for emotional disturbance. Children who have been in previous disasters or who are involved in a family crisis may also have more difficulty coping.

2022

Typical Reactions of Children Following Disaster

Children Ages 1 to 5

Children in this age group are particularly vulnerable to changes in their routines and disruption of their environments. Dependent on family members for comfort, they may be affected as much by the reactions of family members as by the disaster. Focus on reestablishing comforting routines, providing opportunity for nonverbal and verbal expression of feelings, and reassurance.

Regressive Reactions

- Bedwetting
- Thumbsucking
- Fear of darkness
- Fear of animals
- Fear of "monsters"
- Fear of strangers

Emotional/Behavioral Reactions

- Nervousness
- Irritability
- Uncooperative
- Hyperactivity
- Tics
- Speech difficulties
- Anxiety about separation from parents
- Shorter attention span
- Aggressive behavior
- Exaggeration or distortion of disaster experience
- Repetitive talking about experiences
- Exaggeration of behavior problems

Physiological Reactions

- Loss of appetite
- Overeating
- Indigestion
- Vomiting
- Bowel or bladder problems
- Sleep disorders and nightmares

How to Help

- Give additional verbal assurance and ample physical comforting.
- Provide comforting bedtime routines.
- Permit the child to sleep in the parents' room on a temporary basis.
- Encourage expression of emotions through play activities including drawing, dramatic play, or telling stories about the experience.
- Resume normal routines as soon as possible.

Children Ages 5 to 11

Regressive behaviors are especially common in this age group. Children may become more withdrawn or more aggressive. They might be particularly affected by the loss of prized objects or pets. Encourage verbalization and play enactment of their experiences. While routines might be temporarily relaxed, the goal should be to resume normal routines as soon possible.

Regressive Reactions

- Increased competition with younger siblings
- Excessive clinging
- Crying or whimpering
- Wanting to be fed or dressed
- Engaging in habits they had previously given up

Emotional/Behavioral Reactions

- School phobia
- Withdrawal from play group and friends
- Withdrawal from family contacts
- Irritability
- Uncooperative
- Fear of wind, rain, etc.
- Inability to concentrate and drop in level of school achievement
- Aggressive behavior
- Repetitive talking about their experiences
- Sadness over losses
- Overreaction to crises or changes in the environment

Physiological Reactions

- Headaches
- Complaints of visual or hearing problems
- Persistent itching and scratching
- Nausea
- Sleep disturbance, nightmares, night terrors

How to Help

- Give additional attention and ample physical comforting.
- Insist gently but firmly that the child accept more responsibility than younger siblings; positively reinforce age-appropriate behavior.
- Reduce pressure on the child to perform at his or her best in school and while doing chores at home.
- Reassure the child that his competence will return.
- Provide structured but not demanding chores and responsibilities.
- Encourage physical activity.
- Encourage verbal and written expression of thoughts and feelings about the disaster; encourage the child to grieve the loss of pets or toys.
- Schedule play sessions with adults and peers.

EXTREME HEAT

1. Detailed guidance from CDPH for heat related illness in schools is available at: https://www.cdph.ca.gov/Programs/EPO/Pages/Extreme%20Heat%20Pages/extreme-heat-guidance-for-schools.aspx#

2. Use the **CDC HeatRisk Dashboard** to determine the current level of heat risk in your zipcode. Using the Heat Risk score based on zipcode provides the most accurate guidance on actions to take, versus only using outdoor temperature to determine actions. https://ephtracking.cdc.gov/Applications/HeatRisk/

3. Based on the level of heat risk in your zip code, follow actions to take on the **CDPH Heat Risk Grid**, section H-46.

    a. **Young children in San Francisco are considered a vulnerable population for heat illness.** Some children or staff may be at even higher risk.

    b. You may need to move outdoor playtime to early morning e.g. before 10:00AM, cancel outdoor activities, or possibly cancel indoor physical activities if air conditioning is not available.

4. Provide extra water and water breaks for the children and staff.

5. Monitor children and staff for symptoms of heat exhaustion or heat stroke. Symptoms of heat exhaustion includes:

    a. Muscle cramping
    b. Dizziness
    c. Headache
    d. Weakness
    e. Cold and wet (clammy) skin
    f. Flushed face
    g. Rapid, weak heartbeat, low blood pressure
    h. Breathing very fast (hyperventilation)
    i. Vomiting, diarrhea

6. For heat exhaustion symptoms, cool the child by removing extra clothing, taking them to a cool and shady area, use cold wash cloths on their body, and give them lots of water to drink. **Contact parent/guardian for pickup from childcare.**

7. Heat exhaustion can progress to heat stroke – a life threatening emergency which required immediate medical attention. Heat stroke begins with the heat exhaustion symptoms listed above and then progresses to:

    a. Hot, red, **dry** skin. No more sweating due to the body preserving fluid.

    b. Behavioral or cognitive changes (confusion, irritability, aggressiveness, hysteria, emotional instability, impaired judgement, inappropriate behavior)

    c. Staggering, disorientation, drowsiness, loss of consciousness

    d. Difficulty speaking, slurred speech

    e. Seizures

    f. For symptoms of heat stroke, immediately begin to **cool the child and CALL 9-1-1.** Rapidly cooling the child while waiting for emergency responders is critically important.

    g. Cooling a child with symptoms of heat stroke:

        i. Remove extra layers of clothing

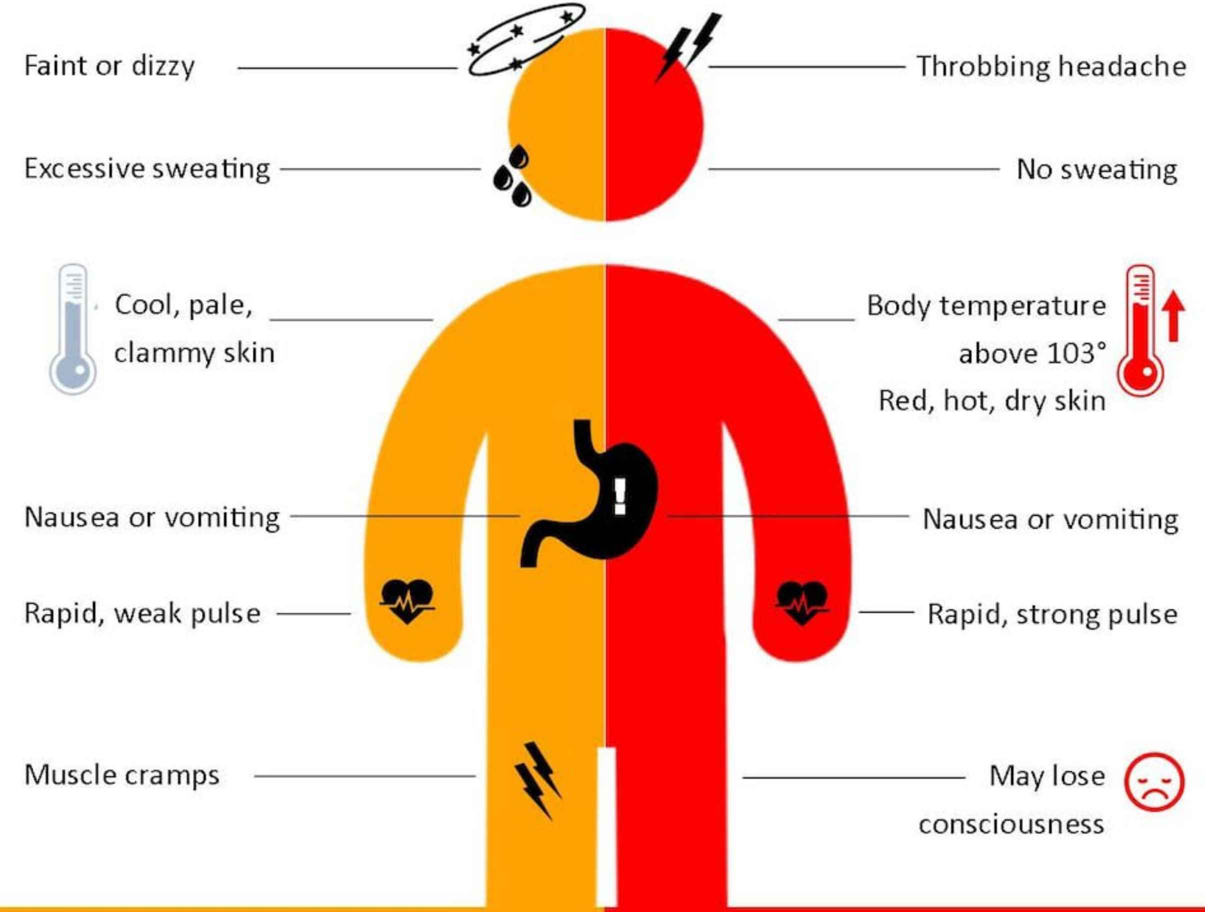
        ii. Cool the child as quickly as possible within 30 minutes via whole body cold water immersion bath or ice water bath (e.g. below 58 degrees). See CDPH Extreme Heat Guidance for Schools, 2024 for more info.

        iii. If cold-water immersion is not possible (no tub), aggressively douse the child's whole body with cold water.

        iv. Or if that's not possible, take the child to a shaded, cool area and use rotating cold, wet towels to cover as much of the body surface as possible.

        v. Notify the parent/guardian and notify licensing of the incident.

HEAT EXHAUSTION OR HEAT STROKE



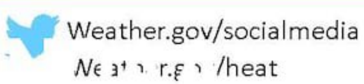
Heat Exhaustion:

- Get to a cooler, air conditioned place
- Drink water if fully conscious
- Take a cool shower or use cold compresses

Heat Stroke:

CALL 9-1-1

- Take immediate action to cool the person until help arrives



CDPH Heat Risk Grid: Understanding "HeatRisk" Level, Who is At Risk, and What Actions to Take

Revised July 27, 2023. Adapted from the National Weather Service (NWS) HeatRisk tool. Learn more about how to stay safe during extreme heat at CDPH Extreme Heat.

Value	Risk	What does this mean?	Who / What is at risk?	What actions can be taken?
0 (Green)	**Little to None**	• This level of heat poses **little to no risk** from expected heat	• No elevated risk	• No preventative actions necessary
1 (Yellow)	**Minor**	• Heat of this type is **tolerated by most**; however, there is a **minor risk for extremely heat-sensitive groups*** to experience negative heat-related health effects	• **Primarily those who are extremely sensitive to heat,*** especially when outdoors without effective cooling and/or adequate hydration	• Increase hydration • Reduce time spent outdoors or stay in the shade when the sun is strongest • Open windows at night and use fans
2 (Orange)	**Moderate**	• Heat of this type is tolerated by many; however, there is a **moderate risk for members of heat-sensitive groups*** to experience negative heat-related health effects, including heat illness • **Some risk for the general population who are exposed to the sun for longer periods of time** • **Living spaces without air conditioning can become uncomfortable during the afternoon and evening**, but fans and leaving windows open at night will help	• **Primarily heat-sensitive or heat-vulnerable groups,*** especially those without effective cooling or hydration • Those not acclimatized to this level of heat (i.e., visitors) • Otherwise healthy individuals exposed to longer duration heat, without effective cooling or hydration, such as in the sun at an outdoor venue • Some transportation and utilities sectors • Some health systems will see increased demand, with increases in emergency room visits	• Reduce time in the sun during the warmest part of the day • Stay hydrated • Stay in a cool place during the heat of the day (usually 10 a.m. to 5 p.m.) • Move outdoor activities to cooler times of the day • For those without air conditioning, use fans to keep air moving and open windows at night to bring cooler air inside buildings
3 (Red)	**Major**	• Heat of this type represents a **major risk to all individuals who are 1) exposed to the sun and active or 2) are in a heat-sensitive group** • **Dangerous to anyone without proper hydration or adequate cooling** • **Living spaces without air conditioning can become deadly during the afternoon and evening. Fans and open windows will not be as effective.** • **Poor air quality** is possible • **Power interruptions** may occur	• **Much of the population, especially anyone without effective cooling or hydration** • Those exposed to the heat/sun at outdoor venues • Health systems likely to see increased demand with significant increases in emergency room visits • Most transportation and utilities sectors	• **Cancel outdoor activities during the heat of the day**** (usually 10 a.m. to 5 p.m.), and move activities to the coolest parts of the day • Stay hydrated • Stay in a cool place especially during the heat of the day and evening • If you have access to air conditioning, use it, or find a location that does. Even a few hours in a cool location can lower risk. Fans may not be adequate.
4 (Magenta)	**Extreme**	• This is a rare level of heat leading to an **extreme risk for the entire population** • **Very dangerous to anyone without proper hydration or adequate cooling** • This is a **multi-day excessive heat event**. A prolonged period of heat is dangerous for everyone not prepared • **Poor air quality** is likely • **Power outages are increasingly likely** as electrical demands may reach critical levels	• **Entire population exposed to the heat is at risk** • For people without effective cooling, especially heat-sensitive groups, **this level of heat can be deadly** • Health systems highly likely to see increased demand with significant increases in emergency room visits • Most transportation and utilities sectors	• **Cancel outdoor activities**** • Stay hydrated • Stay in a cool place, including overnight • If you have access to air conditioning, use it, or find a location that does. Even a few hours in a cool location can lower risk. Fans will not be adequate. • Check on your neighbors

**Populations at higher risk of heat-related health impacts include older adults, young children, unhoused residents, those with chronic health conditions, outdoor workers, those exercising or doing strenuous activities outdoors during the heat of the day, pregnant individuals, those living in low-income communities, and more.*
*** For Extreme (Magenta/4) and Major (Red/3) risk levels, CDPH recommends more caution and therefore guides canceling outdoor activities based on these scenarios.*

I. TRANSPORTATION

Facility Vehicle	I-01
Driver Requirements	I-02
Child Safety Seat Requitements	I-03
Route Planning and Safe Trip	I-04
Vehicle Self Inspection	I-05
Preventing Hot Car Deaths	I-06

FACILITY VEHICLE REQUIREMENTS

POLICY: All transportation of children by childcare personnel will be done as safely as possible.

PURPOSE: To assure the children are safe when being transported.
To comply with state laws.

PROCEDURE:

1. The vehicle used by the childcare program will be licensed and registered with the Department of Motor Vehicles and be insured according to state law. Licensing requires that "vehicles transporting children must be in safe operating condition and be equipped with safety seats or seat belts".

2. The vehicle will be equipped with a first-aid kit and emergency information for all children being transported, including the following information available in the vehicle in case the driver is unable to respond to EMS rescue workers:
   - Name, address, all emergency contact phone numbers
   - Polaroid picture of child, labeled with name
   - Medical insurance information
   - Any allergies and/or medications required by child

3. The vehicle will have a working heater and air conditioner to provide comfort for children during transportation.

4. The vehicle will have a two-way radio or car phone so the provider can call for assistance in case of breakdown or emergencies.

5. A back-up vehicle will be available at ________________________________ and can be dispatched immediately in case of an emergency.

6. The following policy statements will be posted prominently and enforced in each vehicle: "No Smoking", "No Loud Radios or Tapes," and "Buckle Up."

7. The vehicle(s) will be inspected weekly to be sure they are kept clean and safe (interior and exterior). A template is provided in section I-5.

8. The vehicle will be equipped with a notebook containing a weekly safety checklist with corrections made; injury report forms; a trip sheet to record destination, mileage, times of departure and return; and a list of passengers.

DRIVER REQUIREMENTS

POLICY: All transportation of children by childcare personnel will be done as safely as possible.

PURPOSE: To assure the children are safe when being transported.

PROCEDURE: Driver requirements:

1. Drivers will hold a valid California driver's license and will be 18 years of age or older.

2. "Anyone transporting children in your care must have a current driver's license and be covered by the vehicle's insurance. Some vehicles require a specific type of license. The vehicle driver must have the appropriate license for the type of vehicle being used.

3. According to state law, all adults, whether driver or passenger, must refrain from smoking when children are in the vehicle. And, even if someone is transporting one or more children off-site, the appropriate adult-child ratios must be maintained at the facility".

4. Drivers will be certified in Infant/Child First Aid (including choking and rescue breathing) as required of other staff.

5. Drivers will be instructed in child passenger safety precautions (including use of safety restraints, handling of emergency situations, and supervision).

6. Drivers transporting children with special needs will receive specialized training annually on the transportation of children with special needs.

7. Drivers will not be responsible for monitoring children's behavior while operating the vehicle. Drivers will pull over to the side of the road to give children attention if necessary.

8. Drivers will be instructed in the completion of the weekly safety checklists, injury report forms and trip sheets.

9. Drivers will obey the signs posted in the vehicle.

10. Drivers will not use earphones while driving, as per state law.

11. Drivers will not have used alcohol or recreational drugs for at least 12 hours prior to transporting children or operating the program's vehicles.

    a. Drivers will not take any medications that will impair their ability to drive.

    b. The program will require drug testing when non-compliance is suspected.

12. Drivers will know, and keep in the vehicle, the quickest route to the nearest hospital from any point on their route.

CHILD SAFETY SEAT REQUIREMENTS

POLICY: All transportation by parents/legal guardians, those designated by parents/legal guardians, and by childcare personnel will always include use of age-appropriate child safety seats or seat belts. Compliance with this policy will be determined by spot checks and interviews performed by the Director. Information on child passenger restraint systems will be clearly posted at our facility.

PURPOSE: To assure the children are safe when being transported.
To comply with state laws.

PROCEDURE:

1. Licensing requires that child care centers post the California Child Passenger Safety Law (PUB 269 –available in Section N) in a prominent location in your center.

2. Each child will be correctly fastened in his/her own appropriate child safety seat, seat belt or harness according to the child's weight, height, and age.

3. If you are unsure of the types of car seats that can be used, or how to properly install them, contact a Certified Child Passenger Safety Technician (CPST) for more information. A list of certified technicians can be found at: Safe Kids Worldwide - Find a Technician

4. All children **under the age of 8 years old and under 4 feet 9 inches** will be correctly fastened into a child passenger restraint system (car seat or booster seat) that meets federal regulations and in accordance with the manufacturer instructions. (State Law: Vehicle Code 27360)

5. All infants under the age of 2 years old must be in a **rear-facing** car seat with a 5-point harness restraint. (State Law: Vehicle Code 27360)

6. The AAP and other experts strongly recommend that all children stay in a rear facing car seat **as long as possible** until they have reached the maximum height or weight limits of that specific car seat. This is usually between 3-4 years old.

    a. Some infant car seats have a maximum of 20 lbs/20 inches, but many seats have a maximum of 40lbs/40 inches, and some seats go up to 100 lbs and can be converted to forward facing seats and boosters.

    b. Rear facing provides the maximum protection in the event of a collision. Do not hurry to face the child forward. Keep them rear facing as long as possible.

7. After children outgrow a rear facing seat, they should be in a forward facing 5-point harness **as long as possible** until they have reached the maximum height or weight limits of that specific car seat or booster.

    a. Many car seat are convertible seats from rear facing to forward facing.

8. After they outgrow the forward facing 5-point harness's maximum weight or height limit (usually around 5-6 years old), they should continue to use a booster seat with the adult seat belt until a minimum of 8 years old AND a minimum height of 4 feet 9 inches.

    a. Many seats are combination car seat/boosters that convert from forward facing 5-point harness into a booster seat to use with an adult seat belt.

9. Most children are not ready to use an adult seat without a booster until 10-12 years old. To safely use an adult seat belt, the following should be true:

    a. The shoulder belt lies across the middle of the chest and shoulder, not the neck or throat.

    b. The lap belt is low and snug across the upper thighs, not the belly.

    c. The child is tall enough to sit against the vehicle seat back with their knees bent over the edge of the seat without slouching and can comfortably stay in this position throughout the trip.

ROUTE PLANNING AND TRIP SAFETY

POLICY: Transportation of children will be done as safely as possible, in accordance with state law. All children will be accounted for, so no child is left behind at the destination, nor in the vehicle.

PURPOSE: To assure the children are safe when being transported.

PROCEDURE:

1. All child transportation routes will be mapped out in advance. This information will be provided to drivers and parents/legal guardians.

2. Adequate, active vehicle insurance coverage will be confirmed and maintained.

3. Parents/legal guardians will sign a consent form for each child before each trip.

4. Children will be kept entertained during travel through the use of toys, songs, or conversation while traveling, if awake.

5. All children will be identified with a name tag/label that gives the childcare program's name and phone number.

6. Younger children will be kept together through use of a travel rope.

7. Groups will be escorted by a designated adult at the front and back of the lines.

8. Staff will explain rules of the road (e.g. never distract the driver, etc.) and provide a positive example by also obeying these rules.

9. A first aid kit, emergency contact information, and emergency transportation authorization for the children in the group will be taken on all trips.

10. No child will be transported for more than an hour, one way, on a daily basis.

11. Per state law and licensing requirements, children under 6 years old must NEVER be left alone in a car/vehicle, even if they've fallen asleep.

12. All children will be accounted for before the vehicle leaves the facility, after it is loaded, before returning from the trip destination, and after each time that children have exited the vehicle.

VEHICLE SELF INSPECTION

Childcare Facility Name: ________________________ Date of Inspection: ____________

Vehicle: ______________________ Name of Inspector:________________________

ARE THE FOLLOWING IN WORKING ORDER?	YES	NO	REPORTED
Fire extinguisher (readily accessible and fully charged?)			
Horn			
Mirrors			
Turn Signals			
Hazard Signals			
Headlights			
Brake Lights			
Taillights			
Tires			
Windshield Wipers			
Windshield Wiper Fluid Levels			
Seat belts			
Condition of Windows			
Condition of Body			
Brakes			
Heat			
Emergency Doors or Exits			
Emergency Warning Devices (reflective triangles, lighted lamps, road flares, etc.)			
Are First Aid Supplies Current?			
Are Registration and Insurance Current?			

Date of Last Oil Change: _____________ Next Oil Change Due: _____________________

Date of Last Vehicle Maintenance Service: ______________________________ ______________________________

Next Service Due (mileage): ______________________ ______________________

Additional Comments:____
____
____
____
____

PREVENTING HOT CAR DEATHS

POLICY: All children will be accounted for after de-boarding a vehicle, every time, so no child is EVER left inside the vehicle. Children will be supervised at all times to prevent elopement and possibly accessing a vehicle and becoming trapped inside.

PURPOSE: To assure the children are safe.
To prevent child deaths inside hot vehicles.

- In just 10 minutes, the inside temperature of a vehicle can rise by 20 degrees F and become deadly.

- A child's body temperature rises three to five times faster than an adult's. When a child is left in a vehicle, that child's temperature can rise quickly — and the situation can quickly become dangerous. Heatstroke begins when the core body temperature reaches about 104 degrees F. A child can die when their body temperature reaches 107 degrees F.

- In 2022, 33 children died of heatstroke in vehicles. In 2018 and 2019, there was a record number of hot car deaths - 53 children died each year — the most in at least 25 years, according to NoHeatstroke.org. Over the past 25 years, more than 950 children have died of heatstroke, because they were left or became trapped in a hot car.

PROCEDURE:

1. Never leave a child in a vehicle unattended for any length of time. Rolling windows down or parking in the shade does little to change the interior temperature of the vehicle.

2. The driver must make it a habit to check the entire vehicle — all the back seats and possible hiding areas — before locking the doors and walking away.

3. Use a roster to account for all children when de-boarding a vehicle to account for all children, every time.

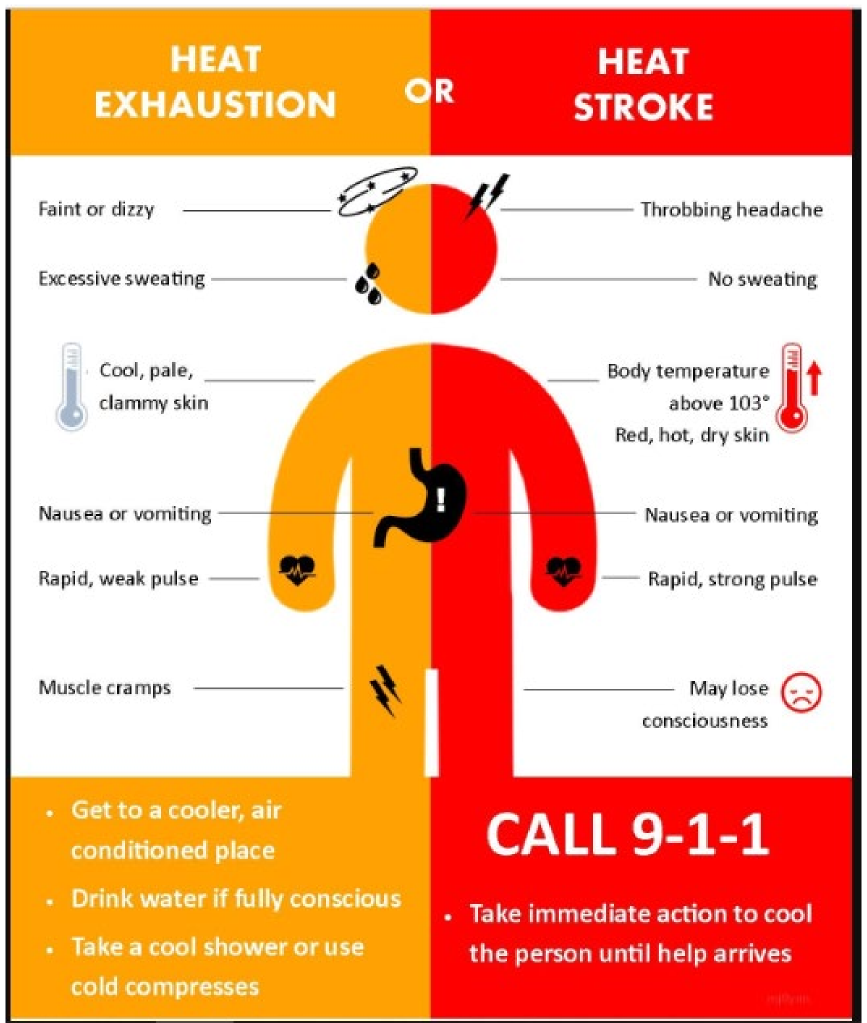
4. Place a personal item like a purse or briefcase in the back seat, out of reach of children, as another reminder to look before you lock. Write a note or place a stuffed animal in the passenger's seat to remind you that a child is in the back seat.

5. Store car keys out of a child's reach and teach children that a vehicle is not a play area.

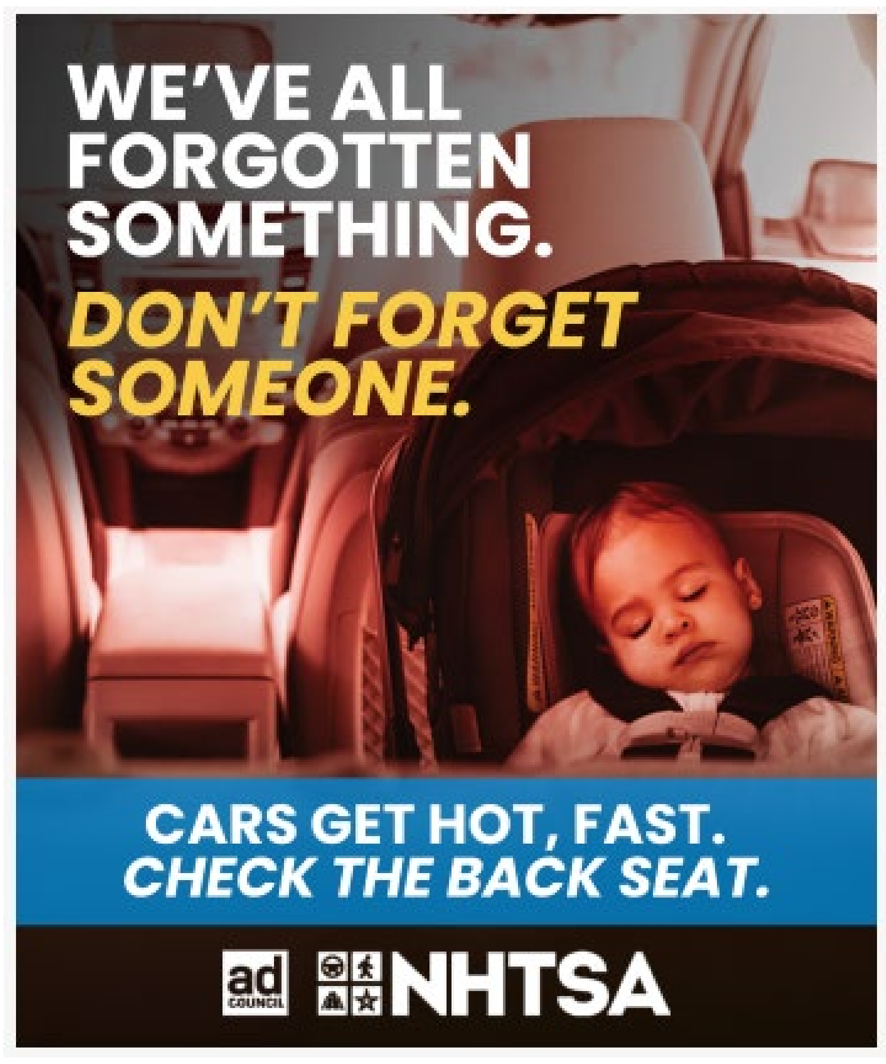
6. Always lock your car doors, year-round, so children can't get into unattended vehicles. Many children have snuck outside, got inside an unlocked vehicle to play, and were unable to get out of the vehicle.

7. If you ever see a child alone in a locked vehicle, act immediately and call 911. A child in distress due to heat should be removed from the vehicle as quickly as possible and rapidly cooled.

8. Symptoms of heat exhaustion and heatstroke include:



9. Call 9-1-1 for symptoms of heatstroke or is the child is unconscious.



Reference: Child Heatstroke Prevention: Prevent Hot Car Deaths | NHTSA

J. STAFF HEALTH & ILLNESS & INJURY PREVENTION

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NEW STAFF HEALTH ORIENTATION

POLICY: Newly hired staff members joining our team will receive orientation to our site's health and safety policies during first week of employment. The staff members will demonstrate understanding of theory and correct application of skills to the teacher or designee in the assigned classroom.

PURPOSE: To assure that all children receive appropriate care in all situations.
To protect the health of the children and staff.
To assure that parent's and child's rights are honored.

PROCEDURE:

1. Health and Wellness Promotion
    a. Infection Control
        i) Handwashing
        ii) Diapering
        iii) Daily Health Inspection
        iv) Observation, Isolation, Exclusion
        v) Cleaning, Sanitizing, Disinfecting, Reporting Reportable Diseases
        vi) Medication Storage and Administration
    b. Injury Prevention
    c. Staff Back Health
        i. https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/back-pain/art-20044526
2. Emergency Preparedness
    a. Earthquake
    b. Fire
    c. Medical Emergencies
    d. Smog Alerts

e. Active Shooter/Lockdown

f. Bomb Threat

g. Wildfire

3. Nutrition and Food Handling

a. Food Preparation

b. Meals and Snacks

c. Toothbrushing and Dental Health

PERSONNEL HEALTH REQUIREMENTS

POLICY: All childcare personnel are required to have on file a current tuberculosis (TB) screening assessment signed by a licensed health care provider, and proof of current immunization status, prior to working with the children. All childcare Center personnel must also have a health assessment (LIC 503) signed by a licensed health care provider (not required for family child care homes).

Immunizations must be current according to the latest state health department standards.

A TB re-assessment is required every 4 years, or sooner if staff develop risk factors for TB.

PURPOSE:

To assure that the individual can sustain personal health during employment.

To protect the health of the children.

To satisfy Licensing Regulations.

PROCEDURE:

1. Staff member's health file will be kept and accessed by the Director only.

2. Staff member's health file shall contain:

   a. Health Screening Report (LIC 503 - for Centers)

   b. Immunization Record: Current requirements are Measles, Pertussis, and Influenza (influenza vaccination can be declined in writing).

   c. TB Form - California School Employee Tuberculosis Risk Assessment Questionnaire for Pre-K, K-12 schools, and community college employees, volunteers and contractors (see J-4)

   d. Injury and Illness Data

   e. Current Credentials

STAFF HEALTH FILE CHECKLIST

STAFF NAME: ________________________________

Required Documents	✓	**Comments**
Emergency Info		
Health Screening Report (LIC 503) and TB Clearance		
Immunization Record		
Background Check (LIC 508) Fingerprint Clearance		
Personnel Record (LIC 501)		
Verified with Child Abuse Index		
Qualifications (Education/Experience)		
Current Assignment and Work Hours		
ECE Required Units		
Mandated Reporter Form (LIC 9108)		
Other if applicable: ______________________		
Verification of Health Training		
CPR/First Aid		
Mandated Reporter Training		
Health and Safety Training (16 hours)		
Employee Exceptions / Waivers		
Integrated Pest Management Training		
Copy Provided to Staff:		
Child Abuse Reporting Laws		
SIDS Pamphlet		
Illness Policy		
Discipline Policy		
Employee Rights (LIC 9052)		
Illness & Injury Prevention Plan		

Please refer to licensing for updated requirements: LIC 311A was updated 2022

California School Employee Tuberculosis (TB) Risk Assessment Questionnaire

(for pre-K, K-12 schools and community college employees, volunteers and contractors)

- Use of this questionnaire is required by California Education Code sections 49406 and 87408.6, and Health and Safety Code sections 1597.055 and 121525-121555.^
- The purpose of this tool is to identify **adults** with infectious tuberculosis (TB) to prevent them from spreading disease.
- **Do not repeat testing** unless there are **new risk factors since the last negative test.**
- **Do not treat for latent TB infection (LTBI) until active TB disease has been excluded**:
  For individuals with signs or symptoms of TB disease or abnormal chest x-ray consistent with TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing.
  A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

Name of Person Assessed for TB Risk Factors: ____

Assessment Date: ________________________ Date of Birth: ________________________

History of Tuberculosis Disease or Infection (Check appropriate box below)
☐ Yes • If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in the previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. If the x-ray does not have evidence of TB, the person is no longer required to submit to a TB risk assessment or repeat chest x-rays.
☐ No (Assess for Risk Factors for Tuberculosis using box below)

TB testing is recommended if any of the 3 boxes below are checked
☐ **One or more sign(s) or symptom(s) of TB disease** • TB symptoms include prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue.
☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month • Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries. • Interferon gamma release assay (IGRA) is preferred over tuberculin skin test (TST) for non-US-born persons.
☐ **Close contact** to someone with infectious TB disease during lifetime
Treat for LTBI if TB test result is positive and active TB disease is ruled out

^The law requires that a health care provider administer this questionnaire. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. A Certificate of Completion should be completed after screening is completed (page 3).

California School Employee Tuberculosis (TB) Risk Assessment User Guide

(for pre-K, K-12 schools and community college employees, volunteers and contractors)

Background

California law requires that school staff working with children and community college students be free of infectious tuberculosis (TB). These updated laws reflect current federal Centers for Disease Control and Prevention (CDC) recommendations for targeted TB testing. Enacted laws, AB 1667, effective on January 1, 2015, SB 792 on September 1, 2016, and SB 1038 on January 1, 2017, require a TB risk assessment be administered and if risk factors are identified, a TB test and examination be performed by a health care provider to determine that the person is free of infectious tuberculosis. The use of the California School Employee TB Risk Assessment and the Certificate of Completion, developed by the California Department of Public Health (CDPH) and California TB Controllers Association (CTCA) are also required.

AB 1667 impacted the following groups on 1/1/2015:

1. Persons employed by a K-12 school district, or employed under contract, in a certificated or classified position (California Education Code, Section 49406)

2. Persons employed, or employed under contract, by a private or parochial elementary or secondary school, or any nursery school (California Health and Safety Code, Sections 121525 and 121555).

3. Persons providing for the transportation of pupils under authorized contract in public, charter, private or parochial elementary or secondary schools (California Education Code, Section 49406 and California Health and Safety Code, Section 121525).

4. Persons volunteering with frequent or prolonged contact with pupils (California Education Code, Section 49406 and California Health and Safety Code, Section 121545).

SB 792 impacted the following group on 9/1/2016:

Persons employed as a teacher in a child care center (California Health and Safety Code Section 1597.055).

SB 1038 impacted the following group on 1/1/2017:

Persons employed by a community college district in an academic or classified position (California Education Code, Section 87408.6).

Testing for latent TB infection (LTBI)

Because an interferon gamma release assay (IGRA) blood test has increased specificity for TB infection in persons vaccinated with BCG, IGRA is preferred over the tuberculin skin test (TST) in these persons. Most persons born outside the United States have been vaccinated with BCG.

Previous or inactive tuberculosis

Persons with a previous chest radiograph showing findings consistent with previous or inactive TB should be tested for LTBI. In addition to LTBI testing, evaluate for active TB disease.

Negative test for LTBI does not rule out TB disease

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. In fact, a negative TST or IGRA in a person with active TB can be a sign of extensive disease and poor outcome.

Symptoms of TB should trigger evaluation for active TB disease

Persons with any of the following symptoms that are otherwise unexplained should be medically evaluated: cough for more than 2-3 weeks, fevers, night sweats, weight loss, hemoptysis.

Most patients with LTBI should be treated

Because testing of persons at low risk of LTBI should not be done, persons that test positive for LTBI should generally be treated once active TB disease has been ruled out. However, clinicians should not be compelled to treat low risk persons with a positive test for LTBI.

Emphasis on short course for treatment of LTBI

Shorter regimens for treating LTBI have been shown to be more likely to be completed and the 3 month 12-dose regimen has been shown to be as effective as 9 months of isoniazid. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug resistant TB are typical reasons these regimens cannot be used.

Repeat risk assessment and testing

If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray should be performed at initial hire. Once a person has a documented positive test for TB infection that has been followed by a chest x-ray (CXR) that was determined to be free of infectious TB, the TB risk assessment (and repeat x-rays) is no longer required.

Repeat risk assessments should occur every four years (unless otherwise required) to identify any additional risk factors, and TB testing based on the results of the TB risk assessment. Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment.

Please consult with your local public health department on any other recommendations and mandates that should also be considered.

Certificate of Completion
Tuberculosis Risk Assessment and/or Examination

*To satisfy **job-related requirements** in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.*

First and Last Name of the person assessed and/or examined:

____

Date of assessment and/or examination: ______mo./______day/______yr.

Date of Birth: ______mo./______day/______yr.

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

X____

Signature of Health Care Provider completing the risk assessment and/or examination

Please print, place label or stamp with Health Care Provider Name and Address (include Number, Street, City, State, and Zip Code):

California School Employee Tuberculosis Risk Assessment Frequently Asked Questions

California law requires that school staff working with children and community college students be free of infectious tuberculosis (TB). These updated laws reflect current recommendations for targeted TB testing from the federal Centers for Disease Control and Prevention (CDC), the California Department of Public Health (CDPH), the California Conference of Local Health Officers and the California Tuberculosis Controllers Association (CTCA).

What specifically did AB 1667 change on January 1, 2015?

1. Replaces the mandated TB examination on initial employment with a TB risk assessment, and TB testing based on the results of the TB risk assessment, for the following groups:
    a. Persons initially employed by a school district, or employed under contract, in a certificated or classified position (California Education Code, Section 49406)
    b. Persons initially employed, or employed under contract, by a private or parochial elementary or secondary school or any nursery school (California Health and Safety Code, Sections 121525 and 121555)
    c. Persons providing for the transportation of pupils under authorized contract (California Health and Safety Code, Section 121525)

2. Replaces the mandated TB examination at least once each four years of school employees who have no identified TB risk factors or who test negative for TB infection with a TB risk assessment, and TB testing based on the TB risk assessment responses. (California Education Code, Section 49406 and California Health and Safety Code, Section 121525)

3. Replaces mandated TB examination (within the last four years) of volunteers with "frequent or prolonged contact with pupils" in private or parochial elementary or secondary schools, or nursery schools (California Health and Safety Code, Section 121545) with a TB risk assessment administered on initial volunteer assignment, and TB testing based on the results of the TB risk assessment.

4. For school district volunteers with "frequent or prolonged contact with pupils," mandates a TB risk assessment administered on initial volunteer assignment and TB testing based on the results of the TB risk assessment. (California Education Code, Section 49406)

What specifically did SB 792 change on September 1, 2016?

California Health and Safety Code, Section 1597.055 requires that persons hired as a teacher in a child care center must provide evidence of a current certificate that indicates freedom from infectious TB as set forth in California Health Safety Code, Section 121525.

What specifically does SB 1038 change on January 1, 2017?

California Education Code, Section 87408.6 requires persons employed by a community college in an academic or classified position to submit to a TB risk assessment developed by CDPH and CTCA and, if risk factors are present, an examination to determine that he or she is free of infectious TB; initially upon hire and every four years thereafter.

California School Employee Tuberculosis Risk Assessment Frequently Asked Questions

Who developed the school staff and volunteer TB risk assessment?

The California Department of Public Health (CDPH) and the California Tuberculosis Controllers Association (CTCA) jointly developed the TB risk assessment. The risk assessment was adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program and the Centers for Disease Control and Prevention.

Who may administer the TB risk assessment?

Per California Education and Health and Safety Codes, the TB risk assessment is to be administered by a health care provider. The risk assessment should be administered face-to-face. The practice of allowing employees or volunteers to self-assess is discouraged.

What is a "health care provider"?

A "health care provider" means any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services.

If someone is a new employee and has a TB test that was negative, would he/she need to also complete a TB risk assessment?

Check with your employer about what is needed at the time of hire.

If someone transfers from one K-12 school or school district to another school or school district, would he/she need to also complete a TB risk assessment?

Not if that person can produce a certificate that shows he or she was found to be free of infectious tuberculosis within 60 days of initial hire, or the school previously employing the person verifies that the person has a certificate on file showing that the person is free from infectious tuberculosis.

If someone does not want to submit to a TB risk assessment, can he/she get a TB test instead? Yes, a TB test, and an examination if necessary, may be completed instead of submitting to a TB risk assessment.

If someone has a positive TB test, can he/she start working before the chest x-ray is completed? No, the x-ray must be completed and the person determined to be free of infectious TB prior to starting work.

If someone has a positive TB test, does he/she need to submit to a chest x-ray every four (4) years?

No, once a person has a documented positive TB test followed by an x-ray, repeat x-rays are no longer required every four years. If an employee or volunteer becomes symptomatic for TB, then he/she should promptly seek care from his/her health care provider.

California School Employee Tuberculosis Risk Assessment Frequently Asked Questions

What screening is required for someone who has a history of a positive TB test or TB disease at hire?

If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. Once a person has a documented positive test for TB infection that has been followed by an x-ray that was determined to be free of infectious TB, the TB risk assessment (and repeat x-rays) is no longer required. If an employee or volunteer becomes symptomatic for TB, then he/she should seek care from his/her health care provider.

For volunteers, what constitutes "frequent or prolonged contact with pupils"?

Examples of what may be considered "frequent or prolonged contact with pupils" include, but are not limited to, regularly-scheduled classroom volunteering and field trips where cumulative face-to-face time with students exceeds 8 hours.

Who may sign the Certificate of Completion?

- If the patient has no TB risk factors then the health care provider completing the TB risk assessment may sign the Certificate of Completion.
- If a TB test is performed and the result is negative, then the licensed health care provider interpreting the TB test may sign the Certificate.
- If a TB test is positive and an examination is performed, only a physician, physician assistant, or nurse practitioner may sign the Certificate.

What does "determined to be free of infectious tuberculosis" mean on the Certificate of Completion?

"Determined to be free of infectious TB" means that a physician, physician assistant, or nurse practitioner has completed the TB examination and provided any necessary treatment so that the person is not contagious and cannot pass the TB bacteria to others. The TB examination for active TB disease includes a chest x-ray, symptom assessment, and if indicated, sputum collection for acid-fast bacilli (AFB) smears cultures and nucleic acid amplification testing.

What if I have TB screening or treatment questions?

Consult the federal Centers for Disease Control and Prevention's *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers* (2013) (http://www.cdc.gov/tb/publications/LTBI/default.htm). If you have specific TB screening or treatment questions, please contact your local TB control program (http://www.ctca.org/locations.html).

Who may I contact to get further information or to download the TB risk assessment?

- California Tuberculosis Controllers' Association
  https://www.ctca.org/providers/
- California Department of Public Health, Tuberculosis Control Branch: (510) 620-3000
  https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TBCB.aspx
- California School Nurses Organization: (916) 448-5752 or email csno@csno.org
  http://www.csno.org/

6/25/18

INJURY PREVENTION

POLICY: Our caregivers will take every reasonable precaution to create a safe environment and prevent injuries to the children in our care, as is the right of each child.

PURPOSE: To ensure every child's safety.
To assure parents that we are knowledgeable, caring, attentive caregivers.
To alert employees that child safety is the responsibility of all and that neglecting that responsibility may cause disciplinary action to be taken.

PROCEDURE:

1. Caregivers will have their "group" of children in constant view. The caregiver will position herself with her back to the wall, fence, or corner, so that children cannot be out of visual range.

2. Caregivers will concentrate attention on the children continuously while with them.

3. The caregiver will avoid all distractions.

4. If attention needs to be directed elsewhere for a period of time, alert another team member to watch over the group.
5. Caregivers will be aware of each child's stage of development and always assure appropriate activities for that child, indoors and out.

6. When a child is trying a new activity, station yourself at his/her side.

7. When children are playing on a piece of equipment known to be risky, stand close by to be there with them.

8. Caregivers will make a visual observation of an area for safety, before taking the children into it. (i.e., play yard, park, or another room)

9. Any animals in the play space?

10. Any foreign objects or body waste in the sand?

11. Trees, fences, power lines and ground intact?

12. Spot potential trouble areas.

13. Caregivers will inspect their own rooms for safety hazards and fix them, daily.

14. Does the injury log identify problem areas in the facility and yard? Have those problems been solved?

15. Are staff demonstrating awareness of hazards for children?

References:

https://www.childrenssafetynetwork.org/child-safety-topics/child-care-safety

https://cchp.ucsf.edu/sites/g/files/tkssra181/f/11_CCHA_Injury_0506.pdf

INJURY & ILLNESS PREVENTION PROGRAM

Every California employer must establish, implement, and maintain a written Injury and Illness Prevention Program (IIPP) and a copy must be maintained at each worksite or at a central worksite if the employer has non-fixed worksites. The requirements for establishing, implementing, and maintaining an effective written Injury and Illness Prevention Program are contained in Title 8 of the California Code of Regulations, Section 3203 (T8 CCR 3203) and consist of the following eight elements:

1. Responsibility
2. Compliance
3. Communication
4. Hazard Assessment
5. Accident/Exposure Investigation
6. Hazard Correction
7. Training and Instruction
8. Recordkeeping

This model program has been prepared for use by employers in industries which have been determined by Cal/OSHA to be non-high hazard. You are not required to use this program. However, any employer in an industry which has been determined by Cal/OSHA as being non-high hazard who adopts, posts, and implements this model program in good faith is not subject to assessment of a civil penalty for a first violation of T8 CCR 3203.

Proper use of this model program requires the IIP Program administrator of your establishment (e.g., Director or Designee) to carefully review the requirements for each of the eight IIP Program elements found in this model program, fill in the appropriate blank spaces and check those items that are applicable to your workplace. The recordkeeping section requires that the IIP Program administrator select and implement the category appropriate for your establishment. Sample forms for hazard assessment and correction, accident/exposure investigation, and worker training and instruction are provided with this model program.

This model program must be maintained by the employer to be effective.

INJURY AND ILLNESS PREVENTION PROGRAM

RESPONSIBILITY

The Injury and Illness Prevention (IIP) Program administrator,

____

(Program Administrator Name)

Has the authority and responsibility for implementing and maintaining this IIP Program for

____

(Establishment Name)

Managers and supervisors are responsible for implementing and maintaining the IIP Program in their work areas and for answering worker questions about the IIP Program. A copy of this IIP Program is available from each manager and supervisor.

COMPLIANCE

All workers, including managers and supervisors, are responsible for complying with safe and healthful work practices. Our system of ensuring that all workers comply with these practices include one or more of the following checked practices:

_____ Informing workers of the provisions of our IIP Program.

_____ Evaluating the safety performance of all workers.

_____ Recognizing employees who perform safe and healthful work practices.

_____ Providing training to workers whose safety performance is deficient.

_____ Disciplining workers for failure to comply with safe and healthful work practices.

COMMUNICATION

All managers and supervisors are responsible for communicating with all workers about occupational safety and health in a form readily understandable by all workers. Our communication system encourages all workers to inform their managers and supervisors about workplace hazards without fear of reprisal.

Our communication system includes one or more of the following checked items:

_____ New worker orientation including a discussion of safety and health policies and procedures.

_____ Review of our IIP Program.

_____ Training programs.

_____ Regularly scheduled safety meetings.

_____ Posted or distributed safety information.

_____ A system for workers to anonymously inform management about workplace hazards.

_____ Our establishment has less than ten employees and communicates with and instructs employees orally about general safe work practices and hazards unique to each employee's job assignment.

HAZARD ASSESSMENT

Periodic inspections to identify and evaluate workplace hazards shall be performed by a competent observer in the following areas of our workplace:

- Offices
- Kitchens
- Classrooms
- Breakroom
- Workroom
- Bathrooms
- Play yard
- Meeting room
- Library
- Other

Periodic inspections are performed according to the following schedule:

- When we initially established our IIP Program.
- When new substances, processes, procedures, or equipment which present potential new hazards are introduced into our workplace.
- When new, previously unidentified hazards are recognized.
- When occupational injuries and illnesses occur.
- Whenever workplace conditions warrant an inspection.

ACCIDENT / EXPOSURE INVESTIGATIONS

Procedures for investigating workplace accidents and hazardous substance exposures:

1. Interviewing injured workers and witnesses.
2. Examining the workplace for factors associated with the accident/exposure.
3. Determining the cause of the accident/exposure.
4. Taking corrective action to prevent the accident/exposure from reoccurring.
5. Recording the findings and actions taken.

HAZARD CORRECTION

Unsafe or unhealthy work conditions, practices, or procedures shall be corrected in a timely manner based on the severity of the hazards. Hazards shall be corrected according to the following procedures:

- When observed or discovered.
- When an imminent hazard exists which cannot be immediately abated without endangering employee(s) and/or property.

We will remove all exposed workers from the area except those necessary to correct the existing condition. Workers who are required to correct the hazardous condition shall be provided with the necessary protection.

TRAINING AND INSTRUCTION

All workers, including managers and supervisors, shall have training and instruction on general and job-specific safety and health practices. Training and instruction are provided:

- When the IIP Program is first established.
- To all new workers, except for construction workers who are provided training through a construction industry occupational safety and health training program approved by Cal/OSHA.
- To all workers given new job assignments for which training has not previously provided.
- Whenever new substances, processes, procedures, or equipment are introduced to the workplace and represent a new hazard.
- Whenever the employer is made aware of a new or previously unrecognized hazard.
- To supervisors to familiarize them with the safety and health hazards to which workers under their immediate direction and control may be exposed.
- To all workers with respect to hazards specific to each employee's job assignment.

General workplace safety and health practices include, but are not limited to, the following:

- Implementation and maintenance of the IIP Program.
- Emergency action and fire prevention plan.
- Provisions for medical services and first aid including emergency procedures.

- Prevention of musculoskeletal disorders, including proper lifting techniques.
- Proper housekeeping, such as keeping stairways and aisles clear, work areas neat and orderly, and promptly cleaning up spills.
- Prohibiting horseplay, scuffling, or other acts that tend to adversely influence safety.
- Proper storage to prevent stacking goods in an unstable manner and storing goods against doors, exits, fire extinguishing equipment, and electrical panels.
- Proper reporting of hazards and accidents to supervisors.
- Hazard communication, including worker awareness of potential chemical hazards, and proper labeling of containers.
- Proper storage and handling of toxic and hazardous substances including prohibiting eating or storing food and beverages in areas where they can become contaminated.

RECORD KEEPING

We have checked one of the following categories as our recordkeeping policy.

_____ **Category 1**. Our establishment has twenty or more workers or has a workers' compensation experience modification rate of greater than 1.1 and is not on a designated low hazard industry list. We have taken the following steps to implement and maintain our IIP Program:

- ❑ Records of hazard assessment inspections, including the person(s) conducting the inspection; the unsafe conditions and work practices that have been identified; and the action taken to correct the identified unsafe conditions and work practices, are recorded on a hazard assessment and correction form; and
- ❑ Documentation of safety and health training for each worker, including the worker's name or other identifier, training dates, type(s) of training, and training providers are recorded on a worker training and instruction form.

Inspection records and training documentation will be maintained according to the following checked schedule:

_____ For one year, except for training records of employees who have worked for less than one year, which are provided to the employee upon termination of employment; or

_____ Since we have less than ten workers, including managers and supervisors, we only maintain inspection records until the hazard is corrected and only maintain a

log of instructions to workers with respect to worker job assignments when they are first hired or assigned new duties.

OR

_____ **Category 2.** Our establishment has fewer than twenty workers and is not on a designated high hazard industry list. We are also on a designated low hazard industry list or have a workers' compensation experience modification rate of 1.1 or less, and have taken the following steps to implement and maintain our IIP Program:

- ❑ Records of hazard assessment inspections; and
- ❑ Documentation of safety and health training for each worker.

Inspection records and training documentation will be maintained according to the following checked schedule:

_____ For one year, except for training records of employees who have worked for less than one year which are provided to the employee upon termination of employment; or

_____ Since we have less than ten workers, including managers and supervisors, we maintain inspection records only until the hazard is corrected and only maintain a log of instructions to workers with respect to worker job assignments when they are first hired or assigned new duties.

OR

_____ **Category 3.** We are a local governmental entity (county, city, district, or and any public or quasi-public corporation or public agency) and we are not required to keep written records of the steps taken to implement and maintain our IIP Program.

HAZARD ASSESSMENT AND CORRECTION RECORD

Date of Inspection: **Person Conducting Inspection:**

Unsafe Condition or Work Practice:

Corrective Action Taken:

Date of Inspection: **Person Conducting Inspection:**

Unsafe Condition or Work Practice:

Corrective Action Taken:

Date of Inspection: **Person Conducting Inspection:**

Unsafe Condition or Work Practice:

Corrective Action Taken:

ACCIDENT/EXPOSURE INVESTIGATION REPORT

Date & Time of Accident:

Location:

Accident Description:

Workers Involved:

Preventive Action Recommendations:

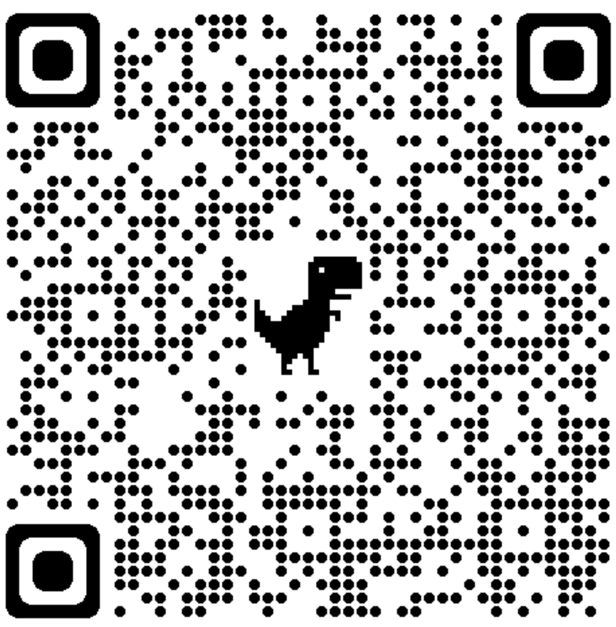
Corrective Actions Taken:

Manager Responsible: **Date Completed:**

WORKER TRAINING AND INSTRUCTION RECORD			
Worker's Name	**Training Dates**	**Type of Training**	**Trainers**

TRAINER GUIDE

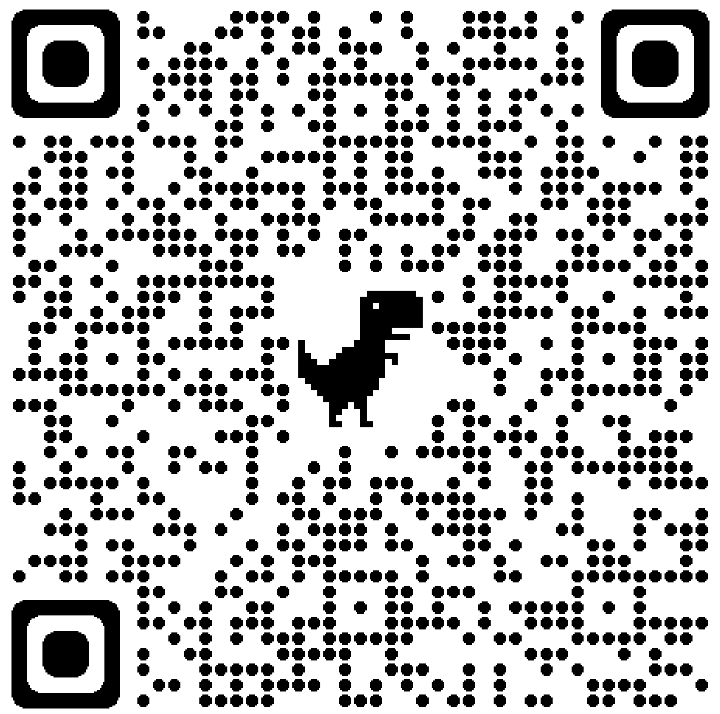
Preventive Health & Safety in the Child Care Setting: A Curriculum for the Training of Child Care Providers 5th Edition (Trainer Guide) QR CODE:



Link:
https://cchp.ucsf.edu/sites/g/files/tkssra181/f/CCHP_Curriculum-Trainer_2022jun20.pdf

STUDENT GUIDE

Preventive Health & Safety in the Child Care Setting: A Curriculum for the Training of Child Care Providers 5th Edition (Student Guide) QR CODE:



Link:
https://cchp.ucsf.edu/sites/g/files/tkssra181/f/CCHP_Curriculum-Student_ENG_2022aug23.pdf

HAZARD EVALUATION FORM FOR GENERAL WORK AREAS AND SPECIFIC JOB SAFETY CLASSIFICATIONS

General Area or Specific Job Classification: Classroom Staff

Date Prepared: ____________________ **Prepared by:**____________________________________

Description of Job/Task	Potential Occupational Safety/Health Hazard	Preventive Work Conditions, Safe Work Practices or Personal Protective Equipment
Caregiving	**Contracting Communicable Diseases**	**Universal Precautions**
	CMV- Of concern to women in childbearing years	Handwashing/ Wearing disposable gloves when handling bodily fluids
	Hepatitis- Symptoms not noticeable in young children	Handwashing/ Wearing disposable gloves when handling bodily fluids
	Rubella- Of concern to women in childbearing years	Exclude children with symptoms of illness
	HIV/AIDS	Consider everyone potentially contagious. Handwashing/ Wearing disposable gloves when handling bodily fluids
Caregiving	**Strains and Sprains**	Correct use of body mechanics for lifting, pulling, pushing, carrying, and moving. Do warm-up exercises before playing with children.
	Falls	Perform tasks and play of which you are physically capable.
Caregiving	**Asbestos Exposure**	Evacuate room if floor or ceiling is disturbed in any way. Avoid contact to skin or inhaling loose materials which may contain asbestos

HAZARD EVALUATION FORM FOR GENERAL WORK AREAS AND SPECIFIC JOB SAFETY CLASSIFICATIONS

General Area or Specific Job Classification: Food Service Staff

Date Prepared: ____________ **Prepared By:** ______________________________

Description of Job/Task	Potential Occupational Safety/ Health Hazard	Preventive Work Conditions, Safe Work Practices or Personal Protective Equipment
Cutting	**Cuts**	Use only sharp knives
		Use accepted food handlers' cutting techniques.
Cooking	**Falls**	Wipe up spills immediately.
		Work at a comfortable pace and avoid rushing.
	Burns	Use dry pot holders to protect hands.
		Cook at moderate temperatures to avoid splashes.
Storing supplies	**Strains/sprains**	Avoid lifting overhead.
		Store items where they can easily be reached.
		Use the dolly or cart for items weighing more than
		25 lbs. or which are bulky.
Driving	**Accidents**	Drive defensively and carry flares.
	Breakdowns	Keep maintenance up-to-date.
		Wear seat belt at all times.

HAZARD EVALUATION FORM FOR GENERAL WORK AREAS AND SPECIFIC JOB SAFETY CLASSIFICATIONS

General Area or Specific Job Classification: Food Service Staff

Date Prepared: ____________ **Prepared By:** ______________________________

Description of Job/Task	Potential Occupational Safety/ Health Hazard	Preventive Work Conditions, Safe Work Practices or Personal Protective Equipment
Cutting	**Cuts**	Use only sharp knives
		Use accepted food handlers' cutting techniques.
Cooking	**Falls**	Wipe up spills immediately.
		Work at a comfortable pace and avoid rushing.
	Burns	Use dry pot holders to protect hands.
		Cook at moderate temperatures to avoid splashes.
Storing supplies	**Strains/sprains**	Avoid lifting overhead.
		Store items where they can easily be reached.
		Use the dolly or cart for items weighing more than
		25 lbs. or which are bulky.
Driving	**Accidents**	Drive defensively and carry flares.
	Breakdowns	Keep maintenance up-to-date.
		Wear seat belt at all times.

HAZARD EVALUATION FORM FOR GENERAL WORK AREAS AND SPECIFIC JOB SAFETY CLASSIFICATIONS

General Area or Specific Job Classification: Health Personnel

Date Prepared: ____________ **Prepared by:** ______________________________

Description of Job/Task	Potential Occupational Safety/ Health Hazard	Preventive Work Conditions, Safe Work Practices or Personal Protective Equipment
Caregiving	**Contracting Communicable Diseases**	Universal Precautions
Caregiving	**Strains and Sprains**	Correct use of body mechanics for lifting, pulling, pushing,
		carrying and moving.
		Do warm-up exercises before playing with children.
	Falls	Only perform tasks and play of which you feel physically capable.
	Asbestos Exposure	Evacuate room if floor or ceiling is disturbed in any way.
		Avoid contact to skin or inhaling loose materials
		which may be asbestos.
Computer Work	**Repetitive wrist movements**	Change tasks frequently
		Keep elbows at a 90° angle when using keyboard.
		Do wrist exercises every two (2) hours.

HAZARD EVALUATION FORM FOR GENERAL WORK AREAS AND SPECIFIC JOB SAFETY CLASSIFICATIONS

General Area or Specific Job Classification: Health Personnel

Date Prepared: ____________ **Prepared by :** ______________________________

Description of Job/Task	Potential Occupational Safety/ Health Hazard	Preventive Work Conditions, Safe Work Practices or Personal Protective Equipment
Computing or Word Processing	**Back, Neck, Wrist, Shoulder injuries**	Use a chair at the correct height for you.
		Have feet flat on the floor.
		Elbows should be at a 90° angle and wrists straight.
Moving around space	**Falls**	Keep file drawers closed when not in use.
		Tape and/or cover wires along the floor.
		Don't open more than one file drawer at a time.
		Have all tall pieces of furniture secured to the wall.
		Store heavy equipment and supplies on bottom shelves.
Mixing Chemicals	**Eye Injury**	Know location of MSDS for particular chemical.
	Skin Burn	Wear protective goggles and disposable gloves.
		Use measuring cups and funnels provided.
		Do process near sink. Flush area with running water if splashed.
		Follow directions for first aid on MSDS.
Working with Copier/Fax	**Cuts, Burns, Crushing**	Follow manufacturer's procedures for problem solving
		on their machine.
Supply Handler	**Sprains, strains**	Use the dolly when moving more than 25 lbs.

HAZARD EVALUATION FORM FOR GENERAL WORK AREAS AND SPECIFIC JOB SAFETY CLASSIFICATIONS

General Area or Specific Job Classification: Office Personnel

Date Prepared: ____________________ **Prepared by:** ____________________

Description of Job/Task	Potential Occupational Safety/ Health Hazard	Preventive Work Conditions, Safe Work Practices or Personal Protective Equipment
Computer Work	**Repetitive wrist movements**	Change tasks frequently.
Processing		Keep elbows at a 90° angle when using keyboard.
		Do wrist exercises every two (2) hours.
	Back and Neck injuries	Use a chair at the correct height for you.
		Have feet flat on the floor.
		Elbows should be at a 90° angle and wrists straight.
Moving around space	**Falls**	Keep file drawers closed when not in use.
		Tape and/or cover wires along the floor.
		Don't open more than one file drawer at a time.
		Have all tall pieces of furniture secured to the wall.
		Store heavy equipment and supplies on bottom shelves.
Working with Copier/Fax	**Cuts, burns, crushing**	Follow manufacturer's procedures for problem solving
		on their machine.
Supply Handler	**Sprains, strains**	Use the dolly when moving more than 25 lbs.
		Use step stool to avoid overhead work.

HAZARD EVALUATION FORM FOR GENERAL WORK AREAS AND SPECIFIC JOB SAFETY CLASSIFICATIONS

General Area or Specific Job Classification: ____________________

Date Prepared: ____________________ **Prepared by:** ____________________

Description of Job/Task	Potential Occupational Safety/ Health Hazard	Preventive Work Conditions, Safe Work Practices or Personal Protective Equipment

INJURY AND ILLNESS PREVENTION PROGRAM TRAINING

The program is in effect as of: _______________. The program being in effect means:

1. Every employee knows the workplace hazards they are subjected to and how to protect themselves.

2. Every employee is subject to disciplinary action if they do not follow our "Safe Work Practices."

3. Supervisors will not change an employee's duty station, work site or job description without retraining the employee in "Safe Work Practices."

4. Each work site should have a copy of the IIPP.

5. Each work site should hang a poster counting the days since there was a work site injury.

6. Each work site should designate a place to display safety information and a place to put their suggestion box.

INJURY AND ILLNESS PREVENTION PROGRAM INITIAL TRAINING GUIDELINE

#	Topic item:	Tell what you will teach them.	Teach them:	Method:	Ask them what they learned.	Evaluate
1	A new safety program	A new way of learning, talking about, and keeping safe at work.				
2	What it is	A system to identify hazards.	Each worksite and task has unique hazards involved with it.	Define & give examples.	Name two other tasks and the hazards involved.	
		A plan to monitor for hazards	All workstations will be inspected monthly for new hazards.	Pass out appropriate hazard ID & inspection sheet.	What would you look for in the workstation to lessen the hazards you mentioned?	
		A method to protect yourself	Every person will know about the hazards of their task, job and worksite prior to doing the job.	Talk about hazard sheet.	How can we make sure everyone has the correct information before doing a job?	
		A means of communicating	Every employee can talk about their safety by written suggestions or contributing at meetings. Every month there will be a safety topic for employees to consider.	Discuss safety concerns and/or injuries.	How can you give information about safety to your supervisor? Co-workers?	
3	Why we have it.	State Law 198 Injured employees are missed.	Every employer must have an IIPP. Injuries interrupt the good work done with the children. Injuries cost us money which could be used for children or staff.	Offer incentive plan for workstations.	Will implementing this plan reduce employee injury and illness?	

INJURY AND ILLNESS PREVENTION PROGRAM INITIAL TRAINING GUIDELINE

#	Topic item:	Tell what you will teach them.	Teach them:	Method:	Ask them what they learned.	Evaluate
		Administration is committed	Each Administrator has signed the IIPP and gives full support.	With '0' injuries every 90 days.	How?	
4	Who regulates it.	Cal OSHA	Responsible for employment conditions in the State.		Could the agency be cited if we don't do this?	
5	Who it is for	All employees: Office, Food Service, Teaching, Sick Care, Health Services, Driver	You must understand the agency plan. You must be aware of the hazards of your specific job. You must protect yourself.	Review cover document. Review worksite hazard ID/Safe Work Practices.	Which worksite plan do you need to know?	
6	When it is in effect	**Immediately and always**	Each person is responsible for knowing the hazards, knowing how to protect themselves, and doing it. It is a shared responsibility to learn how to manage hazards in the workplace.	Pass out workstation "NO INJURY" Posters Mark '#' days	Who is responsible for keeping you safe?	
7	How it works	New employees Meeting Agendas	During orientation this plan will be given to them and their signatures will be required. Safety will be a required agenda item for every meeting. If there is discussion, confusion, conflict, or question, bring it up then.	Pass out signature sheets.	What does signing it mean? If safety is not on the agenda, who should bring it up?	

INJURY AND ILLNESS PREVENTION PROGRAM INITIAL TRAINING GUIDELINE

#	Topic item:	Tell what you will teach them.	Teach them:	Method:	Ask them what they learned.	Evaluate
		Re-training for: Change of workstation Change of work site Change of job New equipment or procedure	Hazards and protection in the new location Hazards and protection Hazards faced with these tasks This will be added to the plan and safe practices developed for it. All chemicals will have MSDS on file in the Health Care office.		Who should initiate this? Who should initiate this? Who should initiate this? Who should initiate this?	
		Monthly reminders: Bulletin Boards Check stuffers Agenda item at reg. meetings	We need suggestions for interesting ideas, topics and displays.	Collect ideas.	What messages could be useful for employees?	
		2-Way Communication: Suggestion Box Incentive awards	Put good stuff in. A possiblity of earning REALLY good stuff!!!	Check stuffers Show watch earned as award.	Are you interested in incentive awards? What would be good ones?	
		Discipline for employees who do not follow the plan to keep themselves safe	Discipline can be up to and including termination.	Collect signatures.	What does this mean? How can we tell if employees do not keep themselves safe?	

San Francisco Department of Public Health: Child Care Health Program

TRAINING ROSTER

DATE: ____________ TIME: ____________ INSTRUCTOR: ____________

INFORMATION COVERED

Worksite:	Task:	Equipment:	
Hazards:	Prevention:		
Print NAME:	Position:	Worksite:	Signature
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			

San Francisco Department of Public Health: Child Care Health Program

INDIVIDUAL SIGNATURE SHEET

DATE:____________ TIME: ____________ INSTRUCTOR: ______________________________

I have attended this training session on the Injury and Illness Prevention Plan (IIPP).

I know where the entire IIPP for _______________ is kept and that I am free to read it at any time.

I have been alerted to my workplace and job hazards and the ways to protect myself.

I was informed of the means of communicating with my employer about safe working conditions.

I understand what I have to do in order to comply with this plan.

I know that safe work practices as described in the plan are a condition of my employment at _______.

Location of the copy for my worksite of ______ Injury and Illness Prevention Plan.

My worksite: Task: Equipment:

Hazards: Prevention:

Print NAME: Position: Worksite: Signature

DATE:____________ TIME: ____________ INSTRUCTOR: ______________________________

I have attended this training session on the Injury and Illness Prevention Plan (IIPP).

I know where the entire IIPP for _______________ is kept and that I am free to read it at any time.

I have been alerted to my workplace and job hazards and the ways to protect myself.

I was informed of the means of communicating with my employer about safe working conditions.

I understand what I have to do in order to comply with this plan.

I know that safe work practices as described in the plan are a condition of my employment at ________.

Location of the copy for my worksite of ______________________ Injury and Illness Prevention Plan.

My worksite: Task: Equipment:

Hazards: Prevention:

Print NAME: Position: Worksite: Signature

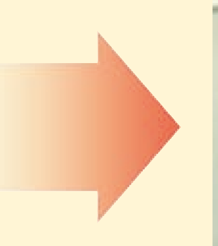
WORK SMARTER, NOT JUST HARDER

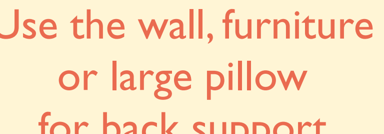
Think Ergonomics-fitting the task to the person

For very small businesses-child care providers

Avoid sitting on the floor too long without back support

1 USE BACK SUPPORT AND STRETCH



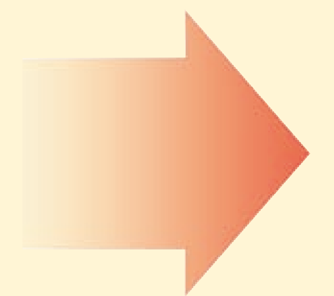


Use the wall, furniture or large pillow for back support

Do stretching exercises

Don't lift children with your back

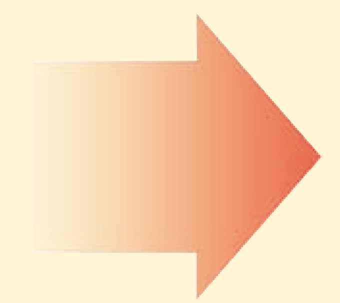
2 LIFT SMART



As you lift, bend your knees and keep the child close to you

Avoid twisting your body when lifting

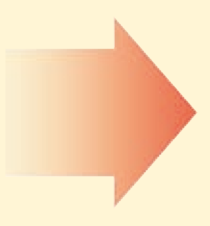
3 AVOID TWISTING WHILE LIFTING



Point your feet in the direction of the lift

Don't carry heavy loads by yourself

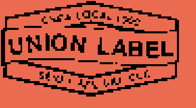
4 AVOID CARRYING HEAVY LOADS



Carry lighter loads

Use a cart, or get a co-worker to help you

To learn more about job safety and receive free publications, please call our toll-free number: 1-800-963-9424 or download from our Web site: www.dir.ca.gov/dosh/puborder.asp



PREVENTING SLIPS, TRIPS, AND FALLS

DON'T RUSH

WEAR PROPER SHOES

WATCH WHERE YOU'RE GOING

Preventing infections in child care facilities

Because their immune systems are less developed, children younger than five are more susceptible to infections. Learn how to stop the spread of germs in child care facilities and keep everyone healthy.

Clean your hands often. Keeping your hands clean is the number one way to prevent the spread of infection. Clean your hands:

- Before and after eating, feeding a child, or preparing food
- After using the bathroom or helping a child use the bathroom
- Before and after diapering a child
- Before and after giving medication or treating sores, cuts, or scrapes
- After sneezing, blowing your nose, coughing, or handling other bodily fluids such as blood or vomit
- Before and after playing in water that is used by more than one person

Stay up-to-date on vaccines and stay home if you are sick. This applies to children, parents, and child care workers.

Make sure surfaces are cleaned regularly. There should be a schedule for when each item is cleaned with an EPA registered disinfectant or a bleach solution, including diaper changing areas and toilets, toys, bottles, and sleeping areas.

Follow food safety guidelines to prevent food-borne illnesses.

Make sure the center follows best practices regarding the health and safety of child care, such as those published by *Caring for Our Children.*

For more information:
www.apic.org/InfectionPreventionAndYou

Resources

Centers for Disease Control and Prevention. Flu information for schools and child care providers. http://www.cdc.gov/flu/school/.

National Resource Center for Health and Safety in Child Care and Early Education. Caring for our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Third Edition. http://cfoc.nrckids.org/.

North Carolina Division of Child Development and Early Education. http://ncchildcare.nc.gov/parents/pr_sn2_checklist.asp.

United States Department of Agriculture, Food Safety and Inspection Service. A guide for safe food handling and sanitation for child care providers. http://www.fns.usda.gov/sites/default/files/appendj.pdf.

University of California San Francisco. California Childcare Health Program. http://cchp.ucsf.edu/.

WHEN TO WASH YOUR HANDS

✔ **Upon arrival for the day, after breaks, or when moving from one child care group to another;**

✔ **Before and after:**

- Preparing food or beverages;
- Eating, handling food, or feeding a child;
- Giving medication or applying a medical ointment or cream in which a break in the skin (e.g., sores, cuts, or scrapes) may be encountered;
- Playing in water that is used by more than one person;

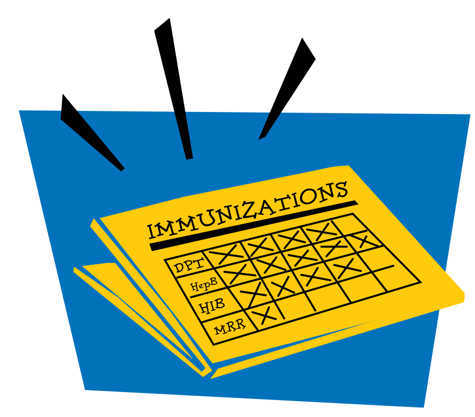
✔ **After:**

- Using the toilet or helping a child use a toilet;
- Diapering;
- Handling bodily fluid (mucus, blood, vomit), from sneezing, wiping and blowing noses, from mouths, or from sores;
- Handling animals or cleaning up animal waste;
- Playing in sand, on wooden play sets, and outdoors;
- Cleaning or handling the garbage.
- Applying sunscreen and/or insect repellent.

Based on: Caring for Our Children, Online Database,2019, Standard 3.2.2.1

PREVENTION OF COMMUNICABLE DISEASES

- Proper hand washing for adults and children
- Proper diapering and toileting techniques
- Environmental cleaning and sanitation
- Food safety
- Daily health checks
- Up-to-date immunizations
- Pets and pest control
- Maintaining good ventilation of indoor space
- Communication with child care health consultants, parents and health care providers



California Childcare Health Program
cchp.ucsf.edu

Rev. 01/03

SAFETY INSPECTION

INSPECT YOUR CHILDCARE FACILITY FOR THE FOLLOWING CONDITIONS.
NOTIFY YOUR DIRECTOR OF ANY UNSAFE CONDITIONS.

1. All objects stored higher than 3 feet above the floor should either be secured in such a manner as to not easily tip or fall or be secured to wall surfaces.

2. Store all heavy objects and chemicals on the lowest shelves. Lock unsafe objects and chemicals for safety. (This will prevent injury during an earthquake.)

3. Separate all glass objects in such a manner that they will not be jolted against each other or against other objects that would cause them to break.

4. Inspect all areas for loose items that might tip or fall during an earthquake (including statues, display items, pictures, etc.) and secure them to wall surfaces or locate them away from child areas.

5. DO NOT block access to doors or exits.

6. DO NOT leave doors to storage cabinets open and unlatched when the cabinets are not in actual use.

7. DO NOT let glass containers of materials accumulate on counter tops or other workspaces; put them back into proper storage areas when you have finished using them.

8. DO NOT allow electrical cords to extend across walkway or exit ways. Remove them immediately after use and store them properly.

9. DO NOT suspend flammable material or other objects from ceilings or from lighting fixtures.

10. Review and follow CCHP Health and Safety Checklist and Recommendations

SELF INSPECTION, CLASSROOM

FACILITY: ______________________ **DATE:** ____________

ITEM:	Satisfactory	Unsatisfactory	Reported
Are all staff members able to identify fire extinguisher locations?			
Is the fire extinguisher mounted, readily accessible and fully charged?			
Do each of the personnel know their responsibilities during a disaster?			
Are equipment and supplies stored safely?			
Is the evacuation route posted?			
Are exit signs and emergency lighting functioning properly?			
Is the outdoor play space free of hazards?			
Are safe work practices being observed?			
Is the dress code being honored?			
Does everyone practice universal precautions routinely?			

Comments: ____

____

____

____

Inspector: ____

SELF INSPECTION, HEALTH OFFICE

FACILITY: ______________________ **DATE:** ____________

ITEM:	Satisfactory	Unsatisfactory	Reported
Is the fire extinguisher mounted, readily accessible and fully charged?			
Do each of the personnel know their responsibilities during a disaster?			
Are equipment and supplies stored safely?			
Is the evacuation route posted?			
Are exit signs and emergency lighting functioning properly?			
Are First Aid and disaster supplies monitored?			
Cal/OSHA poster posted?			
Are fire drill records current?			
Is the fire alarm operational?			
Are safe work practices being observed?			
Is the dress code being honored?			
Are infection control standards and universal precautions being used?			
Are all staff using proper body mechanics?			
Are protective and measuring devices used for mixing chemicals?			

Comments: ____

____

____

Inspector: ______________________________

SELF INSPECTION, KITCHEN

FACILITY: **DATE:**

ITEM:	Satisfactory	Unsatisfactory	Reported
Is the fire extinguisher (Type K, if cooking on premises) mounted, readily accessible and fully charged?			
Has the fire extinguishing system been serviced within the last twelve months?			
Do each of the personnel know their responsibilities during a disaster?			
Does each employee know how to operate and maintain your machinery and equipment?			
Are equipment and supplies stored safely?			
Is kitchen hood operational and steam cleaned within the last year?			
Is grease control good and are all filters present?			
Have floor mats and slip/fall hazards been eliminated?			
Are dolly and step stool readily available?			
Are spills mopped up immediately?			
Are the knife storage and usage as recommended?			
Are knives sharpened as needed?			

Comments: ______________________________

Inspector: ______________________________

SELF INSPECTION, OFFICE

FACILITY: ______________________ **DATE:** ____________

ITEM:	**Satisfactory**	**Unsatisfactory**	**Reported**
Is the fire extinguisher mounted, readily accessible and fully charged?			
Do each of the personnel know their responsibilities during a disaster?			
Are equipment and supplies stored safely?			
Are all exits and corridors unobstructed?			
Have you eliminated extension cords and electrical hazards?			
Does each employee know how to operate and maintain your machinery and equipment?			
Do you have ergonomically-sound work stations?			
Are all floors and walking surfaces safe?			
Is the dolly readily available?			
Is tall furniture over three feet affixed to the wall?			
Do staff routinely practice wrist exercises when using a keyboard for an extended time?			
Are safe work practices being observed by all?			

Comments: ____

____

____

____

Inspector: ______________________________________

K. SLEEPING

Napping	K-01
Linens	K-02
SIDS Prevention	K-03
Back To Sleep	K-04
Infant Sleeping Equipment	K-05
15 Minute Nap Check Log	K-06
NIH Safe Sleep Flyer	K-07

NAPPING

POLICY: Each child will have a safe and comfortable space for sleeping that meets licensing requirements.

PURPOSE: To assure that the child's physical needs are met while in childcare.
To individualize care.
To protect the health of the children and ensure every child's safety.
To reduce the risk of SIDS, suffocation, and sleep-related deaths.
To comply with Licensing Regulations.

PROCEDURE:

1. **Community Care Licensing defines an infant as a child under 2 years old.** Some sleep-related regulations only apply to infants under 1 year old, but many other regulations continue to apply until 2 years old.

2. The napping area will be quiet, dim, and conducive to rest.

3. Children shall have at least 36 inches of space between them.

4. Visual supervision will be maintained at all times.

5. Children will be encouraged to rest by back rubs, music, stories, and other healthy interactions between adult and child.

6. A crib or portable crib, meeting United States Consumer Product Safety Commission safety standards, shall be provided for each infant who is unable to climb out of a crib.

7. Floor mats or cots shall be provided for all infants who are able to climb out of a crib.

8. Each crib, mat or cot shall be occupied by only one child at a time.

9. Cribs, mats, or cots shall be arranged to provide a walkway between them sufficient to permit staff to reach each child without having to step over or reach over any other child.

10. Placement of cribs, mats, or cots shall not hinder entrance or exit to and from the napping space.

11. Each child will have his own cot or crib with his individual linens and blankets.

12. No food or drink will be consumed in the crib or cot.

13. Each infant under 1 year of age must have an Individual Infant Sleep Plan completed (form LIC 9227 – found in section N).

14. Licensing requirements state that "no infant under 1 year of age shall be forced to sleep, forced to stay awake, or forced to stay in the designated sleeping area. All infants shall be given the opportunity to sleep without distraction or disturbance from other activities at the center whenever the infant desires".

15. Infants up to 2 years old must be checked **every 15 minutes** while sleeping, and checks must be **documented:**

    a. Document any trouble breathing, signs of distress, and sleep position

    b. Include name of infant, date, time, and initials of staff

    c. Documentation must be on file for 3 years

References:

California Health and Safety Code, Sections 1596.72, 1596.81, 1596.847

California Code of Regulations Title 22, Division 12:

Chapter 1, Article 6, Section 101239.1

Chapter 1, Subchapter 2, Article 6, Section 101419.2 and Section 101429

Chapter 1, Subchapter 2, Article 7, Section 101439.1

Chapter 3, Article 6, Section 102425

The above regulations were retrieved from: https://www.cdss.ca.gov/inforesources/letters-regulations/legislation-and-regulations/community-care-licensing-regulations/child-care

And

https://www.cdss.ca.gov/inforesources/child-care-licensing/public-information-and-resources/safe-sleep

LINENS

POLICY: Each child will have a clean, safe, and comfortable place for sleeping that meets licensing requirements.

PURPOSE: To protect the health of the children.
To comply with Licensing Regulations.

PROCEDURE:

1. Cot and crib mattresses will be completely covered with a fitted sheet which is secured at the edges to prevent bunching.

2. Blankets and pillows on cots for children over 2 years old are optional depending on preference and temperature. Blankets and pillows for children under 2 years old must NOT be used to prevent SIDS or suffocation.

3. Linens will be changed at minimum **daily** for children in cribs and **weekly** for children in cots, and anytime they become wet or soiled.

4. Each child will have his own cot or crib with his individual linens and blankets.

5. Cots and hard surfaces of cribs will be disinfected at minimum weekly, and anytime they become wet or soiled, with safe cleaning agents that do not aggravate asthma or respiratory conditions.

6. "Sleep sacks" or wearable blankets may be used, **but** a waiver or exception request must be submitted to licensing for approval due to the variety of types of sleep sacks available. If approved by your licensing office, sleep sacks should:

   a. Not restrict the infant's movement in any way

   b. Not be "weighted" (have extra weight on the chest)

   c. Not be used as a swaddle nor have swaddle attachments or wings

References:
California Health and Safety Code, Sections 1596.72, 1596.81

California Code of Regulations Title 22, Division 12, Chapter 1, Subchapter 2, Article 7, Section 101439.1, retrieved from: https://www.cdss.ca.gov/inforesources/letters-regulations/legislation-and-regulations/community-care-licensing-regulations/child-care

And https://www.cdss.ca.gov/inforesources/child-care-licensing/public-information-and-resources/safe-sleep

SIDS PREVENTION

<u>POLICY:</u> Children under the age of 1 year will sleep as safely as possible while in our care. A child has the right to a safe environment and deserves to have caregivers who will take every reasonable precaution to prevent accidents and injury.

<u>PURPOSE:</u> To ensure every child's safety.
To reduce the risk of SIDS, suffocation, and sleep related deaths.
To comply with Licensing Regulations.

<u>PROCEDURE:</u>

1. **<u>See all requirements and recommendations written in section K-4 and K-5 regarding back-to-sleep and infant sleeping requirements.</u>**

2. Parents/legal guardians of infants will be alerted to the center’s policy for back sleeping and be given the pamphlet “Back to Sleep” upon initial enrollment.

3. Parents/legal guardian and staff will complete the Individual Infant Sleeping Plan form (LIC 9227)

4. From the first day of enrollment, for every nap time, infants will be placed on their back to sleep.

5. Infants will be placed on a firm, non-inclined mattress, with a fitted crib sheet, in a crib that meets the Consumer Product Safety Commission safety standards.

6. No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, positioning devices, or extra bedding will be in the crib nor draped over the side of the crib.

7. Sleeping areas will be ventilated and at a temperature that is comfortable for a lightly clothed adult. Infants will not be dressed in more than one extra layer than an adult.

8. If additional warmth is needed, a one-piece wearable blanket sleeper or sleep sack may be used but a waiver must be submitted to licensing for approval due to the many types of sleep sacks available. Sleep sacks must not be weighted, not used as a swaddle, and cannot restrict the infant’s movement in any way.

9. Infants shall never be swaddled; swaddling is prohibited by licensing.

10. The infant's head will remain uncovered for sleep. Bibs and hoods will be removed. Wearing a hat during sleep significantly increases the risk of SIDS and is prohibited by licensing.

11. Infants shall not wear shirts/sweaters with strings on the hood.

12. Sleeping infants will be actively observed by sight and sound.

13. Infants will **never** be allowed to sleep on a couch, chair cushion, bed, pillow, car seat, swing, bouncy chair, or any other surface or product except for a crib or portable crib. If an infant falls asleep anyplace other than a crib, the infant will be moved to a crib right away. These soft surfaces and products are associated with the highest risk of SIDS and suffocation.

14. An infant who arrives asleep in a car seat will be immediately moved to a crib.

15. Infants will not share cribs, and cribs will be spaced 3 feet apart.

16. Infants may be offered a pacifier for sleep, if provided by the parent/guardian.

17. Pacifiers will not be attached by a string to the infant's clothing and will not be reinserted if they fall out after the infant is asleep.

18. When able to roll over both ways, the infant will be put to sleep on their back and allowed to assume a preferred sleep position. Infants who **cannot** roll over both ways shall be turned over to their back if they roll onto their stomach.

19. In the rare case of a medical condition requiring a sleep position other than on the back, the parent/guardian must provide a signed medical exemption from the infant's physician as described on the LIC 9227 form.

20. While awake, infants shall have frequent, supervised Tummy Time play in order to strengthen their neck and back muscles and prevent SIDS and suffocation.

21. The childcare program will support and encourage the use of human milk/ breastfeeding/chest feeding for infants. Breastfeeding significantly reduces the risk of SIDS.

22. The childcare program will maintain a smoke free environment.

Resources

Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment | Pediatrics | American Academy of Pediatrics (aap.org)

Caring for Our Children, National Health and Safety Performance Standards, 3rd Edition. https://nrckids.org/CFOC

California Health and Safety Code, Sections 1596.72, 1596.81, 1596.847

California Code of Regulations Title 22, Division 12:

Chapter 1, Article 6, Section 101239.1

Chapter 1, Subchapter 2, Article 6, Section 101419.2, 101429, and 101430.

Chapter 1, Subchapter 2, Article 7, Section 101439.1

Chapter 3, Article 6, Section 102425

The above regulations were retrieved from:

https://www.cdss.ca.gov/inforesources/child-care-licensing/public-information-and-resources/safe-sleep

And

https://www.cdss.ca.gov/inforesources/letters-regulations/legislation-and-regulations/community-care-licensing-regulations/child-care

BACK TO SLEEP

POLICY: Infants will always be placed on their back for sleep while in our care. A child has the right to a safe environment and deserves to have caregivers who will take every reasonable precaution to prevent accidents and injury.

PURPOSE: To ensure every child's safety.
To reduce the risk of SIDS, suffocation, and sleep-related deaths.
To comply with licensing regulations.

PROCEDURE:

1. Parents/legal guardian will be alerted to the childcare program's policy and licensing requirement for back sleeping and be given the pamphlet "Back to Sleep" upon initial enrollment.

2. Parents/legal guardians and staff shall complete the Individual Infant Sleeping Plan form (LIC 9227)

3. From the first day of enrollment, infants will be placed on their back to sleep for every nap time.

4. If part C of the Infant Sleeping Plan is **NOT** completed, then infants who have rolled onto their stomach or side **must** be turned over on their back.

5. If the parent wrote on Part C that the child can roll over both ways, then it is not necessary to roll the child over to their back if they rolled onto their stomach during sleep. **You should still place them on their back to begin their nap each time.**

6. If rolling both ways is observed by the childcare staff, staff must complete section D of the Sleeping Plan within 1 business day. After which, it is no longer necessary to roll the child over onto their back if they rolled onto their stomach during sleep.

7. If a child resists back sleeping, try holding the child until asleep and then place in the crib on their back. As in all other behavior modifications, you are the expert and persistence will win out.

INFANT SLEEPING EQUIPMENT

POLICY: Each infant will have a safe space for sleeping.

PURPOSE: To protect the health of the children and ensure every child's safety.
To reduce the risk of SIDS, suffocation, and sleep-related deaths.
To comply with licensing regulations.

PROCEDURE:

1. A crib or portable crib, meeting United States Consumer Product Safety Commission safety standards, shall be provided for each infant who is unable to climb out of a crib.

2. Any recalled equipment shall not be kept on site and must be removed from the premises.

3. Recalls can be found at: https://www.cpsc.gov/Recalls

4. When purchasing new cribs or other equipment, there should a card/paper included to complete your contact information and mail it to the manufacturer, so you will be contacted and notified in the event of a recall on your item.

5. Cribs shall not limit the ability of staff to see the infant.

6. Cribs shall not limit the infant's ability to stand upright.

7. Stacking wall cribs or cribs stacked one on top of another, often referred to as tiered cribs, are prohibited and will **not** be used.

8. Mattresses shall be:

   a. Firm and flat. Not inclined.

   b. Made specifically for the size crib in which they are placed.

   c. Covered with vinyl or similar moisture-resistant material.

   d. Wiped with a disinfectant daily and when soiled or wet, with a safe disinfectant that does not exacerbate asthma or respiratory conditions.
   e. Maintained in a safe condition with no exposed foam or coils.

   f. Covered with a fitted sheet that is appropriate to the mattress size, fits tightly on the mattress, and overlaps the underside of the mattress so it cannot

be dislodged.

9. Cribs shall be free from all loose articles and objects, including toys, blankets, and pillows. Infants may be offered a pacifier for sleep, if provided by the parent/guardian, and not attached to the infant with any string or strap.

10. Bumper pads are prohibited and shall **not** be used. Any sale and manufacture of crib bumpers in the U.S. was declared illegal as of May 2022. Crib bumpers are now classified as a banned, hazardous product due to the number of deaths associated with their use.

11. There shall be no objects hanging above or attached to the side of the crib.

12. **NEVER place an infant to sleep on any other surface or product aside from an approved crib or portable crib**.

13. Unsafe products may include infant bouncers, swings, car seats, inclined sleepers, Rock-N-Plays, Doc-A-Tots, pillows, couch, chair, bean bag, waterbed, adult bed/mattress, etc. Sleeping on these products and soft surfaces is associated with the highest risk of sleep related deaths in infants, due to SIDS, suffocation, and positional asphyxia.
14. If an infant falls asleep anyplace other than a crib, the infant will be moved to a crib right away. An infant who arrives asleep in a car seat will be moved to a crib right away upon arrival.

References:

Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment | Pediatrics | American Academy of Pediatrics (aap.org)

Caring for Our Children, National Health and Safety Performance Standards, 3rd Edition. https://nrckids.org/CFOC

California Health and Safety Code, Sections 1596.72, 1596.81, 1596.847

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Chapter 1, Subchapter 2, Article 7, Section 101439.1

Chapter 3, Article 6, Section 102425

Retrieved from: https://www.cdss.ca.gov/inforesources/child-care-licensing/public-information-and-resources/safe-sleep & https://www.cdss.ca.gov/inforesources/letters-regulations/legislation-and-regulations/community-care-licensing-regulations/child-care

15 MINUTE NAP CHECK LOG

(Must be kept on file for 3 years)

Name of Infant: _________________________ **Date of Birth:**____________

"Signs of Distress" includes but is not limited to: labored breathing (such as fast breathing, grunting, or flaring of the nostrils), signs of overheating, flushed skin color, increased body temperature, restlessness, etc.

Licensing Safe Sleep Regulations/ Health and Safety Code Sections 1596.72 and 1596.81

Pediatric Respiratory Rates	
Age	**Rate** (breaths per minute)
Infant (birth–1 year)	30–60
Toddler (1–3 years)	24–40
Preschooler (3–6 years)	22–34

Image from: New York State Department of Public Health

Name of Staff __________________________ Initials _____
Name of Staff __________________________ Initials _____
Name of Staff __________________________ Initials _____

Date	Time	Position (Circle one)	Signs of Distress? (Circle one)	Notes or Action (if applicable)	Staff Initials
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		

Date	Time	Position (Circle one)	Signs of Distress? (Circle one)	Notes or Action (if applicable)	Staff Initials
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		
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	AM PM	Back Stomach Side	NO YES		
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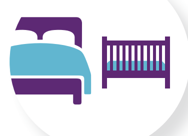
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		
	AM PM	Back Stomach Side	NO YES		

PRINT DOUBLE SIDED SO INFANT NAME AND STAFF NAME ARE ON EACH PIECE OF PAPER IN INFANT'S FILE

WHAT DOES A SAFE SLEEP ENVIRONMENT LOOK LIKE?

The following image shows a safe sleep environment for baby.



Room share: Give babies their own sleep space in your room, separate from your bed.

Use a firm, flat, and level sleep surface, covered only by a fitted sheet*.

Remove everything from baby's sleep area, except a fitted sheet to cover the mattress. No objects, toys, or other items.

Use a wearable blanket to keep baby warm without blankets in the sleep area.

Make sure baby's head and face stay uncovered during sleep.

Place babies on their backs to sleep, for naps and at night.

Couches and armchairs are not safe for baby to sleep on alone, with people, or with pets.

Keep baby's surroundings smoke/vape free.

*The Consumer Product Safety Commission sets safety standards for infant sleep surfaces (such as a mattress) and sleep spaces (like a crib). Visit https://www.cpsc.gov/SafeSleep to learn more.

SAFE SLEEP FOR YOUR BABY

Reduce the Risk of Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Infant Deaths

Feeding babies human milk by direct breastfeeding, if possible, or by pumping from the breast, reduces the risk of SIDS. Feeding only human milk, with no formula or other things added, for the first 6 months provides the greatest protection from SIDS.

Place babies on their backs to sleep for naps and at night.

Stay smoke- and vape-free during pregnancy, and keep baby's surroundings smoke- and vape-free.

Use a sleep surface for baby that is *firm* (returns to original shape quickly if pressed on), ***flat*** (like a table, not a hammock), ***level*** (not at an angle or incline), **and covered only with a fitted sheet.**

Stay drug- and alcohol-free during pregnancy, and make sure anyone caring for baby is drug- and alcohol-free.

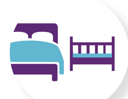
Avoid products and devices that go against safe sleep guidance, especially those that claim to "prevent" SIDS and sleep-related deaths.

Feed your baby human milk, like by breastfeeding.

Avoid letting baby get too hot, and keep baby's head and face uncovered during sleep.

Avoid heart, breathing, motion, and other monitors to reduce the risk of SIDS.

Share a room with baby for at least the first 6 months. Give babies their own sleep space (crib, bassinet, or portable play yard) in your room, separate from your bed.



Get regular medical care throughout pregnancy.

Avoid swaddling once baby starts to roll over (usually around 3 months of age), and keep in mind that swaddling does not reduce SIDS risk.

Keep things out of baby's sleep area—no objects, toys, or other items.

Follow health care provider advice on vaccines, checkups, and other health issues for baby.

Give babies plenty of "tummy time" when they are awake, and when someone is watching them.

Offer baby a pacifier for naps and at night once they are breastfeeding well.

NIH Pub. No. 22-HD-5759 | August 2022

For more information about the Safe to Sleep® campaign, contact us:

Phone: 1-800-505-CRIB (2742) | Fax: 1-866-760-5947
Email: SafetoSleep@mail.nih.gov
Website: https://safetosleep.nichd.nih.gov
Telecommunications Relay Service: 7-1-1

L. FOOD SERVICE

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DRINKING WATER

POLICY: The childcare program will have potable, clean, safe drinking water available and accessible to the children at all times.
Water will also be planned into menus.

PURPOSE: To assure children get safe water to drink when they need or want it. To provide the body with the most important nutrient in the amounts needed by each individual.

PROCEDURE:

1. The water that is available to the children for drinking will be certified safe and free of pollutants and unwanted chemicals, whether public water, well, or bottled.

2. Water must be taken on field trips and to the play yard if not already available there.

3. As of 2018, the new state law requires that child care facilities built before January 2010 have their water tested for lead by 2023 and repeat testing every 5 years. Remediation is mandatory if high lead levels are discovered. This requirement does not apply to Family Child Care Homes but lead testing is highly recommended. Lead exposure causes serious neurological harm to young children. **See section G-8 and G-9 for detailed information on lead testing and lead prevention.**

4. For more information on Water Quality in San Francisco, or to report water concerns such as dirty or discolored water, call 3-1-1 or visit: https://sfpuc.org/accounts-services/water-quality

CHOKING FOODS

POLICY: Children will be served foods that are safe as well as nutritious.

PURPOSE: To avoid the possibility of children choking.
To serve as a role model for families.

PROCEDURE:

1. Children will be closely supervised by an adult seated at the table with them.
2. At mealtime, children will sit upright at the table. Children will eat slowly and take small bites.
3. Foods will be altered in order to make them safe before serving.
4. Cut food into small pieces no larger than **half an inch** or into thin slices.
    a. Cut round or tube shaped food into spears rather than circles / round pieces.
    b. Take small bones out of meat and fish.
    c. Take seeds and pits out of fruit.
    d. Cook or steam hard food (e.g. carrots) until it is soft enough to smash with a fork or squish with your fingers.
5. Children will **not** be served foods that are known to cause choking such as:
    a. Small, firm, slippery foods that can slide down the throat before chewing
        - hard candy
        - peanuts
        - grapes
    b. Small, dry, or hard foods that are difficult to chew and are easy to swallow whole
        - popcorn
        - pretzels

- nuts and seeds
- potato and corn chips
- raw vegetables (carrots, etc) and some hard fruits (cantaloupe, etc)
- ice cubes

c. Sticky or tough foods that do not break apart easily and are hard to remove from the throat

   - hot dogs cut into circles or served whole
   - cheese cubes, blocks, or string cheese
   - spoonful of peanut butter (spread on cracker is OK)
   - tough meat
   - raisins and other dried fruit
   - chewing gum
   - gummy fruit snacks
   - marshmallows

6. Infant bottles shall never be propped up. Cereal shall never be added to infant bottles.
7. Remind children to swallow before talking or laughing.
8. Model safe behavior for children to follow, including eating slowly, taking small bites, and chewing food completely before swallowing.
9. Encourage older children to serve as role models for younger children. All children should avoid playing games with food, as that may lead to an increased risk of choking.
10. See section L-3.

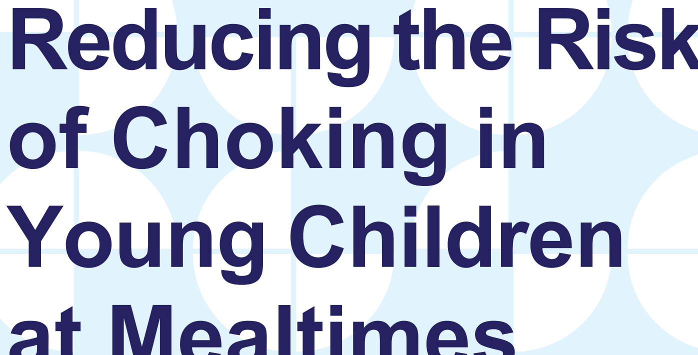
United States Department of Agriculture

Food and Nutrition Service

Reducing the Risk of Choking in Young Children at Mealtimes

Children **under the age of 4** are at a high risk of choking while eating. Young children are still learning how to chew food properly, and they often swallow the food whole. Their small airways can become easily blocked.

You can help reduce children's risk of choking when eating by preparing food in certain ways, such as cutting food into small pieces and cooking hard food, like carrots, until it is soft enough to pierce with a fork. **Remember, always supervise children during meals and snacks.**



FNS-877 September 2020
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Prepare Foods So They Are Easy to Chew

You can make eating safer for young children by following the tips below:

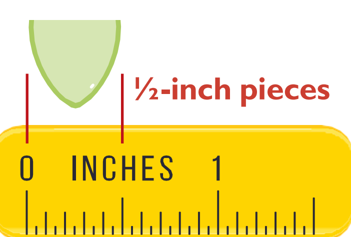
- Cook or steam hard food, like carrots, until it is soft enough to pierce with a fork.
- Remove seeds, pits, and tough skins/peels from fruits and vegetables.
- Finely chop foods into thin slices, strips, or small pieces (no larger than ½ inch), or grate, mash, or puree foods. This is especially important when serving raw fruits and vegetables, as those items may be harder to chew.
- Remove all bones from fish, chicken, and meat before cooking or serving.
- Grind up tough meats and poultry.

Cut Round Foods Into Smaller Pieces

Small round foods such as grapes, cherries, cherry tomatoes, and melon balls are common causes of choking.

Slice these items in half lengthwise.

Then slice into smaller pieces **(no larger than ½ inch)** when serving them to young children.



Avoid Choking Hazards

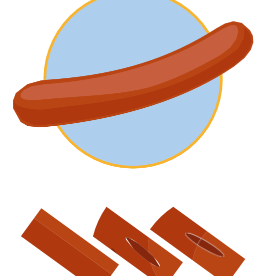
To help prevent choking, do not serve small (marble-sized), sticky, or hard foods that are difficult to chew and easy to swallow whole, including:

- Cheese cubes or blocks. Grate or thinly slice cheese before serving.
- Chewing gum*
- Dried fruit
- Gummy fruit snacks*
- Hard candy, including caramels, cough drops, jelly beans, lollipops, etc.*
- Hard pretzels and pretzel chips
- Ice cubes*
- Marshmallows*
- Nuts and seeds, including breads, crackers, and cereals that contain nuts and seeds
- Popcorn
- Spoonfuls of peanut butter or other nut butters. Spread nut butters thinly on other foods (e.g., toast, crackers, etc.). Serve only creamy, not chunky, nut butters.
- Whole round or tube-shaped foods such as grapes, cherry tomatoes, cherries, raw carrots, sausages, and hot dogs

*Not creditable in the Child Nutrition Programs, including the Child and Adult Care Food Program (CACFP), National School Lunch Program and School Breakfast Program, and Summer Food Service Program.

Cut Tube-shaped Foods Into Smaller Pieces

Cut tube-shaped foods, such as baby carrots, string cheese, hot dogs, etc., into short strips rather than round pieces.



In addition to the foods listed, **avoid serving foods that are as wide around as a nickel**, which is about the size of a young child's throat.

Teach Good Eating Habits

Sit and eat with children at meals and snacks. Remind children to take small bites of food and swallow between bites. Eating together may help you quickly spot a child who might be choking. Other tips to help prevent choking while eating include:

- Only providing foods as part of meals and snacks served at a dining table or high chair. When serving infants, do not prop the bottle up on a pillow or other item for the baby to feed him or herself.
- Allowing plenty of time for meals and snacks.
- Making sure children are sitting upright while eating.
- Reminding children to swallow their food before talking or laughing.
- Modeling safe behavior for children to follow, including eating slowly, taking small bites, and chewing food completely before swallowing.
- Encouraging older children to serve as role models for younger children as well. All children should avoid playing games with food, as that may lead to an increased risk of choking.

For more information, see **FNS.USDA.gov**.

Try It Out!

How can you prepare and serve the following foods to reduce the risk of choking?

1 Whole baby

____

____

2 Whole grapes

____

____

3 Peanut butter

____

____

4 Block of cheddar cheese

____

____

Answer Key

1. Cut carrots lengthwise into thin strips (not circles). You could also cook carrots until soft, or cut into small pieces no larger than ½ inch.
2. Cut grapes in half lengthwise, then cut into smaller pieces no larger than ½ inch.
3. Spread peanut butter thinly on small pieces of toast, crackers, etc. Do not serve spoonfuls of peanut butter.
4. Grate or thinly slice the cheese. Do not serve cheese cubes.

FOOD SERVICE

POLICY: The child care program will provide meal service at breakfast, lunch and morning and afternoon snack.

PURPOSE: To assure the children get proper nutrition while in our care.

PROCEDURE:

1. The Director/designee will assure that the program provides nutritious meals as outlined in the childcare licensing regulations and as reasonably requested by the parents/legal guardians.

2. Menus will be developed or approved by the Director/designee.

3. The Director/designee will assure that the children have breakfast, lunch, and 2 snacks daily, each having a variety of foods chosen from at least two major food groups.

4. The Director/designee will have knowledge of the children with allergies and will assure the supply of appropriate food substitutes for those children.

5. There will be an up-to-date list of children with food allergies and appropriate allergy care plans and emergency medications on-site as needed.

    a. The allergy list shall be posted in the kitchen and the classroom.

    b. The allergy list shall have a cover sheet or be posted in a location that protects the private health information from visitors but is readily available for staff.

6. Milk shall be pasteurized whole milk for children ages 1-2 years old.

7. Milk shall be pasteurized 1% milk for children over 2 years old.

8. Children from ages 1-5 years should not consume more than 600 ml (20 oz) of milk per 24 hours because the risk of iron deficiency increases when children of that age drink more than 24 oz of milk per day.

9. Children with milk sensitivity or allergy will be served a substitute as prescribed by the health care provider.

10. The classrooms will maintain staff, equipment, and supplies sufficient to receive and serve the food or prepare food in the case of an emergency.

10. All dishes and eating utensils will be washed and sanitized in hot water, and diluted bleach solution or SaniDate sanitizer, or washed in a dishwasher (water temperature of at least 165° F).

11. Baby bottles and all perishable foods will be refrigerated at 40° F continuously unless being served. See H-29 and H-30 on food safety in the event of a power outage.

12. Chemicals and cleaning solutions will be stored in a designated, locked cupboard away from all food sources.

13. The food preparation area will not be used for playing, napping, or diapering children. Foot traffic will not be allowed to pass through the food preparation area.

14. Infants will have an individual infant feeding plan and will be introduced to new foods in a timely manner and with the approval of the parent/legal guardian.

15. Formulas and cereals used with be iron-fortified.

16. Children under 1 year of age shall never be given:

    a. Honey

    b. Juice

    c. Liquid Cow's Milk. However, processed milk products such as cheese and yogurt are okay to give to infants over 6 months old.

17. Children under 5 years old will not be fed nuts, raw vegetables, seeds, raisins, grapes, popcorn or hard candies. Hot dogs must be cut lengthwise, not cut in circles and not served whole. See sections L-2 and L-3.

18. Children shall be held when fed a bottle. At no time will a child have a propped bottle, walk with a bottle, nor be put to bed with a bottle.

19. Cultural, religious, and parent's/legal guardian's personal preference to avoid certain foods or follow certain food practices should be honored. The director and parents/ guardians will make a plan together to accommodate feeding related requests. Allergies versus preferences should be clearly differentiated.

20. Child care programs are highly encouraged to participate in the Healthy Apple Program to assess and improve their nutrition practices. For more information on Healthy Apple, contact CCHP or visit https://www.childrenscouncil.org/for-child-care-programs/health-nutrition/healthy-apple-program/

MEAL PLANS AND MENUS

<u>POLICY:</u> The Director or designee will develop, together with the parent/ legal guardian, a pre-service plan for each child.

<u>PURPOSE</u>: To assure the children get proper nutrition while in our care.

<u>PROCEDURE:</u>

1. The service plan for each child will include any special needs and dietary restrictions, including any instructions from a child's health care provider, if applicable.

2. Menus will be developed or approved by the Director/designee.

3. The Director will assure that the children will be served breakfast, lunch, and 2 snacks daily. Each child having a variety of foods chosen from at least two major food groups.

4. The classroom will post a daily activities schedule, including meal and snack times.

5. The menu for the coming week will be posted for parents to see. The menu shall change daily and should have a rotation schedule of about 4-5 weeks. This should include a variety of fruits, vegetables, main dishes/proteins, and whole grains (brown rice, whole grain bread, etc.).

6. Infants will be on individual schedules and feeding plans.

7. **<u>If you are participating in the USDA Child and Adult Care Food Program (CACFP), see section L-6 for more information on meal requirements.</u>**

CACFP FOOD REIMBURSEMENT

The Child and Adult Care Food Program (CACFP) provides reimbursement for eligible children if the meal or snack meets CACFP requirements for the type of food and the amount of food provided. **The information below is subject to change.** Please visit https://www.fns.usda.gov/cacfp, contact your Food Program contact or the use the QR code for more information and to see the up-to-date meal requirements.

INFANTS

Infants	0 – 5 Months	6 – 11 Months
Breakfast and Lunch	4-6 oz human milk or formula	6-8 oz human milk or formula **AND** 0 – ½ oz infant cereal or 0-4 tbs meat, fish, poultry, whole egg, cooked dry beans, or cooked dry peas or 0-2 oz cheese or 0-4 oz cottage cheese or 0-4 oz yogurt or A combination of the above **AND** 0-2 tbs vegetables or fruit or combination of both
Snack	4-6 oz human milk or formula	2-4 oz human milk or formula **AND** 0-½ oz bread or 0-¼ oz crackers or 0-½ oz infant cereal or 0-¼ ounce ready-to-eat breakfast cereal **AND** 0-2 tbs vegetables or fruit or combination of both.

Notes:

1. Infant formula and cereal must be iron-fortified.
2. Refer to the full FNS guidance for additional information on crediting different types of grains.
3. Yogurt must contain no more than 23 grams of total sugars per 6 ounces.
4. Yogurt is a required component when the infant is developmentally ready to accept it.
5. Fruit and vegetable juices must not be served for infants.
6. A serving of grains must be whole grain-rich, enriched meal, or enriched flour.
7. Breakfast cereals must contain no more than 6 grams of sugar per dry ounce (no more than 21.2 grams sucrose and other sugars per 100 grams of dry cereal).
8. For some breastfed infants who regularly consume less than the minimum reimbursable amount of breastmilk per feeding, then a serving of less than the minimum amount of breastmilk may be offered, with additional breastmilk offered later if the infant will consume more.
9. You can claim reimbursement for a meal even if the baby eats the foods at two different times in the day. For example, the baby may be offered breastmilk at 9 a.m. for the breakfast meal and then be offered infant cereal and pureed fruit at 10:30 a.m. based on when the baby shows signs of being hungry.
10. A meal or snack is reimbursable if all required food components are offered to the baby during the day while the infant is in your care. For example, an infant was breastfed at home before arriving at child care, the infant may not be hungry for the breakfast meal when they first arrives. Your child care site may offer the breakfast later in the morning when the infant is hungry and still claim it for reimbursement.
11. Infants do not need to eat the entire meal or drink the entire bottle. If the infant is **served/offered** all the required amounts and components during the day, then the meal is still reimbursable.
12. A mother/parent coming to the childcare site to breastfeed their infant on site can also be claimed for reimbursement!

CHILDREN AGES 1-5

Child	Age 1-2	Age 3-5
Breakfast	4 oz Whole Milk **AND** ¼ cup vegetables, fruits, or combination of both **AND** ½ oz grains	6 oz Milk (1% or skim) **AND** ½ cup vegetables, fruits, or combination of both **AND** ½ oz grains
Lunch	4 oz Whole Milk **AND** 1 serving of Meat or alternative: • 1 oz meat, poultry, or fish • 1 oz tofu, soy product, or protein alternative • 1 oz cheese • ½ large egg • ¼ cup dry beans or peas • 2 tbs peanut butter or other nut butter, soy butter, or seed butter • 4 oz yogurt • The following may be used to meet 50% of the meat requirement: ½ oz peanuts, soy nuts, tree nuts, or seeds **AND** 1/8 cup vegetables, **AND** 1/8 cup fruits **AND** ½ oz grains	6 oz Milk (1% or skim) **AND** 1 serving of Meat or alternative: • 1.5 oz meat, poultry, or fish • 1.5 oz tofu, soy product, or protein alternative • 1.5 oz cheese • ¾ large egg • 3/8 cup dry beans or peas • 3 tbs peanut butter or other nut butter, soy butter, or seed butter • 6 oz yogurt • The following may be used to meet 50% of the meat requirement: ¾ oz peanuts, soy nuts, tree nuts, or seeds **AND** ¼ cup vegetables, **AND** ¼ cup fruits **AND** ½ oz grains
Snack (Ages 1-5)	**Select 2 out of 5 components** (only 1 component can be a beverage) 4 oz Milk Meat or alternative: • ½ oz meat, poultry, or fish • ½ oz tofu, soy product, or protein alternative	

	• ½ oz cheese • ½ large egg • 1/8 cup dry beans or peas • 1 tbs peanut butter or other nut butter, soy butter, or seed butter • 2 oz yogurt • ½ oz peanuts, soy nuts, tree nuts, or seeds ½ cup vegetables, ½ cup fruits ½ oz grains

Notes:

1. Must serve all components for reimbursement.
2. Must be unflavored whole milk for children age of 1. Must be unflavored low-fat (1% fat or less) or unflavored fat-free (skim) milk for children 2 through 5 years old.
3. Pasteurized full-strength juice may only be used to meet the vegetable or fruit requirement at one meal, including snack, per day.
4. At least one serving per day, across all eating occasions, must be whole grain rich. Grain-based desserts do not count towards meeting the grains requirement.
   a. Meat and meat alternates may be used to meet the entire grains requirement a maximum of 3 times a week. One ounce of meat and meat alternates is equal to one ounce equivalent of grains. Refer to full FNS guidance for additional information on crediting different types of grains.
   b. Breakfast cereals must contain no more than 6 grams of sugar per dry ounce (no more than 21.2 grams sucrose and other sugars per 100 grams of dry cereal).
5. Yogurt must contain no more than 23 grams of total sugars per 6 ounces.
6. Alternative proteins must meet CACFP requirements, see full guidance.
7. A vegetable may be used to meet the entire fruit requirement. When two vegetables are served at lunch or supper, two different kinds of vegetables must be served.
8. Children do not need to eat the entire meal, as long as the child is served all the food amounts and components, the meal is still reimbursable.

FOOD BROUGHT FROM HOME

POLICY: The integrity and quality of the nutrition program will be always maintained.

PURPOSE: To avoid the possibility of introducing bacteria to the children.
To provide consistently nutritious foods.
To educate parents/legal guardians to the dietary needs of the children.
To always maintain a safe and healthy environment for the children.

PROCEDURE:

1. Food brought from home must meet the standards for this childcare program and fulfill the same nutritive values as food served at the childcare.

2. Food brought from home shall not be shared with other children, due to the risk of allergies. Staff should closely supervise children while eating, to ensure home foods are not shared.

3. Foods must be safe, as evidenced by, the "Choking Foods" procedure.

4. Staff will not allow known choking foods to be consumed while in childcare.

5. Foods prepared for parties or events must be approved by the Director or Food Service Personnel before being brought to the childcare.

6. Foods that require refrigeration must be transported and stored at 40°F or less.

7. Parents/legal guardian shall not provide homemade formulas for infants. Only commercial infant formulas will be used.

INFANT FEEDING PLAN

POLICY: Each infant will have an individual service plan on file.
Infants less than 1 year of age will be fed either human milk or a commercial, iron-fortified, infant formula as their primary source of nutrition while in childcare.

PURPOSE: To ensure safe and nutritious feeding of all infants for optimal growth and development.
Improper or inadequate feeding during this vulnerable age can harm an infant's health and brain development.

PROCEDURE:

1. As part of the individual service plan, there shall be a feeding plan for each infant completed prior to the infant's first day in childcare. The plan shall be developed together by the Director/designee and the parents/legal guardians.

2. The plan shall include the following items:

   a. If applicable, instructions from the infant's health care provider relating to allergies, special diet, or feeding.

   b. Feeding schedule.

   c. Specify human milk, or specific brand of formula, or both.

   d. Plan of action if an exclusively breastfed infant runs out of breastmilk during the day.

   e. Schedule for introduction of solid foods, new foods, and food consistency.

   f. Food likes and dislikes.

   g. Food allergies, intolerances, sensitivities, or family cultural, religious, or personal preference for avoidance of certain foods. Allergies versus preferences should be differentiated and **food allergies must have an emergency care plan and have emergency medication on-site (e.g., epi-pen).**

   h. Schedule for introduction of cups and utensils.

   i. The plan will be updated when the parent/legal guardian wishes to change from one formula brand to another, or from human milk to formula.

j. The plan may be updated by the parent/legal guardian at any time.

3. Experts recommend beginning solid foods at 6 months old, once signs of developmental readiness are seen in the infant:

    a. Sits up with good head and neck control.

    b. Shows an interest in food. Reaches for food.

    c. Opens mouth for a spoon.

    d. Does not thrust their tongue out while eating solid foods.

4. Infants will be bottle-fed human milk or formula **at least** every 4 hours or more frequently anytime they are showing hunger cues.

5. Healthy infants should begin weaning from a bottle around 1 year old and move to drinking from a cup. The plan for transition should be discussed with the parents/legal guardians.

6. The child care program shall provide only commercially prepared formulas or accept commercially prepared formulas from parents/legal guardians. Homemade formulas shall not be made and shall not be accepted from parents/legal guardian.

INFANT FEEDING POLICIES

POLICY: Infants less than 1 year of age will be fed either human milk or a commercial, iron-fortified, infant formula as their primary source of nutrition while in childcare.
Human milk and formula will be stored, prepared, and served safely.

PURPOSE: To ensure safe and nutritious feeding of all infants for optimal growth and development. Improper or inadequate feeding during this vulnerable age can harm an infant's health and brain development.

PROCEDURE:

1. Infants will be bottle fed human milk or formula **at least** every 4 hours or more frequently anytime they are showing hunger cues or as written in the plan.

2. Infants shall always be held when fed a bottle. At no time will a child have a propped bottle, walk with a bottle, nor be put to bed with a bottle.

3. Solid foods shall always be fed with the infant sitting upright in a high-chair or seated at a table.

4. Bottles shall never be microwaved for warming, neither human milk nor formula.

    a. Place the bottle in hot water to warm up or use a bottle warmer device.

    b. Human milk should never be shaken, instead, **swirl** the bottle to mix it. Shaking human milk can destroy the living white blood cells and immunological components of human milk.

    c. Formula is okay to shake. In fact, shaking powdered formula helps it to mix with the water.

    d. Test the temperature with a few drops on your wrist.

    e. Both human milk and formula can be served cold, room temperature, or warm.

5. For infants who spit up often after bottle-feeding:

    a. Try keeping them in an upright position for about 20 minutes after feeding. Avoid laying them flat or doing tummy time immediately after a bottle (sleeping infants will still need to be laid down flat).

b. Practice “responsive feeding” to reduce spit up (see L-12 and L-13)

c. Minimize swallowing air in the bottle. Remember to burp the infant.

d. If spit up is significant and frequent, the parent/legal guardian should be notified and advised to see their health care provider.

BREASTMILK/HUMAN MILK FEEDING

1. See section L-10 for important detailed information.
2. All human milk shall be labeled with the child’s name and the date it was pumped.
3. Freshly pumped human milk can be stored:
   a. At room temperature for 4 hours (if pumped fresh that morning)
   b. In a cooler bag with ice packs for 24 hours
   c. In the refrigerator for up to 4 days
   d. In the freezer for up to 1 year
4. Thawed human milk that was previously frozen can be stored:
   a. At room temperature for 2 hours once thawed
   b. In the refrigerator for 24 hours once thawed
   c. Can be thawed in the fridge or by placing the bag/bottle in hot water
   d. Thawed milk should never be re-frozen
5. If an infant has drank out of a bottle but does not finish it, **the milk must be thrown out after 2 hours** (versus 1 hour for formula)

FORMULA FEEDING

1. See section L11 for important detailed information.
2. The childcare program shall provide only commercially prepared formulas or accept commercially prepared formulas. Homemade formulas shall not be made and shall not be accepted.
3. Formulas shall be stored and prepared in accordance with label directions.

a. For MOST formulas, this is usually 1 level scoop of powdered formula for every 2 ounces of water. For an accurate water amount, water should be poured into the bottle before the powder. Only use half scoops if the scoop has a line to indicate a half scoop. Do not eyeball/estimate half scoops.

b. Incorrect ratios of formula powder to water can cause inadequate growth and malnutrition, dehydration, stomach discomfort, or constipation.

c. Powdered formula can be mixed with water and stored in the fridge for up to 24 hours.

d. If an infant has drank out of a bottle but does not finish it, the formula **must be thrown out after 1 hour** (versus 2 hours for human milk).

4. Infants who are under 3 months old, were born prematurely, or who are immunocompromised may need extra safety precautions for formula preparation such as boiling water to kill bacteria that could be present in powdered formula. Powdered formula is not sterile. For more information, see: Cronobacter Infection Linked to Infant Formula - CDC

5. Healthy infants over 1 year old do not require infant formula or "toddler formula" unless prescribed by their healthcare provider. The plan for transitioning out the formula after age 1 should be discussed with the parents/legal guardian.

ACCESSIBLE VERSION: https://bit.ly/2dxVYLU

STORAGE AND PREPARATION OF BREAST MILK

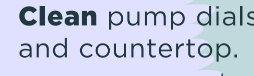
BEFORE EXPRESSING/PUMPING MILK

Wash your hands well with soap and water.

Inspect the pump kit and tubing to make sure it is clean.

Replace moldy tubing immediately.

Clean pump dials and countertop.



STORING EXPRESSED MILK

Use breast milk storage bags or clean food-grade containers with tight fitting lids.

Avoid plastics containing bisphenol A (BPA) (recycle symbol #7).

HUMAN MILK STORAGE GUIDELINES

TYPE OF BREAST MILK	STORAGE LOCATIONS AND TEMPERATURES		
	Countertop 77°F (25°C) or colder *(room temperature)*	**Refrigerator** 40 °F (4°C)	**Freezer** 0 °F (-18°C) or colder
Freshly Expressed or Pumped	Up to **4 Hours**	Up to **4 Days**	Within **6 months** is best Up to **12 months** is acceptable
Thawed, Previously Frozen	1–2 Hours	Up to **1 Day** *(24 hours)*	**NEVER** refreeze human milk after it has been thawed
Leftover from a Feeding (baby did not finish the bottle)	Use within **2 hours** after the baby is finished feeding		

STORE

Label milk with the date it was expressed and the child's name if delivering to childcare.

Store milk in the back of the freezer or refrigerator, not the door.

Freeze milk in **small amounts of 2 to 4 ounces** to avoid wasting any.

When freezing leave an inch of space at the top of the container; breast milk expands as it freezes.

Milk can be stored in an insulated cooler bag with frozen ice packs for **up to 24 hours** when you are traveling.

If you don't plan to use freshly expressed milk **within 4 days**, freeze it right away.

THAW

Always thaw the oldest milk first.

Thaw milk under lukewarm running water, in a container of lukewarm water, or overnight in the refrigerator.

Never thaw or heat milk in a microwave. Microwaving destroys nutrients and creates hot spots, which can burn a baby's mouth.

Use milk **within 24 hours** of thawing in the refrigerator *(from the time it is completely thawed, not from the time when you took it out of the freezer).*

Use thawed milk **within 2 hours** of bringing to room temperature or warming.

Never refreeze thawed milk.

FEED

Milk can be **served cold, room temperature, or warm.**

To heat milk, place the sealed container into a bowl of warm water or hold under warm running water.

Do not heat milk directly on the stove or in the microwave.

Test the temperature before feeding it to your baby by putting a few drops on your wrist. It should feel warm, **not hot.**

Swirl the milk to mix the fat, which may have separated.

If your baby did not finish the bottle, leftover milk should be used **within 2 hours.**

CLEAN

Wash disassembled pump and feeding parts in a clean basin with soap and water. **Do not wash directly** in the sink because the germs in the sink could contaminate items.

Rinse thoroughly under running water. Air-dry items on a clean dishtowel or paper towel.

Using clean hands, store dry items in a clean, protected area.

For extra germ removal, sanitize feeding items daily using one of these methods:

- clean in the dishwasher using hot water and heated drying cycle *(or sanitize setting).*
- boil in water for 5 minutes *(after cleaning).*
- steam in a microwave or plug-in steam system according to the manufacturer's directions *(after cleaning).*

June 2019

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

FOR MORE INFORMATION, VISIT:
https://bit.ly/2dxVYLU

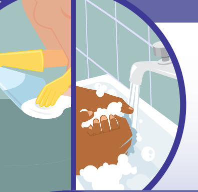
296657-B

HOW TO PREPARE AND STORE **POWDERED INFANT FORMULA**

ARE YOU FEEDING YOUR BABY POWDERED INFANT FORMULA?

Follow these steps to prepare and store your infant formula safely and correctly

STEP 1

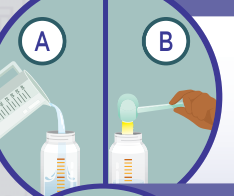


Make sure the formula is **not expired** and the container is **in good condition** (no dents, puffy ends, or rust spots).

STEP 2

Clean the countertops and wash your hands with soap and warm water before preparing bottles. Use a clean bottle and nipple.

STEP 3



Use water from a safe source to mix with formula. Tap water is usually safe, but contact your local health department if you are not sure.

STEP 4

Use the exact amount of water and formula listed on the instructions of the infant formula container. **Always measure the water first and then add the infant formula powder. NEVER dilute formula** by adding extra water. This can make your baby sick.

STEP 5

Shake infant formula in the bottle to mix. Do not stir.

STEP 6

You do not need to warm infant formula before feeding. If you decide to warm the formula, place the bottle under running warm water or into a bowl of warm water for a few minutes. Avoid getting water into the bottle or nipple. This could contaminate the prepared formula. Test the temperature of the formula before feeding it to your baby by putting a few drops on the inside of your wrist. **It should feel warm, not hot.**

Never warm infant formula in a microwave. Microwaving creates hot spots, which can burn your baby's mouth.

STEP 7

After feeding, be sure to **thoroughly clean the bottle and nipple before the next use.**

To learn about cleaning and sanitizing infant feeding items, visit https://go.usa.gov/xpg4F

To learn about infant formula feeding, visit https://www.cdc.gov/nutrition/InfantandToddlerNutrition/formula-feeding/index.html

USE QUICKLY OR STORE SAFELY

Use prepared infant formula within **1 hour from start of feeding** and **within 2 hours of preparation.**

If you are not going to use the prepared infant formula within 2 hours, immediately store the bottle in the refrigerator and use it **within 24 hours.**

Throw out any infant formula that's left in the bottle after feeding your baby. **Do not refrigerate it to save for later.** The combination of infant formula and your baby's saliva can cause bacteria to grow.

TIPS FOR BOTTLE FEEDING

REMEMBER

- **Do not** use a bottle to feed your baby anything besides infant formula or breast milk.
- **Hold your baby close** when you feed him or her a bottle.
- **Always hold the bottle for your baby while feeding.** Propping the bottle in your baby's mouth can increase your baby's risk of choking, ear infections, and tooth decay.
- **Do not put your baby to bed with a bottle.** Infant formula can pool around the baby's teeth and this can cause tooth decay.
- **Do not force your baby to finish the bottle** if your baby is showing signs of fullness.

If your baby is younger than 2 months old, was born prematurely, or has a weakened immune system, you may want to take extra precautions when preparing infant formula.

Visit https://www.cdc.gov/cronobacter/infection-and-infants.html to learn more.

306670-A

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

RESPONSIVE BOTTLE FEEDING

What is Responsive Feeding?

Responsive feeding is a best practice recommended by the AAP and other experts. The term can be applied to bottle feeding, breastfeeding, or feeding of solid foods. The benefits of responsive feeding include:

- Helps the child develop healthy eating habits by learning how to self-regulate their nutritional intake and setting their own pace for feeding.
- Decreases overfeeding, gas, stomach discomfort, and spitting up in bottle-fed infants.
- Develops trust with you when you respond to their hunger or fullness feeding cues.
- May lower child's risk of becoming overweight as they get older because of learning how to self-regulate their nutritional intake and listening to satiety/fullness cues.
- The upright position when responsive feeding can help reduce ear infections.

How to Practice Responsive Bottle Feeding

- Feed infants when they show early signs of hunger
- Hold infants upright at a 45–90-degree angle
- Brush the nipple on infant's lips and wait for them to open their mouth and latch on. Never force the bottle into their mouth.
- Hold the bottle just high enough to prevent the infant from swallowing air, so the nipple is filled with milk.
- Every few sucks, offer the infant a break for a few seconds until they are trying to latch again. Some infants may need more breaks or less breaks than others. The goal is to let the infant set the pace for the feeding and allow them to take breaks when they want to. This requires you to closely watch the infant's behavior during feeding.
- Stop feeding when infant shows signs of fullness. Do not force them to finish the bottle.

Infant Hunger Signs

- Keeps hands near mouth
- Hands in tight fists

- Bends arms and legs toward body
- Makes sucking noises/movements
- Puckers lips
- Searches for nipple (roots)
- Crying is a LATE sign of hunger. Crying infants should be calmed down before starting to feed.

Infant Fullness (Satiated) Signs

- Sucks slower or stops sucking
- Relaxes hands and arms
- Turns away from nipple or refuses to open mouth
- Pushes away
- Falls asleep

Let your baby set the pace for bottle feeding

When you feed your baby at a comfortable pace, your baby can let you know, “I need a break” or “I am full.” Letting your baby set the pace means less chance of overfeeding, gas, stomach discomfort, and spitting up.

Use the steps on the back to follow your baby’s cues.

1 **Is your baby hungry?**
Feed your baby when you see these hunger cues:

- Keeps hands near mouth
- Bends arms and legs toward body
- Makes sucking noises
- Puckers lips
- Searches for nipple (roots)

2 **Offer a bottle.**
Here are 5 easy tips to feeding your baby.

Tip 1: Always hold your baby and the bottle when feeding.

Tip 2: Hold your baby almost upright.

Tip 3: Brush the bottle nipple across your baby's upper lip. Wait for baby's mouth to open.

Tip 4: Hold the bottle in an almost flat position. This position keeps the formula or pumped milk from pouring into your baby's mouth. The nipple will fill and your baby will suck on the bottle.

Tip 5: Let your baby pause and take breaks every few sucks. Your baby may feed for about 15–20 minutes.

3 **Stop when your baby is full.**
Watch for these fullness cues:

- Sucks slower or stops sucking
- Relaxes hands and arms
- Turns away from nipple
- Pushes away
- Falls asleep

California Department of Public Health, California WIC Program
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#920195 Rev 04/20

POLICIES SUPPORTING BREASTFEEDING

POLICY: The child care program will support and accommodate families who wish to provide human milk for their infant.

PURPOSE: To support families in feeding their infant human milk until a minimum of 2 years of age and as long as parent and infant desire, per American Academy of Pediatrics (AAP) and the World Health Organization (WHO) guidelines.
Many families in the U.S. feel that their child care center or provider is not supportive of their desire to provide human milk for their infant.

PROCEDURE:

1. The child care program will have policies, procedures, and attitudes that support and accommodate breastfeeding/chest feeding families in providing human milk for their infant.

2. There are four main evidence-based practices associated with Breastfeeding Friendly Child Care Centers:

    a. Having a written policy on breastfeeding.

    b. Having a suitable space at the center where mothers can breastfeed or express their milk.

    c. Having educational materials available. For example, flyers from https://wicworks.fns.usda.gov/resources/wic-breastfeeding-support

    d. Resources on breastfeeding support available to parents. For example, https://womenshealth.ucsf.edu/whrc/breastfeeding-resources-bay-area

3. Post signs near your entrance such as "Breastfed Babies are Welcome Here" to show your support. A template is available in section L-15.

4. Infant care staff should be knowledgeable in the storage, preparation, and serving of human milk.

5. The CDC considers human milk a food, and not a bodily fluid for the purposes of storage and handling. It can be stored next to other foods in the fridge or freezer. Handling of human milk without gloves has **not** been shown to transmit HIV nor Hepatitis B, so it does not fall under the list of bodily fluids that require universal precautions such as gloves. Professionals who frequently handle human milk may choose

to wear gloves if they wish, or if site policy requires it. (Source: CDC, 2022. www.cdc.gov/breastfeeding/faq/index.htm#precautions).

6. If parents ever request to breastfeed/chest feed their child on-site at the child care center, they shall be allowed to do so without being asked to stop, cover up, or leave. (California state law, Welfare and Institutions Code 11218, section 43.3 states that "a mother may breastfeed her child in any location, public or private, except the private home or residence of another, where the mother and the child are otherwise authorized to be present."

7. In the past, the AAP's guidelines used to recommend breastfeeding until at least 12 months old. As of 2022, the AAP has officially changed their guidance to firmly recommend breastfeeding for a **minimum of 2 years** and continuing to breastfeed for as long as parent and infant desires. See AAP Recommends Longer Breastfeeding Due to Benefits

8. The childcare program should not prohibit parents/legal guardians from supplying human milk after the age of 12 months old, if the parent/guardian is requesting it. A plan for accommodation should be made. Toddlers continue to benefit from human milk beyond infancy, including having less severe and less frequent illnesses. Human milk can provide one third of a toddler's nutritional requirements in the second year of life.

9. The center should have lactation accommodation policies for staff needing to express milk during the workday, in accordance with State Law on Lactation Accommodation. If your staff feel supported in breastfeeding/chest feeding their own infants, this will enhance the culture of breastfeeding support for the staff, for the families you serve, and for the community.

10. Childcare providers' policies and attitudes significantly impact how long a family will breastfeed/chest feeding their infant for.

References:

AAP 2022 Policy Statement: Breastfeeding and the Use of Human Milk

WHO Breastfeeding Recommendation

The State of Our Breastfeeding Friendly Childcare Programs

USDA

ELIMINATION OF DAIRY PRODUCTS FROM THE DIET FOR CHILDREN WITH ALLERGY OR DIETARY RESTRICTION

(Not an easy task!)

1. A child with a documented allergy to milk products should be fed a dairy-free diet. A family may also have religious, cultural, or personal reasons for wanting their child to follow a dairy-free diet.

2. Children with allergies should have appropriate paperwork on file. The staff should be aware of which children have an actual allergy versus a parental/legal guardian preference or request, so that action can be taken for accidental consumption of an allergen.

3. The parent and health care provider can provide a list of which dairy products may be tolerated and which are not.

4. Accommodating a dairy-free diet may involve thorough label reading.

5. **The following terms mean milk in some form is an ingredient:** Lactose, caseinate, sodium caseinate or casein, lactalbumin, lactoglobulin, curds, whey.

6. **Not even "Non-dairy" products are always milk-free**, e.g. those which contain caseinate (milk protein) such as Cool Whip and Coffee Mate. On the other hand, Coffee Rich is okay!

7. First, there is milk in its recognizable, white liquid, homogenized and non-homogenized form; there's skim, low-fat, and buttermilk; powdered milk, condensed milk, and evaporated milk; malted milk, cocoa, and chocolate milk. Then, there is cream: regular, half-and-half, and whipping; butter and most margarine (some diet types are milk-free); and cheeses, such as, cottage cheese, cream cheese, natural cheese, and processed cheese. Let's not forget yogurt and ice cream. Often milk is partially or totally concealed, such as in these foods listed below:

    - Au gratin foods
    - Meat loaf, processed meats such as hot dogs, lunch meats, and sausage
    - Biscuits and their mixes
    - Some salad dressings
    - Breads, rolls, and other bakery products
    - Soufflés, omelets, and often scrambled eggs
    - Cake and cake mixes
    - Mashed potatoes

- Muffins, pancake mixes
- Canned fish balls
- Cookies and their mixes
- Chocolate bars and many candies
- Cream pies
- Cream soups, chowders, and bisques
- Cream sauces and some gravies
- Puddings, such as rice, tapioca, or custard
- Blanc Mange, Flan
- Pudding mixes
- Fritters
- Doughnuts
- Waffle mixes
- Scalloped potatoes
- Macaroni, noodles, and spaghetti

Health and Safety Notes
California Childcare Health Program

Gastric Tubes in the Child Care Setting

Care plan templates for children with G-tube feedings can be found in Section M-11 and M-12 of this manual, and G-tube Consent Form LIC 701b is section M-13

What are gastric tubes?

Gastric tubes—also called gastrostomy tubes or G-tubes—are feeding tubes for the purpose of administering liquid nutrients, medications, or both. Unlike nasogastric tubes (plastic tubes that stretch from the nose down the back of the throat to the stomach) gastric tubes are surgically inserted directly into the stomach.

There are many types of gastric tubes. The most common, called button tubes, are level with the skin. A tube or syringe is attached to the button opening in order to deliver the formula or liquid nutrients and/or medication. Some children with gastric tubes may receive a slow, continuous infusion with the help of a small pump device.

How are gastric tubes inserted?

They are inserted into the stomach through a surgical opening in the abdomen. A gastric tube is kept in place by either sutures (stitches) or an inflated balloon, just inside of the stomach. One end of the tube is in the stomach and the other end is outside of the body. Once the incision is healed the child usually does not experience any discomfort at the tube site.

Who will need a gastric tube?

Infants or children who are not able to eat normally because of problems with their mouth, throat, stomach or intestines may require a gastric tube in order to take in enough nutrients to grow normally and stay healthy. Infants or children with sucking or swallowing difficulties could require a gastric tube as well.

Can gastric tubes come out accidentally?

Yes, they can be dislodged if pulled on and should be kept protected from hazards that could cause snagging. Most gastric tubes have an anchoring device, but extreme care should always be taken to prevent trauma or accidental injury to the site. Gastric tubes should be kept away from the hands of young children and infants—including the child with the gastric tube—to avoid them accidentally pulling out the tube. It is recommended that the child wear a one-piece shirt with the gastric tube tucked inside. If the G-tube comes out accidently, don't panic. Cover the site with a clean piece of gauze or a washcloth, and call the parent. The child care provider should not attempt to reinsert the G-tube.

Does the ADA cover gastric tubes in child care?

The Americans with Disabilities Act (ADA) gives children with special health care needs the right to participate fully in child care programs. The law mandates that child care programs make reasonable modifications in order to accommodate children with special health care needs so that they are fully included in the child care setting.

What should I do if I have a child with a gastric tube in my care?

Understand the reasoning for the gastric tube. Children that have a gastric tube usually have had some other medical problem requiring it. Respond to the whole child so that your focus is not only on this one area.

Develop a written daily plan for the special care of the child with a gastric tube. Involve the parents and all staff members who care for the child in the creation of this plan (a Special Health Care Plan form example is available on the CCHP Web site). If available, involve your Child Care Health Consultant or public health nurse for guidance, resources and continued consultation.

Daily assess the child as he or she enters into care to make sure the gastric tube is not dislodged, infected or causing local irritation of the skin.

Communicate with the child's family about the gastric tube care on a regular basis. Your open and positive attitude will let them know that their child's needs are being meet and that their child is being cared for responsibly and lovingly. Let the family show you how to hold the child during feedings. Ask if they provide any sucking, texture or taste stimulation in the mouth during feeding that you might do as well.

Provide opportunities for the other children in care to be part of the planning for the participation of the child who uses a gastric tube. Children are naturally curious about a child who is different than themselves. Encourage them to share their anxieties and fears, explore their questions and interests, and discuss the issue with each other and in play. Answer their questions with simple and factual answers, using examples that they will understand. Share children's books, songs and other materials that promote the acceptance of individual differences.

Does Community Care Licensing allow feeding by gastric tube in child care?

There is nothing in Community Care Licensing (CCL) in California to prohibit child care personnel from administering routine gastric tube feedings, or administering routine *liquid* medication through a gastric tube to a child in care, as it is not considered a medical procedure. However, child care personnel are prohibited from administering *crushed* medication (pills) to a child through a gastric tube.

Licensed facilities *must* notify CCL in writing of their intent and provide a plan of operation to provide gastric tube care. This must include information on how staff are to be trained in gastric tube care. The facility must obtain approval from CCL to provide gastric tube care for a child [Section 101173(c)].

Written permission from the child's parent/guardian *must* be obtained to provide gastric tube care. It must include parental consent to be able to contact the child's health care provider. Licensing form LIC 701B, "Gastrostomy-Tube Care Consent / Verification (Child Care Facilities)" is to be used to document this permission and must be kept on file at the facility [Section 101226(e)(3)(B)].

A qualified health care professional must properly instruct staff personnel who provide gastric tube care about the procedure for the child. This designated person may be the child's parent/guardian if the physician approves. Licensed facilities must ensure that personnel who give gastric tube feedings are competent to do so and that there is written verifi-cation that the personnel completed the necessary training/instruction in gastric tube care. Form LIC 701A, "Gastrostomy-Tube Care: Physician's Checklist (Child Care Facilities)," is to be used for this purpose and must be kept on file at the facility. A separate form must be used for each person who provides gastric tube care. It is important to ensure that there is trained back-up staff available to assist if necessary [Section 101216(a)].

Personnel who provide gastric tube care must follow specific written instructions from the child's health care provider The instructions including what to do, who to notify if complications occur, and how to receive training should be attached to the child's LIC 701A form and keep on file at the facility. These instructions must include the exact steps needed to provide gastric tube feeding or liquid medication to the child and provide related necessary care. This includes, but may not be limited to: limita-tion or modifications to normal activity, frequency of feeding and amount/type of formula or liquid medication, hydration with water or other liquids, method of administering nutrients or medications, positioning of the child, potential side effects, how and when to flush the gastric tube and what to do if becomes clogged, proper sanitation/cleaning procedures, proper storage of equipment and emer-gency procedures and contact information. These instructions must be updated by the child's health care provider annually, or whenever the child's needs change, by the child's physician or health care provider working with the physician [Section 101226(e)(3)].

M. CARE PLANS

Asthma Info Packet	M-01
Asthma Emergency Care Plan	M-02
Asthma Medication Form – Albuterol	M-03
Allergy Emergency Care Plan	M-04
FARE Food Allergy Care Plan	M-05
Allergy Medication Form – Epinephrine	M-06
Seizure Emergency Care Plan	M-07
Diabetes Emergency Care Plan	M-08
Generic (Blank) Emergency Care Plan	M-09
Generic (Blank) Medication Form	M-10
Special Nutrition and Feeding Plan	M-11
Special Health Care Plan	M-12
G-Tube Consent Form LIC 701b	M-13

Asthma Management Recommendations For Child Care Centers

These recommendations are intended to help provide a safe child care environment for children with asthma. Management of worsening asthma or an asthma emergency should be in accordance with each child's specific Asthma Emergency Care Plan.

Each child with asthma should have an **ASTHMA INFORMATION PACKET**, which contains the following:

1) ASTHMA EMERGENCY CARE PLAN and MEDICATION FORM
   These forms contains information about the child's asthma, triggers, symptoms, asthma medications, and emergency contact numbers. The child's healthcare provider should sign these forms. There should be 2 copies at the child care center: one copy should be stored in the child's medical file and the other copy should be stored with the child's medications so that it can be easily referenced during an exacerbation. These should be updated as needed but no less than annually.
2) NEBULIZER CONSENT FORMS (LIC 9166)
   This form should be provided to the parents by the child care center after the parent has demonstrated how to administer medication to his/her child to all staff members who may be responsible for administering medication to the child. The parent should sign 1 copy of this form for every staff member who has received instruction. This form should be stored at the center in the child's medical file.

You can obtain the **ASTHMA INFORMATION PACKET** from your child care health consultant.

Section A – Responsibilities of **PARENTS/GUARDIANS** of each child with asthma:

- Return the **ASTHMA INFORMATION PACKET** to the child care center manager at the beginning of the year.
- Ensure that all information in the child's medical file is kept up-to-date.
- Communicate regularly with childcare providers about the child's asthma (e.g.. quick-relief medication usage, symptoms, and current coughs, colds or other illnesses).
- Ensure that asthma medication is:
  - Always available.
  - Clearly labeled with the name of the medication, name of the child, dosage, and special instructions.
  - Removed promptly and replaced when expired.
  - Administered with a spacer and mask stored at the center.

A healthcare provider can prescribe an extra set of medications, spacer and mask to be stored at the center.

Section B – Responsibilities of **CHILD CARE PERSONNEL**:

- Provide the **ASTHMA INFORMATION PACKET** to parents/guardians of children with asthma at the beginning of the year.
- Understand:
  - Which children at the center have asthma.
  - How to recognize and respond to worsening asthma and asthma emergencies.

- How to administer quick-relief asthma medications.
- Meet with the child's parents/guardians upon enrollment to discuss the child's particular asthma triggers and tips for administering asthma medications.
- Ensure that quick-relief (albuterol) medication:
  - Is available in the classroom or with the provider if the child is outside of classroom.
  - Use is recorded in the Medication Administration Log.
  - Is disposed of appropriately when expired or when the child is no longer present.
- Communicate with their supervisors and parents/guardians about observed asthma symptoms and administered medications.
- Undergo annual asthma training in-person or online.
- Allow children with asthma to participate in physical activities unless medically contraindicated.

The San Francisco Department of Public Health can provide annual in-person trainings. For online training, we recommend the California Department of Public Health (California Breathing) child care training video: http://californiabreathing.org/resources/childcare-training-video

Section C – Additional considerations

- **CLEANING THE INHALER:** Inhalers should be cleaned at least once a week, depending on frequency of use. Talk to the child's parent/guardian about cleaning.
- **ENROLLMENT:** A child with a known diagnosis of asthma should not be present at a child care center without the appropriate forms, medications, and equipment. A new enrollee's start date may be delayed until the requested information is made available to the child care center manager, at the manager's discretion.
- **ENVIRONMENTAL TRIGGERS:** Steps should be taken to minimize asthma triggers at the center. Child care personnel should be aware of the asthma triggers for children with asthma and take special steps to minimize exposure for these children. Please see the attached checklist for information about common asthma triggers in child care settings. Your child care health consultant can help connect you with an environmental health expert at the San Francisco Department of Public Health if you have specific concerns.
- **EXERCISE:** Some children with asthma need asthma medication prior to physical activity. This information should be provided by the child's healthcare provider on the Asthma Emergency Care Plan and discussed with the parent/guardian. Alternate or indoor activities should be made available to children with asthma, if necessary.
- **FIELD TRIPS:** Children with asthma should be able to participate in field trips as long as asthma triggers are anticipated and minimized and medications are available.
- **FLU SHOTS:** Annual flu shots are recommended for children who are 6 months and older because viral infections are the primary cause of flare-ups in young children.
- **SMOKE:** The center should be smoke-free at all times. Smoking is prohibited within 20 feet of a child care center entrance, exit or operable window. Centers experiencing repeated incidents of smoke should post "No Smoking" signs outside the center. If the incidents continue, notify your child care health consultant.
- **QUESTIONS***:* Please talk to your child care health consultant if you have any questions or concerns about general asthma management or care for specific children.

Asthma cannot be cured, but it can be controlled!

Dear Parent/Guardian,

It has come to our attention that your child has a diagnosis of asthma or uses asthma medications, but certain important items are missing or expired. Please provide the following to the child care center as soon as possible so that we can be sure your child is receiving the best possible care:

- ☐ Current Physical Exam
- ☐ Asthma Emergency Care Plan and Medication Form
- ☐ Nebulizer Consent Form (LIC-9166)
- ☐ Quick-Relief or Rescue (Albuterol) Medication
- ☐ Spacer
- ☐ Mask
- ☐ Other: ______________________

You can expect the child care center to do the following to help your child:

- Minimize exposures to asthma triggers at the center
- Keep a log of asthma medications administered at the center
- Communicate with you about asthma symptoms observed at the center
- Undergo regular training to be prepared to prevent and manage asthma flare-ups
- Talk to me – a certified nurse – if there are any questions or concerns

Let's work together to make sure your child can thrive!

Sincerely,

____

Your Child Care Health Consultant

Child Name: ________________

Medication Log

Date	Time	Medication	Dose/Amount	Reason Given	Staff Initials

How to Use an Inhaler with Spacer and Mask

PRIMING A METERED DOSE INHALER

Priming a metered dose inhaler is important before using it for the first time to be sure it provides the right amount of medicine. It may need to be primed again if it has not been used in a while.

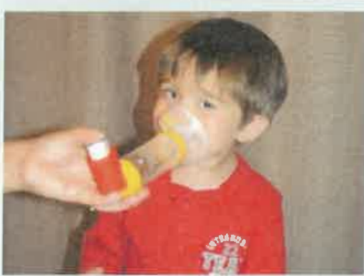
To prime most inhalers, take the cap off the mouthpiece, shake the inhaler well and spray it into the air.

Check the instructions to see how many times you need to spray the inhaler to prime it, and when you need to prime it again. The inhaler is now ready to use.

USING A SPACER WITH A MASK

If your health care provider has prescribed a holding chamber with a mask for your child, follow these steps:

1. Insert the mouthpiece of the plastic holder into the holding chamber.
2. Shake the inhaler well. Keep the inhaler upright.
3. Place the mask on the child's face covering both the nose and mouth firmly.
4. Press the canister only once.
5. Have the child breathe in and out slowly for at least five breaths. Then remove the mask from the face.



If your health care provider has prescribed more than one spray, wait at least one minute and repeat these steps again.

This is general information. Read the instructions that come with the inhaler prescribed by your health care provider and follow them carefully. Also ask your health care provider to show you how to use the inhaler and to watch you use it.

This handout was adapted and modified from the original developed by the Pediatric Asthma Coalition of New Jersey.

Information in this handout is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

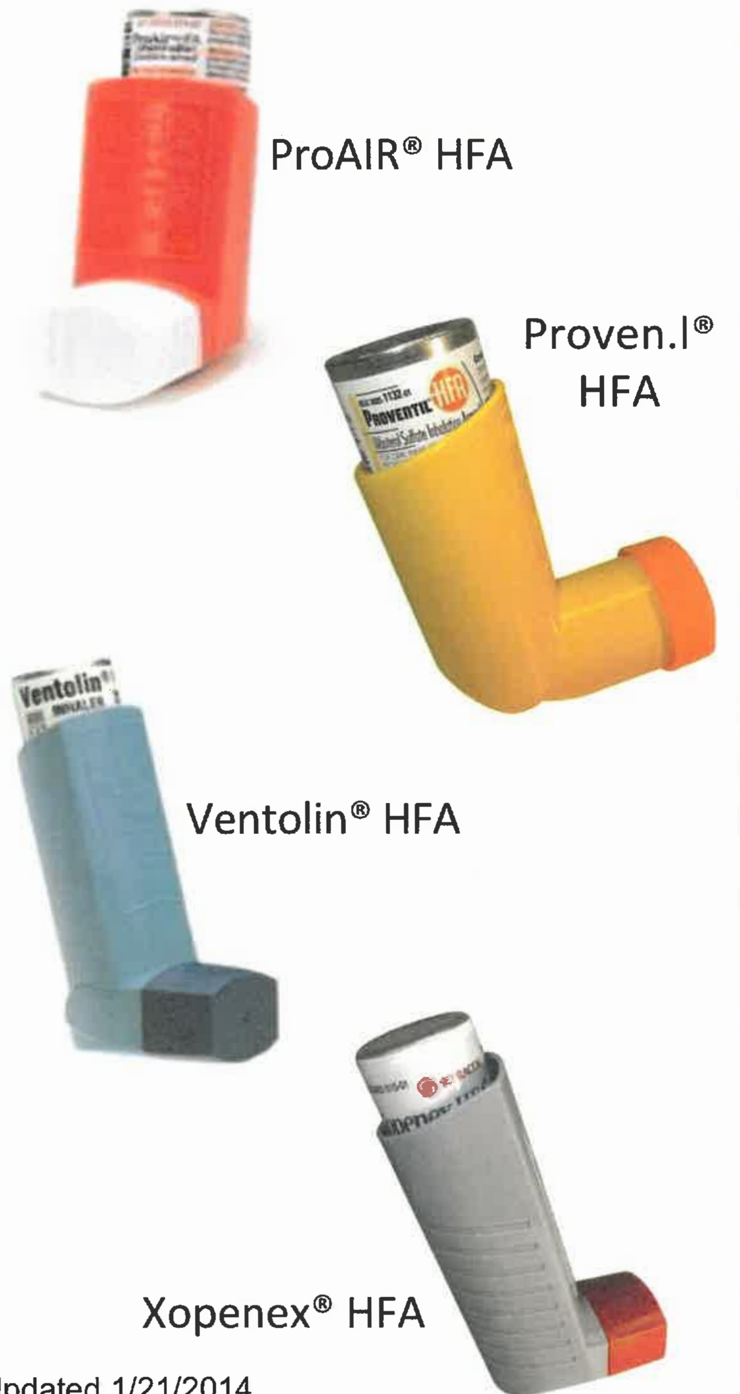
ALBUTEROL

Quick Relief Medication

Medicamentos de Efecto Inmediato

Should always be available at child care center

Siempre tenga disponible en la guardería



ProAIR® HFA

Proven.l® HFA

Ventolin® HFA

Xopenex® HFA

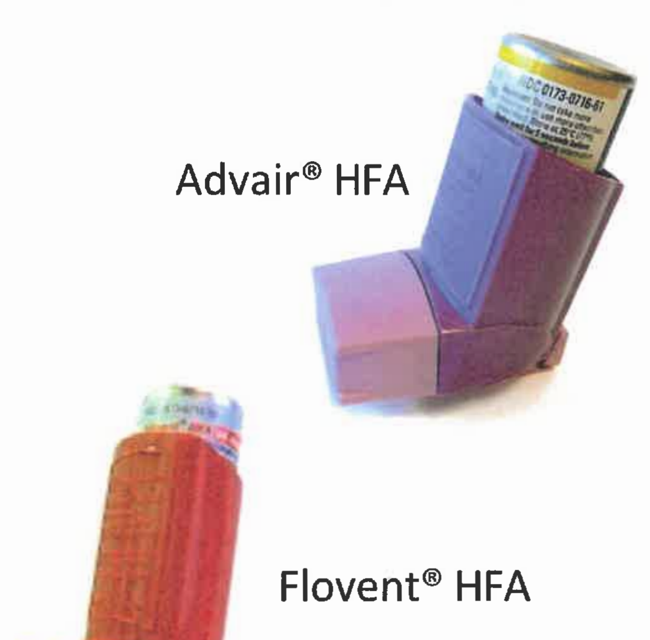
STEROID

Controller Medication

Medicamentos de Efecto Prolongado

For use by the family each day at home

Para uso de la familia todos los días en casa



Advair® HFA

Flovent® HFA

Pulmicort® Flexhaler®

QVAR®

Jpdated 1/21/2014

ASTHMA – FRIENDLY CHILD CARE

A Checklist for Parents and Providers

Asthma is the most common chronic childhood disease. Children with asthma have sensitive airways. They are bothered by many things that start (or "trigger") their symptoms and make their asthma worse. The most common asthma triggers are allergies to dust mites, cockroaches, animal dander, mold, and pollens, and exposure to irritating smoke, smells, or very cold air. Children's asthma can also be triggered by excessive exercise or an upper respiratory infection. The airways of people who have asthma are "chronically" (almost always) inflamed or irritated, especially if they are exposed to their triggers every day. This makes it hard for them to breathe.

Asthma can be controlled by being aware of its warning signs and symptoms, using medicines properly to treat and prevent asthma episodes, and avoiding the things that trigger asthma problems. *Each child's asthma is different,* so it is important to know the asthma triggers and treatment plan of each individual.

Use this checklist to learn how to make your child care setting a safe and healthy environment for children with asthma and allergies, or to help you choose a health child care placement for your child.

Avoiding or Controlling Allergens

Dust mites

	Needs Improvement	O.K.
Surfaces are wiped with a damp cloth daily. (No aerosol "dusting" sprays are used.)	❑	❑
Floors are cleaned with a damp mop daily.	❑	❑
Small area rugs are used, rather than wall-to-wall carpeting. Woven rugs that can be washed in hot water are best. (Water temperature of at least 130· F/54· C kills dust mites.)	❑	❑
If wall-to-wall carpeting can't be avoided, children are prevented from putting their faces, nap mats, blankets or fabric toys directly on the floor.	❑	❑
Children's bed linens, personal blankets and toys, are washed weekly in hot water.	❑	❑
Fabric items (stuffed toys or "dress up" clothes) are washed weekly in hot water, to kill dust mites.	❑	❑
Furniture surfaces are wiped with a damp cloth.	❑	❑
Soft mattresses and upholstered furniture are avoided.	❑	❑
Beds and pillows that children sleep or rest on are encased in allergy-proof covers.	❑	❑
Curtains, drapes, fabric wall hanging and other "dust catchers" are not hung in child care areas.	❑	❑
If light curtains are used they are washed regularly in hot water.	❑	❑
If window shades are used, they are wiped often with a damp cloth.	❑	❑
Books, magazines and toys are stored in enclosed bookcases, closed boxes, or plastic bags.	❑	❑
Supplies and materials are stored in closed cabinets; piles of paper and other clutter are avoided.	❑	❑

Animal substances:
(both pets and pests shed dander, droppings and other proteins which cause allergic responses and trigger asthma symptoms)

	Needs Improvement	O.K.
Furry or feathered pets are not allowed anywhere on the premises (cats, dogs, gerbils, hamsters, birds, etc.).	❑	❑
Cockroaches and mice infestation are aggressively controlled, using preventive practices and least toxic extermination methods.	❑	❑
Feather-stuffed furnishings, pillows or toys are not used.	❑	❑

Mold and mildew:

	Needs Improvement	O.K.
Exhaust fans are used in bathrooms, kitchens and basement areas to help remove humidity.	❑	❑
Wet carpeting and padding are removed if not dry within 24 hours to prevent mold growth.	❑	❑
Mats that are placed on carpeted floors (especially in basement areas) are vinyl-covered, and wiped regularly with diluted chlorine bleach and water (1/4 cup bleach in 1 gallon water).	❑	❑
Mildew growth in bathroom and other damp areas (such as refrigerator drip pans) is prevented by regular wiping with diluted chlorine bleach and water.	❑	❑
Indoor houseplants and foam pillows, which can develop mold growth, are not used.	❑	❑

Outdoor pollen and mold spores:

	Needs Improvement	O.K.
If ventilation is adequate, windows are kept closed during periods of high pollen count	❑	❑
Air conditioners with clean filters are used during warm seasons, if possible.	❑	❑
Outdoor yard and play areas are kept clean of fallen leaves, compost piles, and cut grass.	❑	❑

Latex: (products made with natural rubber)

	Needs Improvement	O.K.
Avoid latex gloves. If gloves are used, only non-powdered, non-latex gloves.	❑	❑
Avoid latex balloons, pacifiers, koosh balls and other latex products (if child or staff member has latex sensitivity).	❑	❑

Avoiding or Controlling Irritants

Tobacco Smoke: (triggers asthma symptoms; causes children to have more respiratory and ear infections, and to need more asthma medication)

	Needs Improvement	O.K.
Smoking is not allowed anywhere on the premises. This rule is strictly enforced.	❑	❑
Staff and parents are encouraged to participate in smoking cessation programs, and given referrals and assistance.	❑	❑

Chemical Fumes, Fragrances, and Other Strong Odors:

	Needs Improvement	O.K.
Arts and crafts materials with fragrances or fumes are avoided (e.g., markers, paints, adhesives). If they are used, extra ventilation is provided.	❑	❑
Staff does not wear perfume or other scented personal products. (Use products labeled "fragrance-free" whenever possible.)	❑	❑
Personal care products (such as hair spray, nail polish, powders) are not used around the children.	❑	❑
Air fragrance sprays, incense, and "air fresheners "are not used. (Open the windows and/or use exhaust fans instead.)	❑	❑
New purchases (such as pressed-wood furnishings or plastic laminated products) are checked for formaldehyde fumes, and aired out before installation.	❑	❑
Cleaning supplies and home repair products with strong smells are not used when children are present; indoor spaces are carefully ventilated during and after their use.	❑	❑
Office equipment that emits fumes (e.g., photocopy) are in vented areas away from children.	❑	❑

Other Irritants:

Fireplaces and wood or coal stoves are not used.	❑	❑

Policies and Practices

Asthma Management and Care:

	Needs Improvement	O.K.
All staff are trained to watch for symptoms of asthma, warning signs that asthma is flaring up, and how to recognize emergency situations. New staff receive this training when hired.	❑	❑
Every child with asthma has a written plan on file, listing allergies and asthma triggers, medication schedule, and emergency instructions.	❑	❑
Staff is trained to administer medication, and in the use and care all of nebulizers, inhalers, spacers and peak flow meters.	❑	❑
Parents and providers communicate regularly about child's asthma status.	❑	❑
Outdoor time is adjusted for cold-sensitive children, and alternative indoor activities are offered (after an asthma episode or viral infection, they are also more sensitive.)	❑	❑
Staff and children wash hands frequently; toys and surfaces are wiped often, to prevent the spread of viral infections that can trigger asthma.	❑	❑

This checklist was developed by the Asthma & Allergy Foundation of America, New England Chapter, with the support of a grant from the U.S. Environmental Protection Agency, Region. I.

General Physical Site/Space:

	Needs Improvement	O.K.
Ventilation provides good air flow in all rooms and halls in every season. There is no stale or musty smell. Outdoor intake and inside supply vents are checked for blockages.	❑	❑
Heating or cooling system filters are properly installed and changed often; other service guidelines and routine maintenance procedures are followed.	❑	❑
Heating or cooling ducts are professionally cleaned once a year.	❑	❑
Outdoor fumes (such as from car exhaust, idling vans or buses, or nearby businesses) are prevented from entering the building through open windows or doors.	❑	❑
The building is checked periodically for leaks and areas of standing water.	❑	❑
Plumbing leaks are fixed promptly.	❑	❑
Humidity level is monitored, using a humidity gauge, if possible. Humidifiers are not used; dehumidifiers are used if necessary. (Dust mites and mold thrive on humidity.)	❑	❑
Wet boots and clothing are removed and stored where they don't track wetness into activity space.	❑	❑
Doormats are placed outside all entrances, to reduce tracking in of allergens.	❑	❑

Cleaning and Maintenance:

	Needs Improvement	O.K.
If rugs or carpets must be used, they are vacuumed frequently (every day or two).	❑	❑
High efficiency vacuum cleaner (ideally with the "HEPA" filter) is used. (Others blow tiny particles back into the air.)	❑	❑
Dusting is done often, with a damp cloth, to avoid stirring up the dust.	❑	❑
Vacuuming and other cleaning is done when children are not present.	❑	❑
Integrated pest management techniques are used, to limit amount of pesticide needed (e.g., seal all cracks in walls, floors and ceilings; eliminate clutter; keep food in air tight containers).	❑	❑
Pesticides are applied properly, with adequate ventilation, when children are not present.	❑	❑
Garbage is kept in tightly covered containers, and removed promptly to outdoor enclosed trash area that is not accessible to children.	❑	❑
Painting, repairs or construction work is done when children are not present. Indoor spaces are protected from construction dust, debris, strong odors and fumes.	❑	❑
Shampooing of rugs and upholstery is done with low emission, fragrance-free products. They are dried thoroughly to prevent growth of mold and dust mites.	❑	❑

This checklist was developed by the Asthma & Allergy Foundation of America, New England Chapter, with the support of a grant from the U.S. Environmental Protection Agency, Region. I.

STUDENT PHOTO

ASTHMA
EMERGENCY CARE PLAN

For School Use Only
Medication:□ NO □ YES (Attach Med Form) Medication Location:_____________
Copies of this ECP & Med Form, the medication, must go on all offsite activities.

TO BE COMPLETED BY PARENT/CAREGIVER

Name: ______________________ Date of Birth: __________ School: ______________

Grade: ________ Homeroom Teacher: ____________________ Room: ________

Parent/Caregiver info: Name_________________ Phone ______________ Email____________

-----------------------------------TO BE COMPLETED BY THE HEALTH CARE PROVIDER-----------------------------------

Health Care Provider Treating Student for Asthma:_____________________________ Ph: ______________

Other asthma medication used at home:____

Does student require inhaler before exercise: ☐ No ☐ Yes

If yes, please specify: medication ____________________ to be given # _____ minutes before exercise

Reduce exposure to the following asthma triggers: ______________________________________

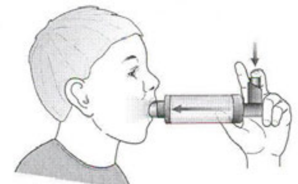
Zone	Symptoms	Actions to Take
Green Zone Doing Well	**SYMPTOMS** ● Breathing is normal ● Feel good doing usual activities ● No cough, wheeze, chest tightness, or shortness of breath	**ACTIONS TO TAKE** Student continues taking daily medication at home as prescribed **GOAL:** Prevent asthma symptoms every day and feel good!
Yellow Zone CAUTION!	**SYMPTOMS** ● Cannot do all of your normal activities ● Regular breathing is a little faster than normal ● Slight cough, wheeze, chest tightness, or shortness of breath ● Mild chest congestion from cold or allergies	**ACTIONS TO TAKE** Staff stays with the student. Staff remains calm and speaks softly Staff seats student in an upright position Staff to encourages student to take slow, deep breaths ("belly breathing") Staff assists with quick relief medication (as prescribed): ______________________________ (name of the medication, *see medication form) Staff to wait with the student for 15 minutes. If symptoms resolve and student remains in Green Zone, may return to class. Staff to call school nurse/parent/guardian to inform **GOAL:** Student is back in the green zone
Red Zone Medical Alert	**SYMPTOMS** ● **Persistent cough or wheeze** ● **Cannot walk, talk, or move well** ● **Rapid or shallow breathing** ● **Flared or enlarged nostrils** ● **Struggling or gasping for breath** ● **Difficulty Speaking** ● **Gray, dusky, or bluish color around mouth or under nails** ● **Quick relief medication hasn't helped**	**EMERGENCY! Get help! Do not leave student alone** **ACTIONS TO TAKE** ● **CALL 911 immediately and notify parents** ● **Administer CPR if breathing stops!** ● **Continue until paramedics (EMS) arrive!** ● **Give a copy of the student's Emergency Card to EMS** ● **Send emergency medication with EMS**

I authorize school personnel to implement this Asthma Emergency Care Plan as described. **I have completed a medication form for the quick relief medication.**

_______________________________________ ____________________
Health Care Provider Signature & NPI # Date

I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent to communicate with the authorized health care provider when necessary.

_______________________________________ ____________________
Parent/Caregiver Signature Date



ASTHMA MEDICATION FORM (One Medication Per Form)

Dear Parent/Guardian/Caregiver:

California Education Code 49423 provides that students required to take medically prescribed or over-the-counter medications during the school day **MAY** be assisted by school personnel **ONLY** if the school district receives a specific written statement from the health care provider **AND** the parent/guardian/caregiver of the student. **Please complete this entire form and return it to the Principal.**

Student Name: Last First Middle	Date of Birth (Month/Day/Year)

HEALTH CARE PROVIDER SECTION

Health Condition for which medication is prescribed: **ASTHMA**	Quick Relief Asthma Medication: __ALBUTEROL__________________ Dose: **2 puffs (give 1 at a time, 1 minute apart), with spacer; inhale each puff and hold for 10 seconds** Frequency: **AS NEEDED, 4-6 hours apart**; if the inhaler is new or not used in the past 2 weeks, prime the device first, as described in the medication instructions. (To prime, spray the inhaler 3-4 times away from the face or follow medication package instructions.)
How is medication to be given? Inhalation **WITH SPACER**	
The medication is to be continued as above until: (please be as specific as possible about date)	If NOT on an as needed basis, about what time(s) does the quick relief medication need to be given at school? _____________AM / PM
Any precautions that school personnel need to know? NONE Contraindications?	What are possible reactions/side effects? Rapid heart rate What should be done in the event of a reaction/side effect? If heartbeat is fast, rest for 10 mins. If Albuterol is not effective, repeat medication dose and seek medical care.

Check appropriate boxes below:

❐ I authorize this student to **self-administer** the above medication.

❐ I authorize designated school personnel to assist the student with taking the above medication.

Print Provider name, address & phone number	Signature and NPI # of Health Care Provider	Date

PARENT / GUARDIAN / CAREGIVER SECTION

Parent/Guardian/Caregiver Name	Home Language	Daytime Phone ( )
Address – Number and Street Apt No. City Zip Code		Evening Phone ( )
School	Children's Center / ES / MS / HS	School Hours

Check appropriate boxes below:

❐ I permit my child to give himself/herself the above medication.

❐ I permit designated school personnel to assist my child with taking the above medication.

1. I agree to hold the San Francisco Unified School District (SFUSD) and its employees harmless from any and all liability for the results of taking the medication or the manner in which the medication is given.
2. I will reimburse the SFUSD and its employees for any liability arising out of these arrangements.
3. I will notify the Principal of the school immediately if there is a change in my child's medication.
4. I understand it is my responsibility to send the medication to school in the **original pharmacy container** labeled with my child's name and the health care provider's instructions.
5. I understand that this form automatically expires at the end of each school year.
6. I give my consent for school authorities to take appropriate action for the safety and welfare of my child.

Parent/Guardian/Caregiver Signature ___________________________________ Date________________________

STUDENT PHOTO

ALLERGY EMERGENCY CARE PLAN

For School Use Only
Location of Medication: ____________________

TO BE COMPLETED BY PARENT/CAREGIVER					
Student Name	***DOB***	***School***	***Grade***	***Homeroom Teacher***	***Room***
Parent/Caregiver Name		***Home Phone***	***Cell Phone***	***Email***	

TO BE COMPLETED BY THE HEALTH CARE PROVIDER		
Type(s) of Allergy(ies)	***Name of Health Care Provider***	***Phone***

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.

LUNG Short of breath, wheezing, repetitive cough

HEART Pale, blue, faint, weak pulse, dizzy

THROAT Tight, hoarse, trouble breathing/ swallowing

MOUTH Significant swelling of the tongue and/or lips

SKIN Many hives over body, widespread redness

GUT Repetitive vomiting or severe diarrhea

OTHER Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of mild or severe symptoms from different body areas.

- ☐ **INJECT EPINEPHRINE AUTO-INJECTOR IMMEDIATELY**
- ☐ **Call 911**
- ☐ Alert parents/caregivers
- ☐ If symptoms do not improve, or symptoms return, give a second dose of Epinephrine 5 minutes after first dose
- ☐ Administer CPR if breathing stops

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

NOSE – Itchy, runny

SKIN – Rash, itchy

MOUTH – Itchy

☐ **Give:**

____
(Medication)

☐ **Stay with student**

☐ **Watch student closely for changes**

☐ **If symptoms worsen, GIVE EPINEPHRINE**

☐ **Other**______________________________

____

I authorize school personnel to implement this Allergy Emergency Plan as described.
I have completed a current (within this school year) medication form FOR EACH medication to be given

Health Care Provider Signature & NPI #	***Date***

I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent to communicate with the authorized health care provider when necessary.

Parent/Caregiver Signature	***Date***

Notify parent/guardian and document about what happened in the First Aid and Medication Logs.

***By law, a completed and signed current (within this school year) Medication Form must be on file at the school before medication can be administered at school.**

GRAPHICS ADAPTED FROM FOOD ALLERGY RESEARCH & EDUCATION (FARE)

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: ______________________________ D.O.B.: ____________

Allergic to: ______________________________

Weight: __________ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens:______________________________

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG Shortness of breath, wheezing, repetitive cough

HEART Pale or bluish skin, faintness, weak pulse, dizziness

THROAT Tight or hoarse throat, trouble breathing or swallowing

MOUTH Significant swelling of the tongue or lips

SKIN Many hives over body, widespread redness

GUT Repetitive vomiting, severe diarrhea

OTHER Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE Itchy or runny nose, sneezing

MOUTH Itchy mouth

SKIN A few hives, mild itch

GUT Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: ____________

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: ____________

Antihistamine Dose: ____________

Other (e.g., inhaler-bronchodilator if wheezing): ____________

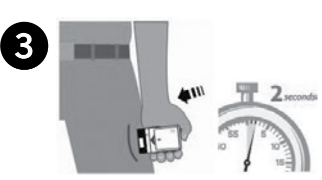
____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

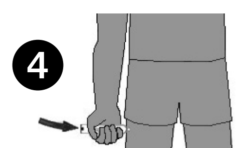
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO



1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN



1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ______________________

DOCTOR: ______________________ PHONE: ____________

PARENT/GUARDIAN: ______________________ PHONE: ____________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ______________________ PHONE: ____________

NAME/RELATIONSHIP: ______________________ PHONE: ____________

NAME/RELATIONSHIP: ______________________ PHONE: ____________

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

MEDICATION FORM for Epinephrine Auto Injector

Dear Parent/Guardian/Caregiver:
California Education Code 49423 provides that students required to take medically prescribed or over-the-counter medications during the school day **MAY** be assisted by school personnel **ONLY** if the school district receives a specific written statement from the health care provider **AND** the parent/guardian/caregiver of the student. **Please complete this entire form and return it to the Principal.**

HEALTH CARE PROVIDER SECTION

Student Name: Last First Middle	Date of Birth (Month/Day/Year)

Health Condition for which medication is prescribed: Severe Allergic Reaction to the following:	**Medication:** Please circle Epinephrine Auto-Injector Adrenaclick Auvi-Q EpiPen EpiPen Jr. Dose: ☐ 0.15 mg ☐ 0.3 mg
Symptom of Severe Allergic Reaction include: * can be life-threatening! Mouth: itching, swelling of lips/tongue Throat*: itching, tightness/closure, hoarseness Skin: itching, hives, redness, swelling Gut: vomiting, diarrhea, cramps Lung*: shortness of breath, cough, wheeze Heart*: weak pulse, dizzy, passing out	
Medication Route: Injection to outer thigh	**Time medication to be given at school?** As needed
The medication is to be given: -If suspicion of exposure to the source of allergy AND at least one symptom -Any life-threatening symptom	**Any precautions that school personnel need to know? Contraindications?**
What are possible side effects of the medication? Increased heart rate, dizziness, shakiness, paleness, weakness, anxiety, headache	**What should be done after administering Epinephrine?** Call 911 after administering medication and give used auto-injector to paramedics to bring to ER with student

Check appropriate boxes below:

❐ **I authorize this student to self-administer the above medication.**

❐ **I authorize designated school personnel to administer the above medication.**

Print Provider name, address & phone number	**Signature and NPI # of Health Care Provider**	**Date:**

PARENT / GUARDIAN / CAREGIVER SECTION

Parent/Guardian/Caregiver Name	Home Language	Daytime Phone ( )
Address – Number and Street Apt No. City	Zip Code	Evening Phone ( )
School	Pre-K/ Elementary / Middle / High	Grade

Check appropriate boxes below:

❐ I permit my child to give himself/herself the above medication.

❐ I permit designated school personnel to give my child the above medication.

1. I agree to hold the San Francisco Unified School District (SFUSD) and its employees harmless from any and all liability for the results of taking the medication or the manner in which the medication is given.
2. I will reimburse the SFUSD and its employees for any liability arising out of these arrangements.
3. I will notify the Principal of the school immediately if there is a change in my child's medication.
4. I understand it is my responsibility to send the medication to school in the **original pharmacy container** labeled with my child's name and the health care provider's instructions.
5. I understand that this form automatically expires at the end of each school year.
6. I give my consent for school authorities to take appropriate action for the safety and welfare of the above named child.

Parent/Guardian/Caregiver Signature ________________________________ **Date**________________________

STUDENT PHOTO

SEIZURE EMERGENCY CARE PLAN

For School Use Only
Location of Medication: ____________________

San Francisco Unified School District
Student and Family Services Division
1515 Quintara Street
San Francisco, CA 94116-1273
Tel: 415.242.2615 | Fax: 415.242.2618

TO BE COMPLETED BY PARENT/CAREGIVER

Name: ________________________ Date of Birth: ___________ School: ___________________

Grade: ________ Homeroom Teacher: __________________________ Room: _________

Parent/Caregiver Name: _______________________ Phone (home): ___________________ (cell):__________________

Address: ____________________________________ Phone (work): ___________________ Email:________________

--------------------------------TO BE COMPLETED BY THE HEALTH CARE PROVIDER--------------------------------

Health Care Provider Treating Student for Seizures:_____________________________________ Ph: _________________

Type of seizure:____

Student's most common signs of seizure:____

ACTIONS TO TAKE

During the seizure

- **Stay calm and stay with the student.**
- **Note length of time of seizure.**
- **Clear any objects out of the way.**
- **Help the student to the floor and place student on their side.**
- **Place something soft and flat under the student's head.**
- **Loosen any tight clothing.**
- **Don't put anything in the student's mouth.**
- **Monitor the student's breathing.**
- **Do not try to stop the seizure, or hold the student down.**

After the seizure

- **Comfort and allow the student to rest afterwards.**
- **Re-orient the student.**

Notify parent/guardian and document what happened in the First Aid and Medication Logs.
***By law, a completed and signed Medication Form must be on file at the school before medication can be administered at school.**

CALL 911 if student has

- **Seizure of 5 minutes or longer duration.**
- **Two or more consecutive (without a period of consciousness between) seizures which total 5 minutes or greater**
- **Unusually pale or bluish skin/lips or noisy breathing after the seizure has stopped.**
- **If administering seizure medication.**

Administer CPR if Pulse or Breathing Stops!

Continue Until Paramedics Arrive!

Per SB 161, I understand that additional forms may be needed for diastat to be administered at school.
I authorize school personnel to implement this Seizure Emergency Care Plan as described.
I have completed a medication form FOR EACH medication needed at school.

______________________________________ ____________________
Health Care Provider Signature & NPI # **Date**

I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent to communicate with the authorized health care provider when necessary.

______________________________________ ____________________
Parent/Caregiver Signature **Date**

STUDENT PHOTO

DIABETES EMERGENCY CARE PLAN

For School Use Only

Location of Medication:	Location of Food:
____________________	____________________

TO BE COMPLETED BY PARENT/CAREGIVER

Name: ______________________________________ Date of Birth: ____________ School: ___________________

Grade: _________ Homeroom Teacher: __________________________ Room: _________

Parent/Caregiver Name: __________________________ Phone (home): ___________________ (cell): ___________

Address: _______________________________________ Phone (work): ___________________ Email: ___________

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Health Care Provider Treating Student for Diabetes: _______________________________ Ph: ____________

SIGNS OF HYPOGLYCEMIA: Headache, tremors, cold sweat, hunger, irritability, nervousness, pale skin, confusion, drowsiness, weakness or fatigue, dizziness, poor coordination, inability to concentrate, slurred speech, combativeness, uncooperativeness, convulsions, unconscious.

Hypoglycemia: Blood Glucose less than ____________

Carbohydrate Source: __________________________

Give #gms______ for Blood Glucose less than_______

Glucagon: IM or SQ Dose: ___________________

Administer Glucagon when: ____________________

CALL 911 IF ADMINISTERING GLUCAGON and/or for: ____

SIGNS OF HYPERGLYCEMIA: Increased urination, increased thirst, blurred vision, increased hunger, fruity breath, vomiting, stomach pain, weakness, sleepiness, difficulty breathing, coma

Hyperglycemia: Blood glucose greater than __________

Treatment for Hyperglycemia: _____________________

____

Student can return to regular activities including PE when: ____

CALL 911 WHEN: ______________________________

____

Contact parent/caregiver when blood glucose is less than___________or greater than___________

Notify parent/guardian and document what happened in the First Aid and Medication Logs.

***By law, a completed and signed Medication Form must be on file at the school before medication can be administered at school.**

I authorize school personnel to implement this Diabetic Emergency Plan as described above.

I have completed the medication form(s) FOR EACH medication that might be given at school.

______________________________________ ____________________

Health Care Provider Signature & NPI # **Date**

I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent for school authorities to communicate with the authorized health care provider when necessary.

______________________________________ ____________________

Parent/Caregiver Signature **Date**

STUDENT PHOTO

EMERGENCY CARE PLAN

For School Use Only
Location of Medication:
____

TO BE COMPLETED BY PARENT/CAREGIVER

Name: ______________________ Date of Birth: __________ School: ______________

Grade: ________ Homeroom Teacher: ____________________ Room: ________

Parent/Caregiver info: Name__________________ Phone ______________ Email______________

---------------------------------TO BE COMPLETED BY THE HEALTH CARE PROVIDER---------------------------------

Health Care Provider Treating Student:__________________________________ Ph: ______________

Health Condition:____

Student's most common symptoms/warning signs: ____

Student's current treatment, medications & possible side effects: ______________________________

____

ACTIONS TO TAKE

(list actions to take below)

-
-
-
-

Notify parents/guardian and document what happened in the First Aid and Medication Logs.
***By law, a completed and signed Medication Form must be on file at the school before medication can be administered at school.**

CALL 911 if student has

List signs and symptoms that indicate an emergency:	Administer CPR if Breathing Stops! Continue Until Paramedics Arrive!
• • • •	

I authorize school personnel to implement this Emergency Plan as described.
I have completed a medication form FOR EACH medication listed above.

______________________________ ______________
Health Care Provider Signature & NPI # **Date**

I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent to communicate with the authorized health care provider when necessary.

______________________________ ______________
Parent/Caregiver Signature **Date**

MEDICATION FORM (One Medication per Form)

Dear Parent/Guardian/Caregiver:

California Education Code 49423 provides that students required to take medically prescribed or over-the-counter medications during the school day **MAY** be assisted by school personnel **ONLY** if the school district receives a specific written statement from the health care provider **AND** the parent/guardian/caregiver of the student. **Please complete this entire form and return it to the site.**

IF POSSIBLE, PLEASE SCHEDULE MEDICATION OUTSIDE OF SCHOOL HOURS

Please print legibly in all sections

Student Name: Last First Middle	Date of Birth (Month/Day/Year)

`

HEALTH CARE PROVIDER SECTION

Health Condition for which medication is prescribed:	Medication: Dose: Frequency:_______________Duration:_________________
How is medication to be given? ☐ By mouth ☐ Inhalation ☐ Injection ☐ Topical ☐ Other:_________________________	Time medication needs to be given at school? _____________AM / PM
The medication is to be continued as above until: (please be as specific as possible about date)	Any precautions that school personnel need to know? Contraindications?
What are possible reactions/side effects?	What should be done in the event of reaction/side effect?

Check appropriate boxes below:

☐ I authorize this student to **self-administer** the above medication.

☐ I authorize designated school personnel to administer the above medication.

Print Provider name, address & phone number	**Signature and NPI # of Health Care Provider**	**Date:**

`

PARENT / GUARDIAN / CAREGIVER SECTION

Parent/Guardian/Caregiver Name	Home Language	Daytime Phone ( )
Address – Number and Street Apt No. City	Zip Code	Evening Phone ( )
School	Children's Center / Elementary / Middle / High	School Hours

Check appropriate boxes below:

☐ I permit my child to give himself/herself the above medication.

☐ I permit designated school personnel to give my child the above medication.

1. I agree to hold the San Francisco Unified School District (SFUSD) and its employees harmless from any and all liability for the results of taking the medication or the manner in which the medication is given.
2. I will reimburse the SFUSD and its employees for any liability arising out of these arrangements.
3. I will notify the Principal of the school immediately if there is a change in my child's medication.
4. I understand it is my responsibility to send the medication to school in the **original pharmacy container** labeled with my child's name and the health care provider's instructions.
5. I understand that this form automatically expires at the end of each school year.
6. **I give my consent for school authorities to take appropriate action for the safety and welfare of my child.**

Parent/Guardian/CaregiverSignature_____________________________________ Date__________________________

Nutrition and Feeding Care Plan

The nutrition and feeding care plan defines all members of the care team, communication guidelines (how, when, and how often), and all information on a child's diet and feeding needs for this child while in child care.

Name of Child: ______________________________ **Date:** ______________________

Facility Name: ______________________________

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

Care Coordinator (responsible for developing and administering *Nutrition and Feeding Care Plan*): ______________________

____

____

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

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

Communication

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

____

____

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

Date and time specifics: ______________________________

Specific Diet Information

❖ Medical documentation provided and attached: ❑ Yes ❑ No ❑ Not Needed

Specific nutrition/feeding-related needs and any safety issues: ______________________

____

____

____

❖ **Foods to avoid (*allergies* and/or *intolerances*):** ______________________

Planned strategies to support the child's needs: ______________________

____

____

____

Plan for absences of personnel trained and responsible for nutrition/feeding-related procedure(s): ______________

____

____

❖ Food texture/consistency needs: ______________________

❖ Special dietary needs: ______________________

❖ Other: ______________________

Eating Equipment/Positioning

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

Special equipment needed: ______________________

Specific body positioning for feeding (attach additional documentation as necessary): ______________________

____

Behavior Changes (be specific when listing changes in behavior that arise before, during, or after feeding/eating)

____

____

Medical Information

❑ **Information Exchange Form** completed by Health Care Provider is in child's file onsite.

❖ Medication to be administered as part of feeding routine: ❑ Yes ❑ No

❑ **Medication Administration Form** completed by health care provider and parents is in child's file on-site (including type of medication, who administers, when administered, potential side effects, etc.)

Tube Feeding Information

Primary person responsible for daily feeding: ______________________________

Additional person to support feeding: ______________________________

❑ Breast Milk ❑ Formula (list brand information): ______________________________

Time(s) of day: ______________________________

Volume (how much to feed): ______________ Rate of flow: ______________ Length of feeding: ______________

Position of child: ______________________________

❑ Oral feeding and/or stimulation (attach detailed instructions as necessary): ______________________________

Special Training Needed by Staff

Training monitored by: ______________________________

1) Type (be specific): ______________________________

Training done by: ______________________________ Date of Training: ______________

2) Type (be specific): ______________________________

Training done by: ______________________________ Date of Training: ______________

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

____

____

____

Emergency Procedures

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

Emergency instructions: ______________________________

____

Emergency contact: ______________________________ Telephone: ______________________________

Follow-up: Updates/Revisions

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

Due date for revision and team meeting: ______________

Special Health Care Plan

To be completed by the Child Care Health Consultant or Health Advocate. The Special Health Care Plan provides information on how to accommodate the special health concerns and needs of this child while attending an early care and education program.

Name of Child:____Date:____/____/___________

Name of Child Care Program: ____

Description of Health Condition(s)

List description each health condition:

____

____

Team Member Names and Titles (include parents)

Parent/Guardian____

Health Care Provider (MD, NP)____

On-site Care Coordinator____

____

Team Members; Other Support Programs Outside of Child Care (name, program, contact information, frequency)

□ Physical Therapist (PT)____

□ Occupational Therapist (OT) ____

□ Speech & Language Therapist: ____

□ Social Worker: ____

□ Mental Health Professional/Consultant: ____

□ Family-Child Advocate: ____

Other:____

Communication

The team will communicate: □ Daily □ Weekly □ Monthly Other__________________________________

The team will communicate by: □ Notes, □ Communication log, □ Phone, □ E mail, □ In Person Meetings,

□ Other____________________Dates and times____

Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) is attached. □ Yes □ No

Staff Training Needs

Type of training:____

Training will be provided by:____

Training will be monitored by:____

Staff who will receive training:____

Dates for training:____

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

____

____

Special Health Care Plan

Medical Information

Medical information from the Health Care Provider is attached: □ Yes □ No

Information Exchange Form cchp.ucsf.edu/InfoExchangeForm has been completed

by Health Care Provider: □ Yes □ No

Medication to be given: □ Yes □ No

Medication Administration Form has been completed by health care provider and parents: □ Yes □ No

Allergies: □ Yes □ No if yes, list:____

Safety

Strategies to support the child's needs and safety issues while in child care: (e.g., diapering/toileting, outdoor play, circle time, field trips, transportation, nap/sleeping)____

____

____

Special equipment:____
Positioning requirements:____
Equipment care/maintenance:____

Nutrition and Feeding Needs

A Nutrition and Feeding Care Plan has been completed □ Yes □ No
Allergies to food: □ Yes □ No if yes, list:____
Other feeding concerns:____

Behavior Concerns

List specific changes in behavior that arise as a result of the health-related condition/concerns ______________

____

____

Emergencies

Emergency contact:________________________Telephone: ______________________________
Health Care Provider:_______________________Telephone:______________________________
Emergency Information Form Completed □ Yes □ No

Follow-up, Updates, and Revisions

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

Due date for revision and team meeting:______/_____/_______.

Attach additional information if needed. Include unusual episodes that might arise while the child is in care, how the situation should be handled, and special emergency or medical procedures that may be required.

GASTROSTOMY - TUBE CARE CONSENT/VERIFICATION
CHILD CARE FACILITIES

This form may be used to demonstrate that the licensee or staff person has obtained permission from a child's authorized representative to provide gastrostomy-tube (G-tube) care to the child. A copy of the completed form should be filed in the child's record and in the personnel file. **A separate form must be filled out for each person who provides G-tube care to the child.**

I,________________________________, give my consent for ________________________________,
(PRINT NAME OF AUTHORIZED REPRESENTATIVE) (PRINT NAME OF LICENSEE OR STAFF PERSON)

who work(s) at ____,
(PRINT NAME AND ADDRESS OF CHILD CARE FACILITY)

to administer G-tube feeding and hydration to my child,______________________________, and to contact my child's health care provider.
(PRINT NAME OF CHILD)

This consent DOES ☐ or DOES NOT ☐ include permission to administer routine LIQUID medication through a G-tube to my child. (Administration of crushed medications through a G-tube is not permitted in a licensed child care facility.) Check and initial the desired response.

I have also provided the child care facility with the following (see reverse side of form for details):

________ Written verification from my child's physician of the name of the person designated by my child's physician to instruct the licensee or designated child care staff on how to provide G-tube care to my child.

________ A copy of the G-tube manufacturer's instructions for the file.

________ A copy of my child's medical assessment (including an assessment that the child's medical condition is stable enough for a layperson in a child care setting to safely administer G-tube care to the child). This requirement applies to children who attend both child care centers and family child care homes.

________ Instructions from my child's physician or from a health care professional working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions must be updated yearly, or more often if the child's needs change; see reverse side for a complete list of instructions required.

SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE

ADDRESS OF AUTHORIZED REPRESENTATIVE

HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER

CHECKLIST FOR AUTHORIZED REPRESENTATIVES:
GASTROSTOMY-TUBE CARE IN CHILD CARE FACILITIES

Have you provided the child care facility with the following? [Please also see the LIC 701A, "Gastrostomy-Tube Care: Physician's Checklist (Child Care Facilities)," which may be used an aid in obtaining some of the information.]

- Written permission. Written permission for the licensee (and, if applicable, designated staff members) to provide G-tube care to your child and to contact your child's health care provider.

- Name of instructor. Written verification from your child's physician of the name of the person designated by your child's physician to instruct the licensee or staff on how to administer G-tube care to your child.

- Manufacturer's instructions. A copy of the G-tube manufacturer's instructions for the file.

- Medical assessment. A medical assessment for your child, including the physician's assessment of whether your child's medical condition is stable enough for a layperson in a child care setting to safely administer G-tube care to the child (applies to children who attend both child care centers and family child care homes).

- Instructions from physician. Specific written instructions from your child's physician or designee, including:

  - Any limitations or modifications to normal activity required by the presence of the G-tube.
  - Frequency of feeding and amount/type of formula or liquid medication to be administered to the child in accordance with the physician's prescription.
  - Hydration of the child with water or other liquids as determined by the child's physician.
  - Method of feeding, administering liquid medication or hydrating the child, including how high the syringe is to be held during the feeding. If applicable, this includes how to use an enteral (means "into the stomach") feeding pump.
  - Positioning of the child.
  - Potential side effects, e.g., nausea, vomiting, abdominal cramping. (Decompression–the removal of gas in the gastrointestinal tract–is not to be performed on the child beyond briefly removing the cap from the gastric feeding button, which may or may not help relieve the child's discomfort.)
  - Specific actions to be taken in the event of specific side effects or an inability to complete a feeding, administration of liquid medication to the child, or hydration of the child in accordance with the physician's prescription. This includes actions to be taken in an emergency.
  - How and when to flush out the G-tube with water, including what to do if the G-tube becomes clogged. Specific instructions on how may cc's of water to use when flushing out the G-tube.
  - Instructions for proper sanitation, including care and cleaning of the stoma site.
  - Instructions for proper storage of the formula or the liquid medication.
  - Instructions for proper care and storage of equipment.
  - The telephone number and address of the child's physician or designee.

N. LIC FORMS

LIC125	Entrance Checklist for Child Care Centers
LIC126	Entrance Checklist for Family Child Care Homes
LIC198A	Child Abuse Central Index Check
LIC282	Affidavit Regarding Liability Insurance for Family Child Care Homes
LIC308	Designation of Facility Responsibility
LIC309	Administrative Organization
LIC311A	Records to be Maintained at the Facility - Child Care Centers
LIC311D	Forms and Records to Keep in Your Family Child Care Home
LIC500	Personnel Report
LIC503	Health Screening Report – Facility Personnel
LIC508	Criminal Record Statement
LIC610	Emergency Disaster Plan for Child Care Centers
LIC610A	Emergency Disaster Plan for Family Child Care Homes
LIC613A	Personal Rights-Child Care Centers
LIC622	Centrally Stored Medication and Destruction Record
LIC624	Unusual Incident & Injury Report
LIC624B	Unusual Incident & Injury Report-Family Child Care Homes
LIC627	Consent for Emergency Medical Treatment
LIC700	Identification and Emergency Information
LIC701	Physician's Report
LIC702	Child's Preadmission Health History
LIC9040	Child Care Facility Roster
LIC9052	Notice of Employee Rights
LIC9095	Evaluation of Teacher Qualifications
LIC9096	Evaluation of Director Qualifications
LIC9108	Statement Acknowledging Requirement to Report Child Abuse
LIC9148	Earthquake Preparedness Checklist
LIC9150	Parent Notification Additional Children in Care
LIC9166	Nebulizer Care Consent
LIC9187	Death Report
LIC9212	Family Child Care Consumer Awareness Information
LIC9221	Parent Consent for Administration of Medications
LIC9224	Acknowledgement of Receipt of Licensing Reports (if applicable)
LIC9227	Individual Infant Sleeping Plan
LIC9275	External Water Sampler Self-Certification Form

LIC995	Notification of Parent's Rights
LIC995A	Family Child Care Home Notification of Parents' Rights
LIC995E	Important Information for Parents
PUB269	Child Passenger Restraint System Poster
PUB271	Shaken Baby Syndrome Flyer
PUB393	Notification of Parents' Rights-Child Care Center
PUB394	Notification of Parents' Rights-Family Child Care Home
PUB515	Risks and Effects of Lead Poisoning Brochure

Link to all LIC forms: https://www.cdss.ca.gov/inforesources/forms-brochures/forms-alphabetic-list/i-l

ENTRANCE CHECKLIST — CHILD CARE CENTERS

The following items are to be made available for inspection by the facility representative.

LICENSE NUMBER:	**EMAIL ADDRESS:**
Documents to be posted in a prominent, publicly accessible area at facility	
Facility License	Waivers (if applicable)
Menus	**LIC 613A** Personal Rights
PUB 269 Child passenger restraint system poster	
PUB 393 Notification of Parents' Rights	
LIC 610 Emergency Disaster Plan	
LIC 9224 Acknowledgment of Receipt of Licensing Reports (if applicable)	
Documents to be reviewed during inspection	
Verification of Disaster and Fire Drills	Sign in/out sheets
Daily Activity Schedule	**LIC 9148** Earthquake Preparedness
Records and other items to make available during inspection	
Personnel records (All staff present)	**Children's records**
Exceptions and Exemptions (if applicable)	**LIC 613A** Personal Rights
Staff Qualifications	Admission agreement
Proof of immunization of measles, pertussis and Influenza (or documentation of exemption)	Needs and Services Plan for Infants (for Infant Centers)
Current Pediatric CPR and First Aid Certification (designated staff)	**LIC 9224** Acknowledgment of Receipt of Licensing Reports (if applicable)
TB Clearance or risk assessment	**LIC 700** Identification and Emergency Information
LIC 503 Health Screening Report	**LIC 701** Physician's Report
LIC 508 Criminal Record Statement	**LIC 995** Notification of Parents' Rights
LIC 9108 Statement Acknowledging Requirement to report Child Abuse	**LIC 627** Consent for Emergency Medical Treatment
Mandated Reporter Training Certificate	Immunization Record (if applicable)
LIC 9052 Employee Rights	
Identify Location	
Medication stored at facility (includes medication for permissible medical services, if applicable)	
Functioning Carbon Monoxide Detector, Smoke Alarm(s), Fire Extinguisher	

ENTRANCE CHECKLIST — FAMILY CHILD CARE HOMES

The following items are to be made available for inspection by the facility representative.

<table>
<tr><td>LICENSE NUMBER:</td><td>EMAIL ADDRESS:</td></tr>
<tr><td colspan="2">Documents to be posted in a prominent, publicly accessible area at facility</td></tr>
<tr><td colspan="2">Facility License</td></tr>
<tr><td colspan="2">Waivers (if applicable)</td></tr>
<tr><td colspan="2">PUB 394 Notification of Parents' Rights</td></tr>
<tr><td colspan="2">LIC 9148 Earthquake Preparedness</td></tr>
<tr><td colspan="2">Documents to be reviewed during inspection</td></tr>
<tr><td colspan="2">LIC 610A Emergency Disaster Plan</td></tr>
<tr><td colspan="2">Verification of Disaster and Fire Drills</td></tr>
<tr><td colspan="2">LIC 9040 Facility Roster</td></tr>
<tr><td colspan="2">Exceptions and Exemptions (if applicable)</td></tr>
<tr><td colspan="2">Records to make available during inspection</td></tr>
<tr><td>Personnel records (Licensees/Assistants present)</td><td>Children's records</td></tr>
<tr><td>Current Pediatric CPR and First Aid Certification issued by American Red Cross or the American Heart Association, or by approved Emergency Medical Services Authority (EMSA) vendor</td><td>LIC 282 Affidavit Regarding Liability Insurance (if licensee has no liability insurance/bond)</td></tr>
<tr><td>LIC 508 Criminal Record Statement</td><td>Immunization Record (if applicable)</td></tr>
<tr><td>LIC 9052 Employee Rights</td><td>LIC 700 Identification and Emergency Information</td></tr>
<tr><td>Proof of immunization of measles, pertussis and Influenza (or documentation of exemption)</td><td>LIC 627 Consent for Emergency Medical Treatment</td></tr>
<tr><td>TB Clearance or risk assessment</td><td>LIC 995A Notification of Parents' Rights</td></tr>
<tr><td>LIC 9108 Statement Acknowledging Requirement to report Child Abuse</td><td>LIC 9224 Acknowledgment of Receipt of Licensing Reports (if applicable)</td></tr>
<tr><td>Mandated Reporter Training Certificate</td><td></td></tr>
<tr><td colspan="2">Identify Location</td></tr>
<tr><td colspan="2">Medication stored at facility (includes medication for permissible medical services, if applicable)</td></tr>
<tr><td colspan="2">Functioning Carbon Monoxide Detector, Smoke Alarm(s), Fire Extinguisher</td></tr>
</table>

CHILD ABUSE CENTRAL INDEX CHECK FOR STATE LICENSED FACILITIES

DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING
CAREGIVER BACKGROUND CHECK BUREAU
744 P ST., MS 9-15-62
SACRAMENTO, CA 95814

Complete ALL items checked (✔)

Include $15.00 for each Child Abuse Central Index Check. (There is no exemption from this fee) Make check or money order payable to the Department of Justice.

All persons subject to a background check are also subject to a Child Abuse Central Index (CACI) check, if the facility to which they are associated provides care and supervision to children. This includes all child care centers; family child care homes; children's residential homes and facilities; and adult residential facilities if, through an approved exception or a specialized license, they provide care to a person under age 18.

If the person is submitting fingerprints for a criminal record background check, a request for a check of the CACI will be transmitted to the Department of Justice at the same time.

If a CACI check is required subsequent to a California Department of Social Services (CDSS) processed criminal record background check, it is the licensee's responsiblity to submit this form and appropriate fees directly to the Department of Justice, P. O. Box 903417, Sacramento, CA 94203-4170.

TYPE OR PRINT INFORMATION

✔ DATE SENT_______________

NAME: LAST	FIRST	MIDDLE
✔		

DATE OF BIRTH — MO., DAY, YEAR	SOCIAL SECURITY NUMBER - SEE PRIVACY STATEMENT ON PAGE 2.
✔	✔

List all other names you have ever used:

MAIDEN NAME:	NAME/AKA:
✔	
NAME/AKA: ✔	NAME/AKA:

CURRENT ADDRESS	STREET	CITY	STATE	ZIP CODE
✔				

✔ ■ MALE ■ FEMALE	FACILITY TELEPHONE NUMBER ✔	DRIVER'S LICENSE NUMBER ✔

✔ FACILITY NUMBER: ____________________

✔ FACILITY NAME: ____________________

✔ FACILITY ADDRESS: ____________________
STREET CITY STATE ZIP CODE

✔ PERSONNEL TYPE OPTIONS

A ■ FACILITY ADMINISTRATOR/DIRECTOR
C ■ CORPORATION BOARD MEMBER
E ■ EMPLOYEE

F ■ CERTIFIED HOME (FFA)
L ■ LICENSEE/APPLICANT
N ■ NONCLIENT ADULT RESIDENT
P ■ PARTNERSHIP MEMBER

S ■ SPOUSE OF LICENSEE (Unless included as a licensee)
U ■ UNKNOWN

FOR LICENSING OFFICE USE ONLY
FOR FOLLOW-UP ONLY

Original Date Sent____________________ Date Re-sent____________________

FOR DEPARTMENT OF JUSTICE USE ONLY

The result of a name search in the Child Abuse Central Index is as follows:

■ The subject of the attached report **MAY** be the same as the subject of your inquiry.
■ No record on the above listed person.
■ Too many possible matches to identify. See attached listing.

PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17 and 1596.871). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

NOTE: IMPORTANT INFORMATION
The Department is required to tell people who ask, including the press, if some one in a licensed facility has a crminal record exemption. The Department must also tell people who ask, the name of a licensed facility that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

AFFIDAVIT REGARDING LIABILITY INSURANCE FOR FAMILY CHILD CARE HOME

SECTION A:

I/We, the parent(s)/guardian(s) of ____________________,
(Child's Name)

acknowledge that ____________________,
(Licensee'sName)

the licensee of ____________________,
(Name of Family Child Care Home)

has informed me/us that this facility does not carry liability insurance or a bond in accordance with standards established by Family Child Care statute.

SECTION B: To be completed only if licensee does not own premises or the licensee is a member of a condominium or Homeowner's Association.

I/We, the parent(s)/guardian(s) of ____________________,
(Child's Name)

acknowledge that____________________,
(Licensee's Name)

the licensee of____________________.
(Name of Family Child Care Home)

has informed me/us that she/he does not own the premises or is a member of a condominium or Homeowner's Association, and the liability insurance, if any, of the owner/Homeowners' Association may not provide coverage for losses arising out of, or in connection with, the operation of the family child care home, except to the extent that the losses are caused by, or result from, an action or omission by the owner/Homeowners' Association, for which the owner/Homeowners' Association would otherwise be liable under the law.

____________________ Signature of Parent(s)/Guardian(s)

____________________ Date

NOTE: The law requires Family Child Care providers to carry liability insurance or bond in the amount of $300,000 annually or to maintain this signed statement in the facility file. Lack of a bond or insurance does not effect the right of parents to bring legal action against the facility.

DESIGNATION OF FACILITY RESPONSIBILITY

Licensed facilities are required to have an authorized person continuously present at the facility during operational hours to represent the facility and to accept licensing reports. Licensees shall use this form to delegate the above authority to appropriate staff. Applicants/licensees who are corporations shall attach board resolutions authorizing this delegation.

Facility Name ______________________________ Date ______________

Facility Number ______________________________

Facility Address ______________________________ Phone ______________

City ______________________________ County ______________

In the event of my absence I designate ______________________________ (NAME). He/She is authorized to receive any documents including reports of inspections and consultations, accusations and civil and administrative processes on my behalf at the above-named facility.

When delegating authority to appropriate staff, Residential Care Facilities for the Elderly shall comply with CCR Title 22, Division 6 Section 87564. Child Care Centers shall comply with CCR Title 22, Division 12 Section 101215.1 and other licensed facilities shall comply with CCR Title 22, Division 6 Section 80064.

I (We) shall notify the licensing agency, in writing, within 10 days of any change in the above authorization.

____
Signature of applicants/licensees

____
Title

____
Address

____
City County Zip

ADMINISTRATIVE ORGANIZATION

(This side is for corporations and limited liability companies only. See reverse for public agencies, partnerships, and other associations.)

INSTRUCTIONS: *This form must be updated and submitted to the Licensing Agency each time there is a change in partners, officers or changes in the corporation or limited liability company as provided in the Callifornia Code of Regulations Title 22, Section 80034(a)(2), or 87235(a)(5), or 101185(a)(2).*

DATE

FACILITY NAME

FACILITY ADDRESS

FACILITY NUMBER

I. CORPORATION/LIMITED LIABILITY COMPANY (LLC)

1. Name *(as filed with Secretary of State)*
2. Chief Executive Officer
3. Incorporation/Registration Date
4. Place of Incorporation/Registration

Corporation/Limited Liability Company Number

5. Please attach (1) A copy of Articles of Incorporation or organization and any amendments (2) A copy of By-Laws or Operating Agreement and any amendments (3) A copy of Resolution authorizing the filing of this application (for Corporations only).
6. Principal office of business:

   Address | City | Zip Code | County | Telephone No.

   Contact Person: | Title: | Telephone No.:
7. Out of state or foreign applicants complete the following:

   a. Name of California Representative | Address | Zip Code | Telephone No.

   b. Please attach a copy of a foreign corporation's or foreign LLC's registration to do business in California.
8. Names and addresses of all persons who own ten percent (10%) or more interest in corporation or LLC. Attach sheet for additional space.
9. Directors (Corporation)/Managers and Managing Members (LLC)

   a. Number of Directors/Managers & Managing Members

   b. Term of Office (if applicable)

   c. Frequency of Meetings (if applicable)

   d. Method of Selection (corporations only)
10. Officers: (For LLCs without officers, skip this section and go to Section II)

Office	Name	Principal Business Address & City & Zip Code *(other than facility address)*	Telephone No.	Term Expires
President				
Vice-President				
Secretary				
Treasurer				

11. List all Directors (Corporations)/Managers and Managing Members (LLC)

Name	Mailing Address & City & Zip Code	Telephone No.	Term Expires

(Attach Sheet for additional space)

II. PUBLIC AGENCY

1. Check type of public agency: ■ Federal ■ State ■ County ■ City ■ Other, specify below

2. Agency providing services:

Name: ______________________ Address: ______________________
CITY/STATE

Mailing Address: ______________________
CITY/STATE/ZIP CODE

Contact Person: ______________ Title: ______________ Phone No.: ______________

3. District or Area to be served: *(attach map if necessary)*

Specify geographic area:

4. Attach copy of Resolution or legal document authorizing this application.

III. PARTNERSHIPS

Attach a copy of partnership agreement (attach additional sheet if necessary)

1st Partner ■ General Name ______________________
TELEPHONE NUMBER

■ Limited Principal Business Address ______________________
CITY/STATE

2nd Partner ■ General Name ______________________
TELEPHONE NUMBER

■ Limited Principal Business Address ______________________
CITY/STATE

3rd Partner ■ General Name ______________________
TELEPHONE NUMBER

■ Limited Principal Business Address ______________________
CITY/STATE

4th Partner ■ General Name ______________________
TELEPHONE NUMBER

■ Limited Principal Business Address ______________________
CITY/STATE

Contact Person: ______________ Title: ______________ Telephone No.: ______________

IV. OTHER ASSOCIATIONS

Other associations must also provide a similar list of persons legally responsible for the organization, contact person, appropriate legal documents which set forth legal responsibility of the organization and accountability for operating the facility.

RECORDS TO BE MAINTAINED AT THE FACILITY

CHILD CARE CENTERS, INFANT CENTERS, SCHOOL-AGE CENTERS, AND CHILD CARE CENTERS FOR MILDLY ILL CHILDREN

THE FOLLOWING INFORMATION, which is required under sections of Title 22, California Code of Regulations and/or Statute, as applicable, MUST BE KEPT IN THE FACILITY, COMPLETE AND CURRENT, AND READILY AVAILABLE FOR REVIEW

I. Child's Records

A. Identification and Emergency Information - Child Care Centers (LIC 700).

B. Child's Pre-admission Health History Parents' Report (LIC 702).

C. Child's Pre-admission Health Evaluation if not enrolled in a public or private elementary school Physician's Report (LIC 701).

D. Consent for Medical Treatment (LIC 627).

E. Written statement from parent(s) or authorized representative exempting child from medical assessment and treatment because of adherence to a religious faith that practices healing by prayer or other spiritual means; or physician's statement that immunization is not indicated.

F. Confirmation of required immunization for children not enrolled in a public or private elementary school. **California School Immunization Record** (CDPH 286) can be downloaded from the following website: https://www.shotsforschool.org/

G. Current Admission Agreement, with authorized signature(s).

H. Centrally Stored Medication and Destruction Record (LIC 622), if medications are handled.

I. Document of unusual behavior or signs of illness, special needs.

J. Unusual Incident/Injury Report (LIC 624).

K. Signed and dated receipt of Notification of Parents' Rights (LIC 995/E).

L. Quarterly infant needs and services plan (for infant centers to be updated quarterly or more often as needed, signed and dated).

M. Toilet-training plan (for infant centers).

N. Infant-feeding plan (for infant centers).

O. Personal Rights — Community Care Facilities, Child Care Facilities (LIC 613A) receipts, signed and dated.

P. Authorizations for dispensing medication, signed by each child's authorized representative.

This information is requested by the Department of Social Services in compliance with Title 22, Division 12 of the California Code of Regulations and Section 1596.70 et. Seq. of Health and Safety Code. Submission of the information is mandatory. The local licensing office is responsible for maintaining the information. Access to this information will be provided unless prohibited by the Information Practice Act of 1977 or other applicable law. Certain authorized public and private agencies may have access to this information including the County Welfare Departments, Department of Justice, Regional Centers, the Department of Developmental Services and the Department of Mental Health

Q. Documentation required for health-related services (e.g., blood-glucose monitoring and nebulizer care) (LIC 9166, LIC 9222).

R. Acknowledgement of receipt of licensing reports (LIC 9224), if applicable.

S. Individual Infant Sleeping Plan (LIC 9227), if applicable.

T. Parent Consent for Administrating Medication (LIC 9221), if applicable.

U. Risks and Effects of Lead Poisoning (PUB 515) must be provided to parents and guardians upon enrolling or reenrolling any child in care

II. Personnel Records for Licensee, Director, Assistant Director, Teachers, Teacher's Aides, Support Staff, and Volunteers, if appropriate. Documentation should be consistent with the LIC 500 and the LIS 555.

A. Health Screening Report Facility Personnel (LIC 503) and TB Clearance.

B. TB Clearance and "Good Health" statement from volunteers.

C. Staff Immunizations (Measles, Pertussis, Influenza-May decline Influenza).

D. Personnel Record (LIC 501) or application/resume.

E. Evaluation of Director Qualifications (LIC 9096).

F. Evaluation of Teacher Qualifications (LIC 9095).

G. For each aide under age 18, verification of high school graduation or current participation in an occupational program conducted by an accredited high school or college.

H. For each infant center aide, verification of graduation from high school or equivalent.

I. Education or be enrolled in course leading to graduation or have skills development potential; have experience in caring for children; verification of on-the-job training.

J. Criminal Record Statement (LIC 508) for staff subject to fingerprint requirements.

K. Fingerprint clearances - Proof of clearance or criminal record exemption (State Criminal History, FBI, and CACI).

L. Appropriate driver's license for person(s) transporting children.

M. Documentation of actual hours worked.

N. Pediatric CPR/first aid cards for designated staff. At least one director or teacher must have the full 16 hours of health and safety training, including nutrition and lead poisoning training. (However, at child care centers for mildly ill children, the director and each fully qualified teacher must have the full 16 hours of health and safety training).

O. Valid water safety certificate for any adult given water-activity staffing responsibility.

P. Notice of Employee Rights (LIC 9052).

Q. Statement Acknowledging Requirement to Report Suspected Child Abuse (LIC 9108).

R. Appropriate transcripts (official).

S. Verification of completing Mandated Reporter Training (renewed every 2 years) (2015 AB 1207).

III. Administrative Records

A. Sign-in/sign-out sheets kept for current 30 days.

B. Admission policies, including admission criteria, ages of children who will be accepted, medical assessment requirements; program activities, supplemental services, if any; field trip provisions, transportation arrangements, food service, if any; written inspection procedures for accepting children daily.

C. Designation of Facility Responsibility (LIC 308).

D. Personnel Report (LIC 500) showing current roster.

E. Licensee affidavit regarding persons exempt from fingerprint requirements (Use back of LIC 500).

F. Evidence satisfactory to the department that there is a fire escape and disaster plan, Emergency Disaster Plan (LIC 610) or equivalent, for the facility and that fire drills and disaster drills will be conducted at least once every six months. Documentation of drills shall be maintained for at least one year.

G. Earthquake Preparedness Checklist (LIC 9148) or equivalent, must be attached to the LIC 610 and available to the public.

H. Up-to-date list of qualified teacher substitutes.

I. Documentation of exceptions and waivers.

J. Annual licensing reports and substantiated complaints from the last three years (must be available at the center for public review).

K. Child Care Facility Roster (LIC 9040).

L. Administrative Organization (LIC 309) reflecting current person(s) in charge of facility.

IV. Documents to be posted at the Facility

A. Facility license.

B. Personal Rights form (LIC 613A).

C. Menus.

D. Child passenger restraint system poster (PUB 269) completed with local health department phone number.

E. Daily activity schedule.

F. Facility Sketch (LIC 999).

G. Parent’s Rights Poster (PUB 393).

H. Notice of Site Visit (LIC 9213).

I. Any licensing report documenting a type “A” citation must be posted for 30 days.

J. Any licensing report or other document verifying compliance or non-compliance with the Department’s order to correct a Type A deficiency must be posted for 30 days.

CHILD CARE CENTERS - FORM NUMBER AND TITLE

Licensing Forms in English or Spanish may be accessed on the CDSS Forms and Brochures webpage:

LIC 198A* Child Abuse Index Check
LIC 308* Designation of Facility Responsibility
LIC 309* Administrative Organization
LIC 500* Personnel Report
LIC 501* Personnel Record
LIC 503* Health Screen Report Facility Personnel
LIC 508* Criminal Record Statement
LIC 610* Emergency Disaster Plan
LIC 613A* Personal Rights
LIC 624* Unusual Incident/Injury Report
LIC 627* Consent for Emergency Medical Treatment
LIC 700* Identification & Emergency Information
LIC 701* Physicians Report
LIC 702* Child's Preadmission Health History (Parent's Report)
LIC 995* Child Care Center Notification of Parents' Rights
LIC 995E Caregiver Background Check Process
LIC 9040* Child Care Facility Roster
LIC 9052* Notice of Employee Rights
LIC 9095 Evaluation of Teachers' Qualifications
LIC 9096 Evaluation of Director Qualifications
LIC 9108* Statement Reporting Suspected Child Abuse
LIC 9148* Earthquake Preparedness Checklist
LIC 9163 Request for LiveScan Service
LIC 9166* Nebulizer Care Consent/Verification
LIC 9182 Criminal Background Clearance Transfer Request
LIC 9188 Criminal Record Exemption Transfer Request
LIC 9194* LiveScan Instructions for State Licensed Facilities
LIC 9213* Notice of Site Visit
LIC 9224* Acknowledgement of Receipt of Licensing Reports
LIC 999 Facility Sketch
LIC 9221 Parent Consent for Administered Medication
LIC 9222 Blood Glucose Testing Consent
LIC 9227 Individual Infant Sleeping Plan

PUB 269* Child Care Seat Law Poster
PUB 393* Child Care Center Notification of Parents' Rights Poster
PUB 271 Never Shake A Baby Brochure
PUB 515* Risks and Effects of Lead Exposure

*Available in Spanish

FORMS/RECORDS TO KEEP IN YOUR FAMILY CHILD CARE HOME

At your home inspection, your Licensing Program Analyst will also review all the required forms and information that you must keep on file in your home, as applicable. ***Please do not submit any of these documents with the application.*** However, have them readily available at the time of your pre-licensing visit so your Licensing Program Analyst can discuss them with you. *Records must be kept for three years.*

CHILDREN'S FORMS/RECORDS

Children's files must contain the following documents/information:

- **Parent Notification, Additional Children in Care** (LIC 9150), if you plan to care for more than 6 children for a Small Family Child Care Home, or more than 12 for a Large Family Child Care Home.
- Copy of document verifying child's enrollment in Kindergarten or K-T (22 CCR 102421(c)).
- **Affidavit Regarding Liability Insurance** (LIC 282) - This form is required to be signed by each parent of a child in care if you do not have either liability insurance or a bond.
- **Consent for Medical Treatment** (LIC 627) - This document gives you permission by the parent to seek emergency medical or dental care for their child if needed.
- **Consent/Verification for Nebulizer Care** (LIC 9166) - Before a child care licensee or staff person can administer inhaled medication to a child in care, this form must be completed and filed in the child's record and in the personnel file. **A separate form must be filled out for each person who administers inhaled medication to the child.**
- **Identification and Emergency Information** (LIC 700) - This form must be kept for each child in care and identifies whom to call in an emergency.
- **Notification of Parents' Rights** (LIC 995A) - This form must be given to each parent at the time a child is accepted for care, along with the LIC 995E.
- **Caregiver Background Check Process** (LIC 995E) - This form must be given to each parent at the time a child is accepted for care, along with the LIC 995A.
- **Family Child Care Consumer Awareness Information** (LIC 9212) - This form must be given to the parents of each child in care.
- **California School Immunization Record** (CDPH 286) or Confirmation of required immunization for children not enrolled in a public or private elementary school - For every infant, toddler, or preschool age child admitted into a Family Child Care Home, the provider must maintain current immunization records. CDPH 286 can be downloaded from the following website: Shots For School NOTE: Personal beliefs statement no longer applies (2015 SB 277).
- **Acknowledgement of Receipt of Licensing Reports** (LIC 9224), if applicable.
- **Blood Glucose Testing Consent** (LIC 9222) Must be signed by parent prior to administering test.
- **Individual Infant Sleeping Plan** (LIC 9227) – Must be kept for infants up to 12 months of age.
- Sleep Logs – must be kept for infants up to 24 months of age.
- **Risks and Effects of Lead Poisoning** (PUB 515)- This form must be given to the parents of each child in care.

FACILITY FORMS/RECORDS

Facility files must contain the following documents/information:

- Personnel Records as required in Title 22, Division 12, Chapter 3, Section 102416.1, including but not limited to, proof of current pediatric first aid, CPR and preventive health practices certificate, lead poisoning

training, mandated reporter training (2015 AB 1207), TB test results, measles, pertussis and influenza/may decline influenza, and documentation of either a criminal record clearance or a criminal record exemption.

- **Unusual Incident/Injury Report** (LIC 624B) - You must use this form and submit it to your local licensing office when reporting any incidents or injuries occurring during day care hours.
- **Child Care Facility Roster** (LIC 9040) - It is required that each child care facility maintain a current roster of children who are provided care.
- **Notice of Employee Rights** (LIC 9052) - This form must be filled out by all employees working in the Family Child Care Home.
- **Statement Acknowledging Requirement to Report Suspected Child Abuse** (LIC 9108) -This form is the Child Care Custodian's acknowledgement of the requirement to report suspected child abuse.
- **Property Owner/Landlord Consent Form** (LIC 9149), if you plan to care for more than 6 children for a Small Family Child Care Home or more than 12 for a Large Family Child Care Home.
- **Property Owner/Landlord Notification Form** (LIC 9151).
- Proof of control of property, including but not limited to a copy of your deed, mortgage statement or property tax bill, or lease/rental agreement.
- Verification that fire drills and disaster drills are conducted every six months.
- **Emergency Disaster Plan** (LIC 610A) - Evidence satisfactory to the department that there is a fire escape and disaster plan for the facility and that fire drills and disaster drills will be conducted at least once every six months.
- **Earthquake Preparedness Checklist** (LIC 9148) or equivalent, must be attached to the LIC 610A and available to the public.

INFORMATION TO BE POSTED IN YOUR FAMILY CHILD CARE HOME

You are required by law to post the following in your home:

- **Notification of Parents' Rights Poster** (PUB 394) - This poster must be placed in an area of the home where all parents can see it.
- **Facility License** (LIC 203) - Your Family Child Care Home License must be posted in an area of the home where it can be easily seen. **Notice of Site Visit** (LIC 9213) must remain posted for 30 days (during the hours that children are in care) after each site visit by a licensing representative.
- Any licensing report documenting a type "A" citation must be posted for 30 days during the hours that children are in care.
- Any licensing report or other document verifying compliance or non-compliance with the Department's order to correct a Type "A" deficiency must be posted for 30 days during the hours that children are in care.

This information is requested by the Department of Social Services in compliance with Title 22, Division 12 of the California Code of Regulations and Section 1596.70 et. Seq. of Health and Safety Code. Submission of the information is mandatory. The local licensing office is responsible for maintaining the information. Access to this information will be provided unless prohibited by the Information Practice Act of 1977 or other applicable law. Certain authorized public and private agencies may have access to this information including the County Welfare Departments, Department of Justice, Regional Centers, the Department of Developmental Services and the Department of Mental Health

PERSONNEL REPORT

INSTRUCTIONS: *This form is intended for keeping a current roster of all the facility personnel, other adults and licensees residing in the facility, including backup persons, volunteers and licensee if administrator/director. Show license/certificate number if applicable for specialized staff [e.g., Social Worker and other consultant(s)]. Show coverage for twenty-four hour supervision in residential facilities. Report any changes in personnel to the licensing agency as required by regulations. Send original to Licensing Agency and retain copy in facility file.*

NAME OF FACILITY	FACILITY TYPE	FACILITY NUMBER

PREPARED BY	DATE

A. **STAFF SUBJECT TO CRIMINAL BACKGROUND CHECK REQUIREMENTS:** The following staff members are subject to a criminal background check pursuant to Sections 1522, 1568.09, 1569.17 and 1596.871 of the Health and Safety Code. A California background clearance or a criminal record exemption shall be obtained prior to employment, residence or initial presence in the facility.

NAME	DATE EMPL'D	JOB TITLE	SPECIFY DAYS AND HOURS ON DUTY			SPECIFY DAYS AND HOURS ON DUTY			SPECIFY DAYS AND HOURS ON DUTY		
			DAYS	FROM	TO	DAYS	FROM	TO	DAYS	FROM	TO
Licensee/Administrator											

B. STAFF EXEMPT FROM CRIMINAL BACKGROUND CHECK REQUIREMENTS: The following are believed exempt from criminal background check requirements pursuant to Sections 1522, 1568.09, 1569.17 and 1596.871 of the Health and Safety Code. The licensee or designated representative shall sign below to verify that he or she believes the indicated persons are exempt from criminal background check requirements pursuant to statute.

Signature ______________________________ Date ____________

NAME	DATE EMPL'D	JOB TITLE	SPECIFY DAYS AND HOURS ON DUTY			SPECIFY DAYS AND HOURS ON DUTY			SPECIFY DAYS AND HOURS ON DUTY		
			DAYS	FROM	TO	DAYS	FROM	TO	DAYS	FROM	TO

HEALTH SCREENING REPORT - FACILITY PERSONNEL

All personnel, including applicant, licensee or employed staff of Residential Care Facilities for the Elderly, Community Care or Child Care Facilities must demonstrate that their health condition allows them to perform the type of work required. This health appraisal is to be completed by or under the direction of a physician.

A health screening, by or under the direction of a physician must have been performed not more than one year prior to employment or within seven (7) days after employment.

FACILITY NAME

FACILITY ADDRESS

PERSON'S NAME			AGE	
POSITION TITLE	TYPE OF FACILITY		WORK DAYS PER WEEK	WORK HOURS PER DAY

DUTY STATEMENT

TYPES OF PERSONS SERVED *(Check appropriate items)*

■ Infants ■ Adults ■ Developmentally Disabled ■ Physically Handicapped

■ Children ■ Elderly ■ Mentally Disordered ■ Drug/Alcohol Addiction

■ Other *(specify)* ____________________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT.

SIGNATURE OF APPLICANT/LICENSEE OR EMPLOYEE ▶	ADDRESS	DATE

NOTE TO PHYSICIAN: *Personnel in Residential Care Facilities for the Elderly, Community Care or Child Care Facilities shall be free from communicable disease, and capable of performing assigned tasks. Please complete the following information on the above named person.*

EVALUATION OF GENERAL HEALTH

EVALUATION OF ABILITY TO PERFORM WORK DESCRIBED IN THE ABOVE DUTY STATEMENT

NOTE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THE PERSON, CLIENTS, CHILDREN OR OTHER PERSONNEL

DATE OF T.B. TEST	■ POSITIVE ■ NEGATIVE	ACTION TAKEN (IF POSITIVE)	
DATE OF HEALTH SCREENING	NAME OF PHYSICIAN (PHYSICIAN'S STAMP)		DATE

HEALTH SCREENING BY: (ORIGINAL SIGNATURE) ▶	**TELEPHONE #**	**DATE**

CRIMINAL RECORD STATEMENT & OUT-OF-STATE DISCLOSURE

State law requires that persons associated with licensed care facilities, Home Care Aide Registry or TrustLine Registry applicants be fingerprinted and disclose any conviction. A conviction is any plea of guilty or nolo contendere (no contest) or a verdict of guilty. The fingerprints will be used to obtain a copy of any criminal history you may have.

Have you ever been convicted of a crime in California? ■ **YES** ■ **NO**

You do not need to disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.

Have you ever been convicted of a crime from another state, federal court, military, or jurisdiction outside of U.S.? ■ **YES** ■ **NO**

You do not need to disclose convictions that were a result of one's status as a victim of human trafficking and that were dismissed pursuant to Penal Code Section 1203.49, nor any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7. However, you are required to disclose convictions that were dismissed pursuant to Penal Code Section 1203.4(a).

Criminal convictions from another State or Federal court are considered the same as criminal convictions in California.

For Children's Residential Facilities, not including Foster Family Agency Staff, Youth Homelessness Prevention Centers, Private Alternative Boarding Schools, Private Alternative Outdoor Program, or Crisis Nurseries:
Have you lived in a state other than California within the last five years? ■ **YES** ■ **NO**

If yes, list each state below and then complete an LIC 198B for each state:

You must check yes to the corresponding question(s) above to report every conviction (including reckless and drunk driving convictions), you have on your record even if:

- It happened a long time ago;
- It was only a misdemeanor;
- You didn't have to go to court (your attorney went for you);
- You had no jail time, or the sentence was only a fine or probation;
- You received a certificate of rehabilitation; or
- The conviction was later dismissed, set aside or the sentence was suspended.

NOTE: IF THE CRIMINAL BACKGROUND CHECK REVEALS ANY CONVICTION(S) THAT YOU DID NOT REPORT ON THIS FORM BY CHECKING YES, YOUR FAILURE TO DISCLOSE THE CONVICTION(S) MAY RESULT IN AN EXEMPTION DENIAL, APPLICATION DENIAL, LICENSE REVOCATION, DECERTIFICATION, RESCISSION OF APPROVAL, OR EXCLUSION FROM A LICENSED FACILITY, CERTIFIED FAMILY HOME, OR THE HOME OF A RESOURCE FAMILY.

If you move or change your mailing address, you must send your updated information to the Caregiver Background Check Bureau within 10 days to:

Caregiver Background Check Bureau
744 P Street, M/S T9-15-62
Sacramento, CA 95814

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses and any accompanying attachments are true and correct.

FACILITY/ORGANIZATION/AGENCY NAME:		FACILITY/ORGANIZATION/AGENCY NUMBER:
YOUR NAME (print clearly):		
YOUR ADDRESS (street, city, state, zip):		
SOCIAL SECURITY NUMBER: *(See Privacy Statement on Page 3)*:	DRIVER'S LICENSE NUMBER/STATE:	DATE OF BIRTH:
SIGNATURE:		DATE:

<u>Instructions to Licensees</u>:
If the person discloses that they have ever been convicted of a crime, maintain this form in your facility/ organization personnel file <u>and</u> send a copy to your Licensed Program Analyst (LPA) or assigned analyst.

<u>Instructions to Regional Offices and Foster Family Agencies</u>:

If 'Yes' is indicated in any box above, forward a copy of this completed form (and the LIC 198B, as applicable) to the Caregiver Background Check Bureau, 744 P Street, MS T9-15-62, Sacramento, CA 95814.

If 'No' is indicated above in all boxes, keep this completed form in the facility file.

Privacy Notice

As Required by Civil Code § 1798.17

Collection and Use of Personal Information. The California Justice Information Services (CJIS) Division in the Department of Justice (DOJ) collects the information requested on this form as authorized by Penal Code sections 11100-11112; Health and Safety Code sections 1522, 1569.10-1569.24, 1596.80-1596.879; Family Code sections 8700-87200; Welfare and Institutions Code sections 16500-16523.1; and other various state statutes and regulations. The CJIS Division uses this information to process requests of authorized entities that want to obtain information as to the existence and content of a record of state or federal convictions to help determine suitability for employment, or volunteer work with children, elderly, or disabled; or for adoption or purposes of a license, certification, or permit. In addition, any personal information collected by state agencies is subject to the limitations in the Information Practices Act and state policy. The DOJ's general privacy policy is available at http://oag.ca.gov/privacy-policy.

Providing Personal Information. All the personal information requested in the form must be provided. Failure to provide all the necessary information will result in delays and/or the rejection of your request. Notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

Access to Your Information. You may review the records maintained by the CJIS Division in the DOJ that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

Possible Disclosure of Personal Information. In order to be licensed, work at, or be present at, a licensed facility/organization, or be placed on a registry administered by the Department, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17 and 1596.871). The Department will create a file concerning your criminal background check that will contain certain documents, including personal information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.).

Under the California Public Records Act (Government Code section 6250 et seq.), the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

NOTE: IMPORTANT INFORMATION

The Department is required to tell people who ask, including the press, if someone in a licensed facility/ organization has a criminal record exemption. The Department must also tell people who ask the name of a licensed facility/organization that has a licensee, employee, resident, or other person with a criminal record exemption. This does not apply to Resource Family Homes, Small Family Child Care Homes, or the Home Care Aide Registry. The Department shall not release any information regarding Home Care Aides in response to a Public Records Act request, other than their Home Care Aide number.

The information you provide may also be disclosed in the following circumstances:

- With other persons or agencies where necessary to perform their legal duties, and their use of your information is compatible and complies with state law, such as for investigations or for licensing, certification, or regulatory purposes.
- To another government agency as required by state or federal law.

Contact Information. For questions about this notice, CDSS programs, and the authorized use of your criminal history information, please contact your local licensing regional office.

For further questions about this notice or your criminal records, you may contact the Associate Governmental Program Analyst at the DOJ's Keeper of Records at (916) 210-3310, by email at **keeperofrecords@doj.ca.gov**, or by mail at:

Department of Justice
Bureau of Criminal Information & Analysis Keeper of Records
P.O. Box 903417
Sacramento, CA 94203-4170

Applicant Notification and Record Challenge

Your fingerprints will be used to check the criminal history records of the FBI. You have the opportunity to complete or challenge the accuracy of the information contained in the FBI identification record. The procedure for obtaining a change, correction, or updating an FBI identification record are set forth in Title 28, CFR, 16.34. You can find additional information on the FBI website at **https://www.fbi.gov/aboutus/cjis/background-checks.**

Federal Privacy Act Statement

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

Noncriminal Justice Applicant's Privacy Rights

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below.

- You must be provided written notification[1] that your fingerprints will be used to check the criminal history records of the FBI.
- You must be provided, and acknowledge receipt of, an adequate Privacy Act Statement when you submit your fingerprints and associated personal information. This Privacy Act Statement should explain the authority for collecting your information and how your information will be used, retained, and shared.[2]
- If you have a criminal history record, the officials making a determination of your suitability for the employment, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The officials must advise you that the procedures for obtaining a change, correction, or update of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the criminal history record.[3]

You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.[4]

If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at https://www.fbi.gov/services/cjis/identity-history-summary-checks.

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.) You can find additional information on the FBI website at
https://www.fbi.gov/about-us/cjis/background-checks.

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1. Written notification includes electronic notification, but excludes oral notification.
2. https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement
3. See 28 CFR 50.12(b)
4. See U.S.C. 552a(b); 28 U.S.C. 534(b); 34 U.S.C. § 40316 (formerly cited as 42 U.S.C. § 14616), Article IV(c)

EMERGENCY DISASTER PLAN FOR CHILD CARE CENTERS

INSTRUCTIONS:

Post a copy in a prominent location in facility, near telephone.
Licensee is responsible for updating information as required.
Return a copy to the licensing office.

NAME OF FACILITY		ADMINISTRATOR OF FACILITY
FACILITY ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE)		TELEPHONE NUMBER ( )

I. ASSIGNMENTS DURING AN EMERGENCY (USE REVERSE SIDE IF ADDITIONAL SPACE IS REQUIRED)

NAME(S) OF STAFF	TITLE	ASSIGNMENT
1.		DIRECT EVACUATION AND PERSON COUNT
2.		HANDLE FIRST AID
3.		TELEPHONE EMERGENCY NUMBERS
4.		TRANSPORTATION
5.		OTHER (DESCRIBE)
6.		

II. EMERGENCY NAMES AND TELEPHONE NUMBERS (IN ADDITION TO 9-1-1)

POLICE OR SHERIFF	OFFICE OF EMERGENCY SERVICES
RED CROSS	POISON CONTROL
HOSPITAL(S)	OTHER AGENCY/PERSON
CHILD PROTECTIVE SERVICES	

III. FACILITY EXIT LOCATIONS (USING A COPY OF THE FACILITY SKETCH [LIC 999] INDICATE EXITS BY NUMBER)

1.	2.
3.	4.

IV. TEMPORARY RELOCATION SITE(S) (IF AVAILABLE, SUBMIT LETTER OF PERMISSION FROM RENTER/LEASSOR/MANAGER/PROPERTY OWNER)

NAME	ADDRESS	TELEPHONE NUMBER ( )
NAME	ADDRESS	TELEPHONE NUMBER ( )

V. UTILITY SHUT—OFF LOCATIONS (INDICATE LOCATION(S) ON THE FACILITY SKETCH [LIC 999])

ELECTRICITY

WATER

GAS

VI. FIRST AID KIT (LOCATION)

VII. EQUIPMENT

SMOKE DETECTOR LOCATION (IF REQUIRED)

FIRE EXTINGUISHER LOCATION (IF REQUIRED)

TYPE OF FIRE ALARM SOUNDING DEVICE (IF REQUIRED)

LOCATION OF DEVICE

VIII. AFFIRMATION STATEMENT

AS ADMINISTRATOR OF THIS FACILITY, I ASSUME RESPONSIBILITY FOR THIS PLAN FOR PROVIDING EMERGENCY SERVICES AS INDICATED BELOW. I SHALL INSTRUCT ALL CLIENTS/RESIDENTS, AGE AND ABILITIES PERMITTING, ANY STAFF AND/OR HOUSEHOLD MEMBERS AS NEEDED IN THEIR DUTIES AND RESPONSIBILITIES UNDER THIS PLAN.

SIGNATURE	DATE

EMERGENCY DISASTER PLAN FOR FAMILY CHILD CARE HOMES

Type or print clearly. Post next to phone. Keep current - Return a copy to the licensing office.

LICENSEE NAME:	DATE:

1. **EMERGENCIES - LIFE THREATENING** - Call 9-1-1 - Tell them: Number Calling from:

HOME ADDRESS:

MAJOR CROSSROAD:

HOME DIRECTION FROM CROSSROAD:

2. **EMERGENCY NAMES AND TELEPHONE NUMBERS** (In addition to 9-1-1)

Fire/Paramedics:		Office of Emergency Services:	
Red Cross:	Licensing:	Ambulance:	Other:
Hospital:	Police/Sheriff:	Child Protective Services:	
	Poison Control:		

3. **FACILITY EVACUATION** - Some disasters require evacuation of the building. Using a copy of the Facility Sketch (LIC 999A), show arrows for the safest way to exit rooms. Be sure that exit doors are not locked from the inside. In the event of a fire, get everyone out, follow the escape routes, meet at a prearranged location, account for everyone, do not let anyone return to the building and call the fire department.

4. **TEMPORARY RELOCATION SITE(S)** - Some disasters require moving to a safe location. When relocating, determine whether you need food, water, blankets and flashlight and meet at a prearranged easily accessible location. Be sure to obtain permission from the property owner.

NAME:	PHONE:
ADDRESS:	
NAME:	PHONE:
ADDRESS:	

5. **UTILITY SHUT OFF** -Indicate locations on the Facility Sketch (LIC 999A) with the exit routes.

GAS:	GAS CO. PHONE:
ELECTRIC:	ELECTRIC CO. PHONE:
WATER:	WATER CO. PHONE:

6. **EQUIPMENT LOCATION** - The fire department may help you with installation information.

FIRE EXTINGUISHER LOCATION:	SMOKE DETECTOR LOCATION:
FIRE ALARM LOCATION (IF YOU HAVE ONE):	TYPE

7. **OTHER EMERGENCY EQUIPMENT** - Where appropriate identify location of first aid kit, blankets, food and water, flashlight, radio and other emergency equipment.

LOCATION:

EMERGENCY DISASTER PLAN FOR FAMILY CHILD CARE HOMES

Need help filling out the Emergency Disaster Plan Form?

Applicants need to submit a plan to handle possible emergencies. The Emergency Disaster Plan is a plan that identifies resources when an emergency occurs. A copy of the form must be posted in a conspicuous place near a telephone and a copy given to the licensing agency with the application packet. Licensee is responsible for updating information as required and all information should be typed or clearly handwritten.

1. **EMERGENCIES - LIFE THREATENING** - Whenever a life threatening emergency occurs, use the 9-1-1 telephone number. Operators are able to speed dial help for any life threatening emergency. If the call is interrupted, they are usually able to identify the home address from the open line. It is important to write out exactly what needs to be said to direct help to the home. This means that you need to write out the home phone, the address of the home, the nearest major cross street and directions to the home from the cross street.

2. **EMERGENCY NAMES AND TELEPHONE NUMBERS** (In addition to 9-1-1) - This is a list of additional emergency resources that you may need. Most of the numbers are listed on the form. The Office of Emergency Services (OES) assists local government and the public with emergencies that threaten lives, property and the environment. The telephone number for your local OES can be found in the white pages of the telephone book under Government Listings, County Government Offices, “Emergency Operations”. It may also be found under County Sheriff’s Department. The “Other” is extra space for other numbers that you think may be needed in an emergency.

3. **FACILITY EVACUATION** - The most important action in a fire emergency is getting the children safely out and grouped together in a safe location. As part of your application packet, you need to complete a facility sketch. Take a copy of the sketch and identify the quickest exiting routes from each room. Copies of the exiting routes should be posted in conspicuous locations. You also need to identify a safe location where everyone should gather to be sure everyone is counted and no one remains in the building. **You need to have regular fire drills with the children.** Your fire department is an excellent resource for fire and evacuation instructions.

4. **TEMPORARY RELOCATION SITES** - In the event of an emergency or disaster, you need to make arrangements to move to a temporary site, such as at the home of a friend or a local church. You need to identify a second site in the event the first site is not immediately available in the emergency. Be sure to get permission from the property owner of the relocation site.

5. **UTILITY SHUT OFF** - In emergencies such as floods and earthquakes, it may be necessary to shut the utilities off. It is important to identify the locations of the utility shut off for such emergencies. You should also have a wrench on hand for the gas line. It also may be helpful to put the utility shut off locations on the Facility Sketch.

6. **EQUIPMENT LOCATION** - Your home must contain a fire extinguisher and smoke detector device which meet the standards established by the State Fire Marshal. The fire extinguisher must be in a location that is easily accessible and identified in this plan. The local fire department may help you with the location of fire equipment. In addition to smoke alarms, you need to identify and locate any other emergency alarms that are on the premises. If a fire is just beginning, it may be possible to extinguish the fire with a fire extinguisher. However, the children should be safely relocated before attempting to extinguish any fire.

7. **OTHER EMERGENCY EQUIPMENT** - In the event of a flood or earthquake, it may be necessary to have a first aid kit, blankets, food and water, radio, flashlight and other provisions. The plan needs to identify where this other emergency equipment is kept.

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

ADDRESS

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

CENTRALLY STORED MEDICATION AND DESTRUCTION RECORD

I. CENTRALLY STORED MEDICATION

INSTRUCTIONS: *Centrally stored medications shall be kept in a safe and locked place that is not accessible to any person(s) except authorized individuals. Medication records for each client/resident shall be maintained for at least one year.*

Facility Name:

Facility Number:

Name: (Last First Middle)	Admission Date:	Attending Physician:	Administrator:

Medication Name	Strength/ Quantity	Instructions Control/Custody	Expiration Date	Date Filled	Date Started	Prescribing Physician	Prescription Number	No. of Refills	Name of Pharmacy

Medication Name	Strength/ Quantity	Instructions Control/Custody	Expiration Date	Date Filled	Date Started	Prescribing Physician	Prescription Number	No. of Refills	Name of Pharmacy

II. MEDICATION DESTRUCTION RECORD

INSTRUCTIONS: *For facilities other than Residential Care Facilities for the Chronically Ill (RCFCI) and Residential Care Facilities for the Elderly (RCFE), prescription medication that is not taken with a client or resident when services are terminated or otherwise disposed of must be destroyed in the facility by the administrator or designated representative and witnessed by one other adult who is not a client or resident. Medication destruction records must be retained for at least one (1) year.*

For ***RCF-CIs:*** *Prescription medication that is not taken with a resident when placement is terminated or which is not to be retained must be destroyed by the administrator and the facility manager. Medication destruction records must be retained for at least three (3) years.*

For ***RCFEs:*** *Prescription medications which are not taken with a resident when services are terminated, not returned to the issuing pharmacy, not retained in the facility as ordered by the resident's physician and documented in the resident's record, not disposed of according to the established procedures of a hospice agency, or not otherwise disposed of must be destroyed by the administrator and one other adult who is not a resident of the RCFE, in the RCFE. Records documenting destruction of medication must be retained for at least three (3) years.*

Medication Name	Strength/ Quantity	Date Filled	Prescription Number	Disposal Date	Name of Pharmacy	Signature of Administrator or Designated Representative	Signature of Witness Adult Non-Client/Resident

Medication Name	Strength/ Quantity	Date Filled	Prescription Number	Disposal Date	Name of Pharmacy	Signature of Administrator or Designated Representative	Signature of Witness Adult Non-Client/Resident

UNUSUAL INCIDENT/INJURY REPORT

INSTRUCTIONS : NOTIFY LICENSING AGENCY, PLACEMENT AGENCY AND RESPONSIBLE PERSONS, IF ANY, BY NEXT WORKING DAY.

SUBMIT WRITTEN REPORT WITHIN 7 DAYS OF OCCURRENCE.

RETAIN COPY OF REPORT IN CLIENT'S FILE.

NAME OF FACILITY	FACILITY FILE NUMBER	TELEPHONE NUMBER
		( )
ADDRESS	CITY, STATE, ZIP	

CLIENTS/RESIDENTS INVOLVED	DATE OCCURRED	AGE	SEX	DATE OF ADMISSION

TYPE OF INCIDENT

Unauthorized Absence	Alleged Client Abuse	Rape	Injury-Accident	Medical Emergency
Aggressive Act/Self	Sexual	Pregnancy	Injury-Unknown Origin	Other Sexual Incident
Aggressive Act/Another Client	Physical	Suicide Attempt	Injury-From another Client	Theft
Aggressive Act/Staff	Psychological	Other	Injury-From behavior episode	Fire
Aggressive Act/Family, Visitors	Financial		Epidemic Outbreak	Property Damage
Alleged Violation of Rights	Neglect		Hospitalization	Other *(explain)*

DESCRIBE EVENT OR INCIDENT (INCLUDE DATE, TIME, LOCATION, PERPETRATOR, NATURE OF INCIDENT, ANY ANTECEDENTS LEADING UP TO INCIDENT AND HOW CLIENTS WERE AFFECTED, INCLUDING ANY INJURIES:

PERSON(S) WHO OBSERVED THE INCIDENT/INJURY:

EXPLAIN WHAT IMMEDIATE ACTION WAS TAKEN (INCLUDE PERSONS CONTACTED):

MEDICAL TREATMENT NECESSARY? YES NO IF YES, GIVE NATURE OF TREATMENT:

WHERE ADMINISTERED:	ADMINISTERED BY:

FOLLOW-UP TREATMENT, IF ANY:

ACTION TAKEN OR PLANNED (BY WHOM AND ANTICIPATED RESULTS:

LICENSEE/SUPERVISOR COMMENTS:

NAME OF ATTENDING PHYSICIAN

REPORT SUBMITTED BY:	NAME AND TITLE	DATE
REPORT REVIEWED/APPROVED BY:	NAME AND TITLE	DATE

AGENCIES/INDIVIDUALS NOTIFIED *(SPECIFY NAME AND TELEPHONE NUMBER)*

LICENSING____________________

ADULT/CHILD PROTECTIVE SERVICES____________________

LONG TERM CARE OMBUDSMAN____________________

PARENT/GUARDIAN/CONSERVATOR____________________

LAW ENFORCEMENT____________________

PLACEMENT AGENCY____________________

UNUSUAL INCIDENT/INJURY REPORT - FAMILY CHILD CARE HOME

EVENTS THAT MUST BE REPORTED TO PARENTS/AUTHORIZED REPRESENTATIVES AND/OR THE DEPARTMENT:

A. No later than the same business day, notify a child's parent or authorized representative of the events listed in #11 that affect that child.
B. Within the next business day, notify the Department by telephone or fax of the events listed in #11.
C. If reported to the Department by telephone, submit written report within 7 calendar days of the event.
D. Keep a copy of the report submitted to the Department in the (affected) child's record.

GENERAL INSTRUCTIONS FOR COMPLETION

1. Enter the facility number as shown on the license
2. Enter the licensee's name as shown on license.
3. Enter the name of the facility as shown on the license.
4. Enter the number and street address, city, and zip code.
5. Enter the first and last name of each child involved in the incident or injury.
6. Enter the child's age or the month, date, and year of birth.
7. Enter the gender of each child as M for Male or F for Female.
8. Enter the month, date, and year each child was accepted into the family child care home.
9. Enter the language that the child or parent speaks*(i.e., English, Spanish, etc.)*.
10. Enter the month, date, year and the time of day that the incident or injury happened.
11. Event to be reported:
    a. Check if any child has died from any cause.
    b. Check if a child was injured, and the injury required treatment by a medical professional.
    c. Check if a child in care leaves or wanders (is missing) from the facility without permission or supervision, including when a child is missing during any outing or special event away from the facility, or a child does not return from school.
    d. Check if it is suspected that a child has been abused or neglected.
    e. Check if there is a fire or explosion in or on the premises of the family child care home.
    f. Check if there is a communicable disease outbreak when determined by the local health authority.
    g. Check if any child is poisoned while in care.
    h. Check if there is some other incident that threatens the physical or emotional health and safety of any child.
12. Describe what happened. Be specific. Include name of person(s) involved in or suspected of causing the injury.
13. Include medical findings and treatment.
14. Describe how this incident or injury will be prevented in the future.
15. Enter the first and last name and title of the physician or other health care provider providing care to child, if known.
16. Enter the area code and telephone number of the physician or other health care provider.
17. Enter the name(s) and telephone number of the child's parent(s), or authorized representative(s).
18. Enter the month, date, and year that the child's parent(s), or authorized representative(s) were notified.
19. Check one or more of the agencies notified of the incident or injury.
20. Enter the name of the person *(for each agency)* with whom you spoke when reporting the event.
21. Enter the month, day, and year next to the agency person's name that was contacted.
22. Enter the area code and telephone or fax number of the agency contacted.
23. Enter your signature here.
24. Enter your area code and telephone number.
25. Enter the month, date, and year this report is signed.

1. FACILITY LICENSE NUMBER:	2. LICENSEE NAME:
3. FACILITY NAME:	4. FACILITY ADDRESS:

5. Name of Child(ren) Involved	6. Birth Date/Age	7. Sex M / F	8. Admission Date	9. Primary Language	10. Date/Time of Incident/Injury

11. EVENT REPORTED TO THE DEPARTMENT *(CHECK ALL THAT APPLY)*

a. Death of any child from any cause.

b. Any injury to a child that requires treatment by a medical professional.

c. Any child absence meaning any instance where a child in care is missing.

d. Any suspected child abuse or neglect of any child in care. (Must also be reported to local law enforcement or Child Protective Services.)

e. Fires or explosions in or on the premises of the family child care home.

f. A communicable disease outbreak when determined by the local health authority.

g. Poisonings

h. Other incident that threatens the physical or emotional health and safety of any child.

12. DESCRIBE WHAT HAPPENED:

13. BRIEFLY DESCRIBE THE INJURY, IF ANY:

14. DESCRIBE STEPS TAKEN TO PREVENT THIS INCIDENT OR INJURY IN THE FUTURE:

15. NAME OF PHYSICIAN OR OTHER HEALTH CARE PROVIDER, IF APPLICABLE:	16. PHYSICIAN OR HEALTH CARE PROVIDER TELEPHONE NUMBER: ( )
17. NAME AND TELEPHONE NUMBER OF PARENT(S), OR AUTHORIZED REPRESENTATIVE:	18. DATE THE PARENT/AUTHORIZED REPRESENTATIVE OF THE AFFECTED CHILD WAS NOTIFIED:

19. Agency(ies) Notified	20. Name of Person(s) Contacted	21. Date	22. Telephone or Fax
State Child Care Licensing			( )
County Child Care Licensing			( )
Child Protective Services			( )
Law Enforcement			( )

23. LICENSEE SIGNATURE	24. TELEPHONE NUMBER. ( )	25. DATE:

(TO BE COMPLETED BY DEPARTMENT)

Date report received in Licensing Office: ____________ Date report reviewed and logged : ______________________

EVALUATION OF REPORT:

Follow up inquiry required Yes No Investigation required Yes No

REFERRED TO:

Licensing Program Analyst Date Reviewed:_________________ Case Management Visit Yes No

Licensing Program Manager/Sup Date Reviewed:_________________

Regional/Program Manager Date Reviewed:_________________ Other __________________________________

DISPOSITION:

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

______________________________ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

______________________________ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD

NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE	PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE
HOME ADDRESS	
HOME PHONE ( )	WORK PHONE ( )

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS NUMBER STREET	CITY	STATE	ZIP	BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE	ZIP	HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE	ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

■ CALL EMERGENCY HOSPITAL ■ OTHER EXPLAIN: ______________________________

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

________________________, born ________________________ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

________________________ . This Child Care Center/School provides a program which extends from _____ : ____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to ______ a.m./p.m. , __________ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

________________________ (SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)
________________ (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing:	Allergies: medicine:
Vision:	Insect stings:
Developmental:	Food:
Language/Speech:	Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

- ☐ Risk factors not present; TB skin test not required.
- ☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
  ___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician:________________________ Date of Physical Exam: ________________
Address:________________________ Date This Form Completed: ________________
Telephone: ________________________ Signature ________________

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

* Have a family member or contacts with a history of confirmed or suspected TB.
* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
* Live in out-of-home placements.
* Have, or are suspected to have, HIV infection.
* Live with an adult with HIV seropositivity.
* Live with an adult who has been incarcerated in the last five years.
* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
* Have abnormalities on chest X-ray suggestive of TB.
* Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

CHILD'S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME	SEX	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
IS / HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/ MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY *(*For infants and preschool-age children only)*

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
________ MONTHS	________ MONTHS	________ MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox ☐ Asthma ☐ Rheumatic Fever ☐ Hay Fever		☐ Diabetes ☐ Epilepsy ☐ Whooping Cough ☐ Mumps		☐ Poliomyelitis ☐ Ten-Day Measles (Rubeola) ☐ Three-Day Measles (Rubella)	

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES *(*For infants and preschool-age children only)*

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST
	LUNCH
	DINNER
WHAT ARE USUAL EATING HOURS?	BREAKFAST
	LUNCH
	DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*

WORD USED FOR “BOWEL MOVEMENT”*	WORD USED FOR URINATION*

PARENT / AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD’S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR’S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD’S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT/AUTHORIZED REPRESENTATIVE SIGNATURE	DATE

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: ______________________________

   Licensing Office Address: ______________________________

   Licensing Office Telephone #: ______________________________

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.

8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

LIC 995 (9/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of ______________________________, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

____
Name of Child Care Center

______________________________ ______________
Signature (Parent/Authorized Representative) Date

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.

For the Department of Justice "Registered Sex Offender"database go to www.meganslaw.ca.gov

FAMILY CHILD CARE HOME
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the family child care home without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the family child care home, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the family child care home without discrimination or retaliation against you or your child.
5. Be notified and receive, from the licensee, a written notice that lists the name of any person not allowed in the family child care home while children are present. ***(NOTE: This notice is only required when the Department has, in writing, excluded someone from the family child care home on or after January 1, 2001).***
6. Request in writing that a parent not be allowed to visit your child or take your child from the family child care home, provided you have shown a certified copy of a court order.
7. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: ________________________________

   Licensing Office Address: ________________________________

   Licensing Office Telephone #: ________________________________
8. Be informed by the licensee, upon request, of the name and type of association to the family child care home for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
9. Receive, from the licensee, the Caregiver Background Check Process form.
10. Be informed, by the licensee, that the facility has or does not have liability insurance (or a bond) that covers injury to clients due to the negligence of the licensee or employees of the facility.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE FAMILY CHILD CARE HOME TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

LIC 995A (8/08) (Detach Here - Give Upper Portion to Parents))

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of__________________________, have received a copy of the "FAMILY CHILD CARE HOME NOTIFICATION OF PARENTS' RIGHTS", the CAREGIVER BACKGROUND CHECK PROCESS and the FAMILY CHILD CARE CONSUMER AWARENESS INFORMATION form from the licensee.____

Name of Family Child Care Home

Signature (Parent/Authorized Representative) ________________________________ Date__________________

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to the parent/authorized representative.

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

IMPORTANT INFORMATION FOR PARENTS

CAREGIVER BACKGROUND CHECK PROCESS
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

The California Department of Social Services works to protect the safety of children in child care by licensing child care centers and family child care homes. Our highest priority is to be sure that children are in safe and healthy child care settings. California law requires a background check for any adult who owns, lives in, or works in a licensed child care home or center. Each of these adults must submit fingerprints so that a background check can be done to see if they have any history of crime. If we find that a person has been convicted of a crime other than a minor traffic violation or a marijuana-related offense covered by the marijuana reform legislation codified at Health and S afety Code sections 11361.5 and 11361.7, he/she cannot work or live in the licensed child care home or center unless approved by the Department. This approval is called an exemption.

A person convicted of a crime such as murder, rape, torture, kidnapping, crimes of sexual violence or molestation against children **cannot by law be given an exemption that would allow them to own, live in or work in** a licensed child care home or center. If the crime was a felony or a serious misdemeanor, the person must leave the facility while the request is being reviewed. If the crime is less serious, he/she may be allowed to remain in the licensed child care home or center while the exemption request is being reviewed.

How the Exemption Request is Reviewed

We request information from police departments, the FBI and the courts about the person's record. We consider the type of crime, how many crimes there were, how long ago the crime happened and whether the person has been honest in what they told us.

The person who needs the exemption must provide information about:

- The crime
- What they have done to change their life and obey the law
- Whether they are working, going to school, or receiving training
- Whether they have successfully completed a counseling or rehabilitation program

The person also gives us reference letters from people who aren't related to them who know about their history and their life now.

We look at all these things very carefully in making our decision on exemptions. By law this information cannot be shared with the public.

How to Obtain More Information

As a parent or authorized representative of a child in licensed child care, you have the right to ask the licensed child care home or center whether anyone working or living there has an exemption. If you request this information, and there is a person with an exemption, the child care home or center must tell you the person's name and how he or she is involved with the home or center and give you the name, address, and telephone number of the local licensing office. You may also get the person's name by contacting the local licensing office. You may find the address and phone number on our website. The website address is **http://ccld.ca.gov/contact.htm.**

CHILD CARE FACILITY ROSTER (RETAIN FOR 3 YEARS) CHILD CARE CENTERS, INFANT CARE CENTERS, SCHOOL AGE CENTERS AND FAMILY CHILD CARE HOMES

NOTE: This roster must be kept in a central location at the facility, updated as needed and made available to the licensing agency upon request.

Health and Safety Code Section 1596.841 requires that each child care facility maintain a current roster of children who are provided care in the facility. The roster shall include the child's name, address, names and day phone numbers of the parent(s) or guardian(s) and name and phone number of the child's physician. This is an optional form that may be used for this purpose.

FACILITY NAME:	FACILITY LICENSE NUMBER:	DATE/UPDATE:

CHILD'S NAME/ BIRTHDATE	ADDRESS	PARENT/GUARDIAN NAME(S)	DAYTIME PHONE OF PARENT/GUARDIAN	PHYSICIAN NAME AND PHONE	DATE ENROLLED	DATE LEFT

NOTICE

EMPLOYEE RIGHTS

Instructions:

This form is intended to meet the requirements of Health and Safety Code Sections 1596.881 and 1596.882 which require that employees be informed of their rights, at the time of employment, to filing complaints against their employer for violating any licensing law or regulation. The child care facility licensee is required to give the employee this form, to have the employee complete and detach the bottom of the form, and to maintain the signed acknowledgement of receipt of the form in the employee's file.

No employer shall discharge, demote, suspend or threaten to discharge, demote or suspend, or in any manner discriminate against any employee for taking any of the following actions:

1. Making an oral or written complaint against the employer to the California Department of Social Services or other agency having statutory responsibility for enforcement of the law or to the employer or representative of the employer for the violation of any licensing law or other laws (including but not limited to laws relating to child abuse, staff-child ratios, etc.).
2. Instituting or causing to be instituted any proceeding against the employer regarding the violation of any licensing law or other laws.
3. Is, or will be, a witness or testifier in a proceeding regarding the violation of any licensing law or other law.
4. Refusing to perform work that is in violation of a licensing law or regulation after notifying the employer of the violation.

Pursuant to Health and Safety Code Section 1596.882, an employee alleging the violation by the employer of any action described above shall do the following:

1. Present the employer with a claim alleging violation of the employee's rights within 45 days after the discharge, demotion, suspension or threat thereof or for discriminating against the employee for taking such action.
2. File a claim with the Division of Labor Standards Enforcement no later than 90 days after the employer takes any of the above described actions against the employee.

Upon receipt of the employee's complaint, the Division of Labor Standards Enforcement shall do whatever investigation it deems appropriate to resolve the complaint. If it is determined that the employer has violated the employee's rights, the Division of Labor Standards Enforcement shall take action against the employer in any appropriate court. The court shall have jurisdiction of any action taken as well as to issue restraining orders and any other appropriate relief, including rehiring and reinstatements of the employee to his or her former position with backpay and benefits.

Within 30 days of receipt of a complaint from an employee as outlined above, the Division of Labor Standards Enforcement shall review the facts of the complaint and set either a hearing date or notify the employee and the employer of its decision. Where necessary, the Division of Labor Standards Enforcement shall begin the appropriate court action to enforce the decision.

Except for any grievance procedure or arbitration or hearing that is available to the employee pursuant to a collective bargaining agreement, Section 1596.882 is the exclusive means for presenting claims.

To file a claim with the Division of Labor Standards Enforcement, check the white pages of the local telephone directory under State Government Offices, California State of, Industrial relations Department, Labor Standards Enforcement-Working Conditions, for the local telephone number and address of the nearest office, or contact the headquarters office at P.O. Box 603, San Francisco, CA 94101, telephone (415) 703-4810.

(Detach Here)

(This form is to be retained in the employee's file)

EMPLOYEE RIGHTS

This is to acknowledge that I ______________________________ have received a copy of
(PLEASE PRINT NAME OF EMPLOYEE)

"EMPLOYEE RIGHTS" from my employer ______________________________ , who is the
(PLEASE PRINT NAME OF EMPLOYER)

licensee or authorized representative of ______________________________
(PLEASE PRINT NAME OF FACILITY)

______________________________ ______________
(SIGNATURE OF EMPLOYEE) (DATE)

EVALUATION OF TEACHER QUALIFICATIONS

The courses listed below have been reviewed and verified by the Department of Social Services, Community Care Licensing Division, as meeting the requirements for child care center teachers in the California Code of Regulations, Title 22, Division 12.

The original of this form, along with copies of transcripts or other relevant documentation, must be kept in the teacher's personnel file at the licensed center. This form is transferable to other centers and will be accepted by all District Offices.

I. PERSONAL INFORMATION	COMPONENTS	FACILITY NUMBER
TEACHER:	■ Preschool	
FACILITY:	■ Infant	
ADDRESS:	■ School-Age	
	■ Mildly Ill Child	

II. EDUCATION/EXPERIENCE

- ■ Children's Center Permit (Copy attached.)
- ■ Regional Occupational Program Certificate (Copy attached.)
- ■ Child Development Associate Credential (Copy attached.)
- ■ Coursework only and six months of experience (Copy of transcripts attached.)

III. QUALIFYING POSTSECONDARY COURSES

COURSEWORK IN CD/ECE	COURSE #	UNITS (S/Q)	COLLEGE/UNIVERSITY
CHILD/HUMAN GROWTH AND DEV.			
CHILD, FAMILY AND COMMUNITY			
PROGRAM/CURRICULUM			
OTHER: INFANT, SCHOOL-AGE, ETC.			
TOTAL:			
ADDITIONAL UNITS REQUIRED:			

IV. QUALIFYING EXPERIENCE

FROM	TO	HOURS PER DAY	POSITION(S)	EMPLOYER(S)/ADDRESS(ES)	TOTAL: MO/DAY/YR

V. OTHER APPLICABLE EDUCATION/COURSES (based on statutory/regulatory changes) (Backup documentation attached.)

COURSE TITLE	DATE COMPLETED	VERIFIED BY
CPR		
First Aid		
Others		

Was an exception granted? ■ No ■ Yes (Copy of exception attached.)

Based on the completion of the requirements identified above, this employee is approved as a :

■ Fully qualified preschool teacher ______________________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

■ Fully qualified infant teacher ______________________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

■ Fully qualified school-age teacher ______________________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

■ Fully qualified mildly ill child teacher ______________________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

CHILD CARE CENTER COPY (ORIGINAL)

Directions for Completing Evaluation of Teacher Qualifications

The LPA should fill out this form using the following instructions.

Type or print clearly using black ink. Return the original form to the director of the licensed center. Retain one copy in the teacher's personnel file at the licensed center. Retain one copy in the teacher's file at the licensed center and return a copy to the teacher. Attach (to each evaluation) copies of the forms and documents identified below.

I. PERSONAL INFORMATION:

Name: Enter the name of the person applying for an evaluation of qualifications. Include first, middle, and last names.

Facility: Enter complete name, address, and number of facility where the evaluated individual is currently employed.

Components of Program: Check appropriate box(es).

II. EDUCATION/EXPERIENCE:

Check appropriate box and attach appropriate documentation.

III. QUALIFYING POSTSECONDARY COURSES:

Courses: Enter course number, number of units (specify semester or quarter units), and the college where credits were earned. Indicate each course completed. Enter the total units for all courses completed. Enter any additional units required.

IV. QUALIFYING EXPERIENCE:

Employment: Enter the dates of employment; include month/day/year, as well as hours per day. List position(s) held, employer(s)/address(es), and the total number of months, days, and/or years employed.

V. OTHER APPLICABLE EDUCATION/COURSES:

Complete if other additional education/course requirements are applicable based on new statutory/regulatory changes. If not applicable, indicate N/A. Verification of course completion must be attached to this form. Indicate course title and date of completion, and initial.

Exceptions: Check appropriate box. Attach exception if required.

Check the appropriate box(es), and date and sign for every area for which it has been determined that the teacher is qualified under Title 22 licensing regulations.

EVALUATION OF DIRECTOR QUALIFICATIONS

The courses listed below have been reviewed and verified by the Department of Social Services, Community Care Licensing Division, as meeting the requirements for child care center directors in the California Code of Regulations, Title 22, Division 12.

The original of this form, along with copies of transcripts or other relevant documentation, must be kept in the facility file at the District Office. A copy of this form, along with copies of the backup documentation, must be kept in the personnel records of the licensed facility. This form is transferable to other centers and will be accepted by all District Offices.

I. PERSONAL INFORMATION	COMPONENTS	FACILITY NUMBER
DIRECTOR:	■ Preschool	
FACILITY:	■ Infant	
ADDRESS:	■ School-Age	
	■ Mildly Ill Child	

II. EDUCATION/EXPERIENCE

- ■ Children's Center Supervisory Permit (Copy attached.)
- ■ BA in Child Dev. or ECE and one year of experience (Copy of degree or transcripts attached.)
- ■ AA in Child Dev. or ECE and two years of experience (Copy of degree or transcripts attached.)
- ■ Coursework only and four years of experience (Copy of transcripts attached.)

III. QUALIFYING POSTSECONDARY COURSES

COURSEWORK IN CD/ECE	COURSE #	UNITS (S/Q)	COLLEGE/UNIVERSITY
CHILD/HUMAN GROWTH AND DEV.			
CHILD, FAMILY AND COMMUNITY			
PROGRAM/CURRICULUM			
ADMINISTRATION/STAFF RELATIONS			
OTHER: INFANT, SCHOOL-AGE, ETC.			
TOTAL:			
ADDITIONAL UNITS REQUIRED:			

IV. QUALIFYING EXPERIENCE

FROM	TO	HOURS PER DAY	POSITION(S)	EMPLOYER(S)/ADDRESS(ES)	TOTAL: MO/DAY/YR

V. OTHER APPLICABLE EDUCATION/COURSES (based on statutory/regulatory changes) (Backup documentation attached.)

COURSE TITLE	DATE COMPLETED	VERIFIED BY
CPR		
First Aid		
Others		

Was an exception granted? ■ No ■ Yes (Copy of exception attached.)

Based on the completion of the requirements identified above, this employee is approved as a:

■ Fully qualified preschool director ______________________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

■ Fully qualified infant director ______________________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

■ Fully qualified school-age director ______________________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

■ Fully qualified mildly ill child director ______________________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT CHILD ABUSE

NOTE: RETAIN IN EMPLOYEE/LICENSEE FILE

NAME	
POSITION	FACILITY NUMBER

California law REQUIRES certain persons to report known or suspected child abuse. As a licensee or an employee at a licensed facility or a child care institution, YOU are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include a licensee, an administrator, or an employee of a licensed community care or child day care facility. [Penal Code ("PC") § 11165.7(a)(10)] Mandated reporters also include an employee of a child care institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities. [PC § 11165.7(a)(14)] No supervisor or administrator may impede or inhibit an individual's reporting duties or subject the mandated reporter to any sanction for making the report. [PC § 11166(h)]

WHEN REPORTING ABUSE IS REQUIRED

A mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has knowledge of or observes a person under the age of 18 years whom he or she knows or reasonably suspects has been the victim of child abuse or neglect must report the suspected incident. The reporter must contact a designated agency immediately or as soon as practically possible by telephone, and shall prepare and send a written report within 36 hours of receiving the information concerning the incident. [PC § 11166(a)]

ABUSE THAT MUST BE REPORTED

Physical injury inflicted by other than accidental means on a child. [PC § 11165.6]

Sexual abuse meaning sexual assault or sexual exploitation of a child. [PC § 11165.1]

Neglect meaning the negligent treatment, lack of treatment, or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. [PC § 11165.2]

Willful harming or injuring or endangering a child meaning a situation in which any person inflicts, or willfully causes or permits a child to suffer, unjustifiable physical pain or mental suffering, or causes or permits a child be placed in a situation in which the child or child's health is endangered. [PC § 11165.3]

Unlawful corporal punishment or injury willfully inflicted upon a child and resulting in a traumatic condition. [PC § 11165.4]

WHERE TO CALL IN AND SEND THE WRITTEN ABUSE REPORT

Reports of suspected child abuse or neglect must be made to any police department or sheriff's department (not including a school district police or security department), county probation department, if designated by the county to receive mandated reports, or the county welfare department. [PC § 11165.9] The written report must include the information described in Penal Code section 11167(a) and may be submitted on form SS 8572.

IMMUNITY AND CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

Persons legally mandated to report suspected child abuse have immunity from criminal or civil liability for reporting as required or authorized by law. [PC § 11172(a)] The identity of a mandated reporter is confidential and disclosed only among agencies receiving or investigating reports, and other designated agencies. [PC § 11167(d)(1)] Reports are confidential and may be disclosed only to specified persons and agencies. Any violation of confidentiality is a misdemeanor punishable by imprisonment, fine, or both. [PC § 11167.5(a)-(b)]

PENALTY FOR FAILURE TO REPORT ABUSE

A mandated reporter who fails to make a required report is guilty of a **misdemeanor** punishable by up to six months in jail, a fine of $1000, or both. [PC § 11166(b)]

COPY OF THE LAW

Prior to my employment in a licensed community care or child day care facility, or child care institution, my employer provided me with a copy of Penal Code sections 11165.7, 11166, and 11167. [PC § 11166.5(a)]

ACKNOWLEDGMENT OF RESPONSIBLITY

I, ____, have knowledge of my responsibility to report known or suspected child abuse in compliance with Penal Code section 11166. [PC § 11166.5(a)]

SIGNATURE	DATE

EARTHQUAKE PREPAREDNESS CHECKLIST (EPC) *

Health & Safety Code 1596.867 requires an Earthquake Preparedness Checklist be included as an attachment to the Emergency Disaster Plan (LIC 610, LIC 610A and 610A (SP)) and be made accessible to the public. This form is intended to meet this requirement.

A. ELIMINATE POTENTIAL HAZARDS IN CLASSROOMS AND THROUGHOUT THE SITE:

Bolt bookcases in high-traffic areas securely to wall studs.

Move heavy books and items from high to low shelves.

Secure and latch filling cabinets.

Secure cabinets in high traffic areas with child safety latches.

Secure aquariums, computers, typewriters, TV/VCR equipment to surfaces (e.g., by using Velcro tabs).

Make provisions for securing rolling portable items such as TV/VCRs, pianos and refrigerators.

Move children’s activities and play areas away from windows, or protect windows with blinds or adhesive plastic sheeting.

Secure water heater to wall using plumber’s tape.

Assess and determine possible escape routes.

Enlist parent and community resource assistance in securing emergency supplies or safeguarding the child care site.

Store a 3-day supply of nonperishable food (including juice, canned food items, snacks, and infant formula).

Store a 3-day supply of water and juice.

Store food and water in an accessible location, such as portable plastic storage containers.

Store other emergency supplies such as flashlights, a radio with extra batteries, heavy gloves, trash bags, and tools.

Maintain a complete, up-to-date listing of children, emergency numbers, and contact people for each class-room stored with emergency supplies.

B. ESTABLISH A COORDINATED RESPONSE PLAN INVOLVING ALL OF THE FOLLOWING:

CHILDREN:

Teach children about earthquakes and what to do (see resource list below).

Practice “duck, cover, and hold” earthquake drills under tables or desks no less than 4 times a year.

PARENTS:

Post, or make available to parents, copies of the school earthquake safety plan (including procedures for reuniting parents or alternate guardians with children, location of planned evacuation site and method for leaving messages and communicating).

C. CHILD CARE PERSONNEL AND LOCAL EMERGENCY AGENCIES:

Identify and assign individual responsibilities for staff following an earthquake (including accounting for and evacuating children, injury control and damage assessment).

Involve and train all staff members about the earthquake safety plan, including location and procedure for turning off utilities and gas.

Contact nearby agencies (including police, fire, Red Cross, and local government) for information and materials in developing the child care earthquake safety plan.

*** For more free resources contact:**

(1) Federal Emergency Management Agency (FEMA)

(2) Office of Emergency Services (OES)

(3) Red Cross

PARENT NOTIFICATION
ADDITIONAL CHILDREN IN CARE

As required by Health and Safety Code Sections 1597.44(c) and 1597.465(c), you are hereby notified that: *(Check one)*

☐ I am licensed as a Small Family Child Care Home and may provide care for more than six and up to eight children when one child is enrolled in and attending kindergarten (including transitional kindergarten) or elementary school, and another child is at least six years old, and no more than two infants are in care.

☐ I am licensed as a Large Family Child Care Home, and with an assistant provider, may provide care for more than 12 and up to 14 children when one child is enrolled in and attending kindergarten (including transitional kindergarten) or elementary school, and another child is at least six years old, and no more than three infants are in care.

____
(PRINT FACILITY ADDRESS)

- -
(CUT ALONG DOTTED LINE)

RECEIPT OF PARENT NOTIFICATION (Facility Copy)
Additional Children in Care

I,______________________________, acknowledge receipt of the notification that this Small Family Child Care Home may be providing care for more than six and up to eight children, or that this Large Family Child Care Home may be providing care for more than 12 and up to 14 children in accordance with Health and Safety Code Sections 1597.44 and 1597.465.

____ ______________________
(PARENT/AUTHORIZED REPRESENTATIVE SIGNATURE) (DATE)

____
(CHILD'S NAME)

Maintain the completed and signed bottom half of this form in the child's record and provide the completed top half of this form to the child's parent or authorized representative.

NEBULIZER CARE CONSENT/VERIFICATION
CHILD CARE FACILITIES

This form may be used to show compliance with Health and Safety Code Section 1596.798 before a child care licensee or staff person administers inhaled medication to a child in care. A copy of the completed form should be filed in the child's record and in the personnel file. ***A separate form must be filled out for each person who administers inhaled medication to the child.***

I,______________________________, give my consent for______________________________,
(PRINT NAME OF AUTHORIZED REPRESENTATIVE) (PRINT NAME OF LICENSEE OR STAFF PERSON)

who work(s) at ____,
(PRINT NAME AND ADDRESS OF CHILD CARE FACILITY)

to administer inhaled medication to my child,______________________________, and to contact my child's health care provider.
(PRINT NAME OF CHILD)

In addition, I certify that I have personally instructed the above-named licensee or staff person on how to administer inhaled medication to my child.

I have also provided the child care facility with written instructions from my child's physician, or from a health care provider working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions include:

- Specific indications (such as symptoms) for administering the inhaled medication in accordance with the physician's prescription.
- Potential side effects and expected response.
- Dose form and amount to be administered in accordance with the physician's prescription.
- Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician's prescription. This includes actions to be taken in an emergency.
- Instructions for proper storage of the medication.
- The telephone number and address of the child's physician.

SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE
ADDRESS OF AUTHORIZED REPRESENTATIVE	
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER

FOR PUBLIC FILE

CHILD CARE CLIENT DEATH REPORT

NOTE: Effective July 1, 2000, it is the policy of the Community Care Licensing Division to place in the Licensing Offices' facility public file, information regarding the death of any child in a child care setting. Any instance of a death of a child in care results in a licensing visit. The results of the initial and subsequent visit may be documented in the public section of the file. Additional information may be available on other forms in this file.

LICENSING OFFICE INFORMATION

Responsible Licensing Office ______________________________

FACILITY INFORMATION

Facility Name ______________________________

Facility Number ______________________________

Census at Time of Death ______________________________

CLIENT INFORMATION

Sex of Client ______________________________

Client's Age ______________________________

Date of Death ______________________________

Place of Death ______________________________

Cause of Death ______________________________

This form is placed in the public file, as soon as the cause of death is known.

FAMILY CHILD CARE
CONSUMER AWARENESS INFORMATION

Family Child Care (FCC) is provided by the home of a licensed provider for up to eight children with one adult or up to 14 children with one adult and one assistant. FCC homes provide a home like setting. Making sure that the licensed FCC homes are providing safe care is the job of the licensing agency, the parents and the provider.

HEALTH and SAFETY CHECKLIST

You should check for basic health and safety practices in the home. Your FCC Provider, by state law and regulation, must do the following:

- Get a license from the local licensing agency.
- Provide care to no more than eight children (with no more than two children under age 2) or 14 children with an assistant (with no more than 3 children under age 2).
- Make sure the home has heat in cold weather and is cool in hot weather.
- Keep detergents and cleaning products out of children's reach.
- Make sure swimming pools are fenced or have a pool cover.
- Baby gates must block stairs in facilities when children less than five years old are in care.
- Store guns, other weapons, and poisons in locked areas.
- Have an emergency plan in case of fire or earthquake.
- Keep an emergency information card on every child in care.
- Keep a fire extinguisher and working smoke alarm in the FCC home.
- Provide a smoke free environment.
- Not use baby walkers, bouncers or similar items.

WHAT SHOULD THE FAMILY CHILD CARE HOME PROVIDE?

You should get answers to these questions before placing your child in the home:

- Is the home clean and safe?
- Are there enough toys and games?
- How will my child be disciplined? **(Spanking, hitting, slapping, shaking and so forth are not permitted in licensed homes.)**
- What meals will my child be given?
- How will the food I bring be stored and prepared?
- Is there enough room *(indoor and outdoor)* for my child to play?
- What activities are planned for my child?
- How will my child be cared for when he or she gets sick?
- How many other children will be in care?
- What ages are the other children?
- What are the sleeping/napping/rest arrangements?
- How will I find out if my child is hurt or injured while in care?

DISCUSS THE FOLLOWING WITH THE PROVIDER:

- **Setting times** for arrival and pickup.
- **Bringing items** from home *(food, toys, change of diapers, change of clothes, toothbrush, infant furniture, and so forth)*.
- **Providing instructions** for giving medicines or special food.
- **Providing telephone numbers** for home, work, spouse's work, doctor and neighbor.
- **Providing a list of names** and telephone numbers of people who may pick up your child.

GOOD CHILD CARE INCLUDES THESE THINGS:

- **A provider** who provides warm and loving care and guidance for your child, and who works with you and your family to make sure your child grows and learns in the best way possible.
- **A home** that keeps your child safe, secure, and healthy.
- **Activities** that help your child grow mentally, physically, socially and emotionally.
- **Your involvement** in your child's care.

WHAT ARE PARENTS' RESPONSIBILITIES?

The California Department of Social Services licenses homes to provide child care, and wants you to understand the licensing laws and the ways in which you can check the quality of care your child receives.

WHAT SHOULD PARENTS DO?

- **Ask** to see the FCC home license. Homes caring for children from more than one family must be licensed.
- **Check** the condition of the FCC home frequently. Parents have the legal right to "drop in" at any time care is being provided.
- **Know** your rights as a parent by reading and keeping the Notification of Parents' Rights form.
- **Make sure** the Parents' Rights Poster is displayed in the home.
- **Watch** how your child acts in the home.
- **Listen** to what your child tells you about the care received in the home.
- **Talk** with the provider about any problems. Inform the provider of anything in the home which could hurt your child.
- **Call or write** the licensing agency if the provider fails to fix a hazard or if you believe your child has been harmed while in the provider's care. (See "How to file a complaint")
- **Ask** to see the licensing reports on file in the home.
- **Call or visit** the licensing office and ask to look at your provider's licensing file
- **Ask** if there are any adults in the home that have a criminal background.

PARENTS OF BABIES SHOULD ENSURE THAT:

- The baby receives **good nutrition** and is fed at the proper times.
- **A stimulating environment** is provided.
- The provider gives **emotional support**, and holds the child regularly.
- The provider cares for **no more than four babies**.
- Babies are **placed on their backs** when put down to sleep or nap.

HOW TO FILE A COMPLAINT ABOUT A FAMILY CHILD CARE HOME

COMPLAINT PROCESS

1. If you think a FCC provider is breaking the licensing laws, you may file a complaint with the local licensing office. You can find the address and telephone number in the following ways:
   - the provider's license
   - your copy of the Parents' Rights Notification form
   - the telephone book under:

     STATE OF CALIFORNIA
     DEPARTMENT OF SOCIAL SERVICES
     COMMUNITY CARE LICENSING

     OR

     COUNTY OF ______________________________
     WELFARE OR SOCIAL SERVICES DEPARTMENT
     CHILD CARE LICENSING
   - The California Department of Social Services Community Care Licensing Division's website at **www.ccld.ca.gov**
2. Call or write your local licensing office and explain your complaint. Your name will remain anonymous unless you give us permission to use it. You will be notified of the results when the investigation is done.
3. If you believe your child is being physically or sexually abused, you should also report it to your local Police Department or Sheriff's Department.
4. Contact the local licensing office about any issues or questions you may have.
5. To learn more about the Child Care Licensing program and services, please visit our website. There you will find child care licensing updates, regulations, and information about the child care advocate program.

WHEN YOU REPORT SUSPECTED VIOLATIONS YOU NOT ONLY PROTECT YOUR CHILD BUT ALSO PERFORM A SERVICE TO YOUR COMMUNITY.

WHAT THE LICENSING AGENCY DOES

- Visits each FCC home before issuing a license to operate.
- Does criminal background checks and child abuse index checks on all adults in the home.
- Requires tuberculosis (TB) tests of providers.
- Investigates complaints.
- Makes unannounced visits to the FCC home.
- Denies applications and revokes licenses when necessary.

PARENT CONSENT FOR ADMINISTRATION OF MEDICATIONS AND MEDICATION CHART

NOTE: *Regulation Section 101221 requires the following information be on file.*

Child Care Center Name:	License Number:	Date:

PARENT'S INSTRUCTIONS:

1. All prescription and nonprescription medications shall be maintained with the child's name and shall be dated.
2. Prescription and nonprescription medications must be stored in the original bottle with unaltered label. Medications requiring refrigeration must be properly stored.
3. Prescription and nonprescription medication shall be administered in accordance with the label directions.
4. Written consent must be provided from the parent, permitting child care facility personnel to administer medications to the child. Instructions shall not conflict with the prescription label or product label directions.

Child's Name:	Date Of Birth:
Medication Name:	Dosage:

I authorize child care personnel to assist in the administration of medications described above to the child named above for the following medical condition/s:

From ________________ to ________________ at ________________ daily while in attendance.
Beginning Date Ending Date Time of Day

Parent's Signature:	Date:

MEDICATION CHART
Staf f Documentation of Medication Administration

Date:	Time Given:	Staff Signature:
Date:	Time Given:	Staff Signature:
Date:	Time Given:	Staff Signature:
Date:	Time Given:	Staff Signature:
Date:	Time Given:	Staff Signature:

Upon completion, return medicine to parent or destroy, and place form in child's record.

Staff:	Date:

ACKNOWLEDGEMENT OF RECEIPT OF LICENSING REPORTS

I, as the parent/legal guardian of ____________________________________ , currently attending or newly enrolled at ______________________________ child care center/family child care home acknowledge I have received the following information as required by Health and Safety Code sections 1596.8595 and 1596.8895.

Copy of any licensing report that documents a Type A deficiency cited at this facility; Type A deficiencies are those that, if not corrected, represent an immediate risk to the health, safety or personal rights of children in care. This includes facility visits and substantiated complaint investigations.

Date(s) of licensing report(s) provided: ____

Copy of licensing documents pertaining to a conference conducted by a local licensing agency management representative and the licensee of this child care center/family child care home in which issues of noncompliance are discussed.

Date of document provided: ___________________________

Copy of the Accusation Summary indicating the Department's intent to revoke the license of this child care center/family child care home, until that accusation is either dismissed or resolved through the administrative hearing process or stipulated agreement.

Date of document provided: _______________________

As a parent/legal guardian of a newly enrolled child in this child care center/family child care home, I have been provided the documents identified above received by the licensee during the 12-month period prior to my child's enrollment.

My signature below verifies I have received the documents identified above.

PARENT/LEGAL GUARDIAN SIGNATURE:	DATE DOCUMENTS RECEIVED:

INDIVIDUAL INFANT SLEEPING PLAN

Date of plan: ___________________________

SECTION A: INFANT'S INFORMATION

Infant's Name	Gender	Birth Date
Authorized Representative's Name (Primary Contact)		Phone Number
Authorized Representative's Name (Secondary Contact)		Phone Number

SECTION B: SLEEPING ENVIRONMENT INFORMATION

At home, the infant sleeps in: n Crib n Play Yard n Other (Specify) ____________________	What are the Infant's usual sleeping hours? ___________ ___________ ___________ ___________
What is the infant's average length of the Infant's nap(s) during the day time? __________ minutes _________ hours	Does the infant use a pacifier? n Yes n No n Sometimes If **yes**, brand: _______________

SECTION C: INFANT'S ABILITY TO ROLL

My child, _________________________ is able to roll from their back to their stomach and stomach to their back beginning _______ / _______ / _______.

Authorized Representative Signature	Date

SECTION D: INFANT'S ABILITY TO ROLL IN CHILD CARE

Provider observed the infant is capable of rolling from their back to their stomach and stomach to their back.

Provider Signature	Date
Authorized Representative Signature (To be completed no later than the next business day following observation)	Date

SECTION E: MEDICAL EXEMPTION

Does the infant have a medical exemption? n Yes n No

If the infant has a medical exemption to sleep in a position other than on their back a licensed physician must provide instruction on an alternate sleeping position.

The following shall be included with the medical exemption:

- Instructions on how the infant shall be placed to sleep, including sleep position.
- Duration the exemption is to be in place
- The licensed physician's contact information
- Signature of the licensed physician and date of signature

ATTACH REQUIRED DOCUMENTS TO THIS FORM AND MAINTAIN IN THE INFANT'S FILE PURSUANT TO TITLE 22, SECTION 101429(a)(2)(c) FOR CHILD CARE CENTERS OR SECTION 102425(c)(2) FOR FAMILY CHILD CARE HOMES.

I certify that all information contained in this form is complete and accurate to the best of my ability.

Authorized Representative Signature	Date

EXTERNAL WATER SAMPLER SELF-CERTIFICATION FORM

(Including lab requirements for testing water for lead at licensed Child Care Centers)

Name:	Phone Number:
Company Name:	Email Address:
Address:(City, State, Zip code)	Type of Certification, Date and Number:

Part One is to ensure that the above-named individual meets the qualifications of a Certified External Water Sampler as established by the California Department of Social Services (CDSS) in partnership with the California State Water Resources Control Board, Division of Drinking Water (SWRCB-DDW).

Part 1A - Certification of Certified Water Sampler

1. Check at least one of the following requirements that applies:

- ☐ Have received water sampling training for the collection of lead in drinking water through a California water district within the last 36 months.
- ☐ Have a Baccalaureate or higher degree in engineering or science from an accredited institution of higher education.
- ☐ Have the equivalent of one year of experience in water sampling.

Or be currently employed in at least one of the following capacities:

- ☐ A California Department of Public Health (CDPH) Certified Lead Inspector/Assessor.
- ☐ A CDPH Lead Sampling Technician.
- ☐ A Certified Treatment or Water Distribution Operator – lists are updated monthly on the California State Water Resources Control Board website.
- ☐ An employee of an engineering firm under the oversight of a California licensed Professional Engineer in Civil Engineering with at least one year of experience conducting water sampling.

Part 1B - Certification of Certified Water Sampler	Yes	No
1. I have reviewed and fully understand the Environmental Protection Agency (EPA) 3Ts method outlined in the CDSS written directives.	☐	☐
2. I viewed and understand the video created by the Office of Water Programs (OWP) at Sacramento State University outlining the procedures for a sampler testing Child Care Centers for lead in drinking water. (Required)	☐	☐
3. I will ensure that all samples are delivered to the testing laboratory as required for preservation.	☐	☐
4. I will conduct sampling using the 3Ts Module 5 as guidance.	☐	☐

CALIFORNIA CHILD PASSENGER SAFETY LAW

Protect your child — it is the law.

Use of child passenger restraint system for child under age 8

Except as provided in Section 27363 of the Vehicle Code, a parent, legal guardian, or driver shall not transport on a highway in a motor vehicle a child who is under eight (8) years of age, without properly securing that child in a back seat in an appropriate child passenger restraint system meeting federal motor vehicle safety standards.

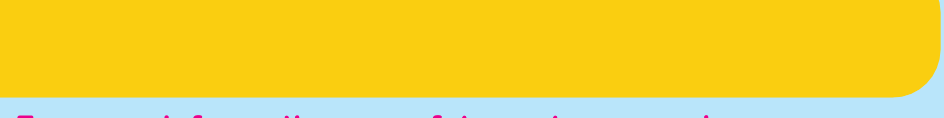
Exemptions:

- A child under eight (8) years of age may ride properly secured in an appropriate child passenger restraint system in the front seat under any of the following circumstances:
  - There is no rear seat.
  - The rear seats are side-facing seats.
  - The rear seats are rear-facing seats.
  - The child passenger restraint system cannot be installed properly in the rear seat.
  - All rear seats are already occupied by children seven years of age or under.
  - Medical reasons require that a child cannot ride in the rear seat. Proof of the child's medical condition may be required.
  - However, a child cannot be transported in a rear-facing child passenger restraint system in a front seat that is equipped with an active frontal passenger airbag.
- A child under eight (8) years of age who is four feet nine inches (4'9") in height or taller may be *properly restrained by a safety belt* instead of a child passenger restraint system. *Properly restrained by safety belt means that the lower (lap) portion of the belt crosses the hips or upper thighs and the upper (shoulder) portion of the belt crosses the chest in front of the occupant.*
- A child weighing more than 40 pounds may be transported in the backseat of a vehicle while wearing only a lap safety belt when the backseat of the vehicle is not equipped with a combination lap and shoulder safety belt.
- In case of a life-threatening emergency or when a child is being transported in an authorized emergency vehicle, if there is no child passenger restraint system available, a child may be transported without the use of that system, but the child must be secured by a seatbelt.
- A court may exempt a child from the Child Safety Belt and Passenger Restraint Requirements if certain determinations are made.

Use of child passenger restraint system for child between 8 and 16

A parent, legal guardian, or driver shall not transport on a highway in a motor vehicle a child who is eight (8) years of age or older, but less than 16 years of age, without properly securing that child in an appropriate child passenger restraint system or safety belt meeting federal motor vehicle safety standards.

Call your local health department for more information at:



For more information on safety seats: www.chp.ca.gov

STATE OF CALIFORNIA • CHILD CARE LICENSING • DEPARTMENT OF SOCIAL SERVICES

PUB 269 (9/15)

Do Your Homework Before Choosing a Care Provider

It's important that you ask yourself the following questions when carefully considering a caregiver for your child:

- Does this person have a history of violence?
- Will this person become frustrated or angry if my baby cries?
- Have I told this person that a baby should never be shaken?
- Is this person good with babies?
- Has this person had children removed from his or her care because he or she was unable to care for them?
- Does this person know to call someone immediately if they become frustrated while caring for the baby?
- Did I find this person from someone I know?
- Does this person abuse alcohol or drugs?

For more information call **TRUSTLINE** California's Background Check for In-Home Child-Care at (800) 822-8490 or visit http://www.trustline.org

Preventing Shaken Baby Syndrome/ Abusive Head Trauma

Resources

Get Help Now!

CHILDHELP NATIONAL ABUSE HOTLINE

This is a free, confidential 24/7 counseling & crisis line for parents.

(800) 4-A-CHILD | (800) 422-4453

Other Resources

National Center on Shaken Baby Syndrome

http://www.dontshake.org

https://www.cdss.ca.gov/inforesources/ocap

PUB 271 (5/21)

To care for your baby, you need to care for yourself.

Helping parents find ways to cope with crying and understand the long-term effects of shaking an infant.

Never Ever Shake a Baby

To care for your baby, you need to care for yourself.

- If you are getting upset or losing control, focus on calming yourself down. Put the baby in a safe place and walk away to calm down, checking on the baby every 5 to 10 minutes.
- Call a friend, relative, neighbor, or parent helpline for support.
- Remember that caring for a crying baby can be very frustrating, but infant crying is normal and it will get better.
- Be sensitive and supportive in situations when other parents are trying to calm a crying baby.

Why do babies cry?

Babies cry because it's the only way they know how to express their wants and needs. They cry to let you know that they are:

- Hungry
- Thirsty
- Tired
- Hot
- Cold
- Not feeling well
- Need a diaper change
- Uncomfortable
- Teething
- Scared

Have a Plan:

Knowing what to do when your baby is crying can help reduce your stress level.

Try to keep a daily routine:

- Eat healthy and drink plenty of water
- Get as much rest as possible
- Create a solid support system for your family
- Do something for yourself everyday

How to calm your crying baby:

Check and tend to physical needs. Is your baby:

- Hungry
- Thirsty
- Hot
- Cold

Does your baby:

- Need to be burped
- Need a diaper change
- Have something wrapped around his/her finger or toe, causing them pain (hair tourniquet)

The 5 S's of soothing your baby*:

- **S**waddling and laying your baby on its back
- **S**ide or stomach position is comfortable for your baby while you are holding him/her
- **S**ounds like your voice, soft music or white noise can be soothing to your baby
- **S**winging your baby gently in your arms or a rocker
- **S**ucking on a pacifier or feeding can help calm your baby

**as developed by Dr. Harvey Karp*

What is Shaken Baby Syndrome/Abusive Head Trauma?

This is a serious brain injury from enduring blunt impact to the head or being forcefully shaken. When a baby is shaken, the brain is at serious risk for trauma caused by movement in the skull.

The most common trigger for caregiver conduct leading to abusive head trauma is inconsolable crying. Babies less than one year old are at greatest risk of injury from abusive head trauma.

Shaking a baby can cause:

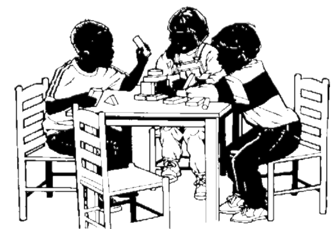
- Brain damage
- Blindness
- Spinal injuries
- Paralysis
- Seizures
- Learning and behavior problems
- In extreme cases, death

Signs your baby may have been shaken:

- Rigidity
- Seizures
- Lethargy
- Vomiting
- Coma
- Difficulty breathing
- Dilated pupils
- Blood spot in eyes

Seek immediate or urgent medical care if you notice any of the listed signs.

Community Care Licensing



NOTIFICATION OF PARENTS' RIGHTS

THIS NOTICE MUST BE POSTED IN A PROMINENT, PUBLICLY ACCESSIBLE AREA OF THE CHILD CARE CENTER

AS A PARENT/AUTHORIZED REPRESENTATIVE, YOU HAVE A RIGHT

1. **Enter and inspect the child care center without advance notice whenever children are in care.**
2. **File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.**
3. **Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.**
4. **Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.**
5. **Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.**
6. **Receive from the licensee the name, address and telephone number of the local licensing office.**
7. **Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.**
8. **Receive from the licensee the Caregiver Background Check Process form.**

http://www.ccld.ca.gov

For the Department of Justice "Registered Sex Offender" database, go to **www.meganslaw.ca.gov**

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

Licensing Office Name: ______________________________

Licensing Office Address: ______________________________

____

Licensing Office Telephone Number: ______________________________

NOTIFICATION O F PARENTS ' RIGHTS

THIS NOTICE MUST BE POSTED IN A PROMINENT, PUBLICLY ACCESSIBLE AREA OF THE FAMILY CHILD CARE HOME

AS A PARENT/AUTHORIZED REPRESENTATIVE, YOU HAVE A RIGHT TO:

1. Enter and inspect the family childcare home without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the family child care home, reports of licensing visits and substantiated complaints against thelicensee made during the last three years.
4. Complain to the licensing office and inspect the family child care home without discrimination or retaliation against you or your child.
5. Be notified and receive, from the licensee a written notice that lists the names of any person not allowed in the family child care home while children are present. (NOTE: This is only required when the Department has, in writing, excluded someone from the family child care home on or after January 1, 2001).
6. Request in writing that a parent not be allowed to visit your child or take your child from the family child care home, provided you have shown a certified copy of a court order.
7. Receive from the licensee the name address and telephonenumber of the local licensing office.
8. Be informed by the licensee, upon request, of the name and type of association to the familychild care home for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
9. Receive, from the licensee, the Caregiver Background Check Process form.
10. Be informed, by the licensee, that the facility has or does not have liability insurance that covers injury to clients due to the negligence of the licensee or employees of the facility.

http://www.ccld.ca.gov

For the Department of Justice "Registered Sex Offender" database, go to www.meganslaw.ca.gov

NOTE: CALIFORNIASTATELAWPROVIDESTHATTHELICENSEEMAYDENYACCESSTOTHEFAMILY CHILD CARE HOME TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZEDREPRESENTATIVEPOSESARISKTOCHILDRENINCARE.

Licensing Office Name: ____________________

Licensing Office Address: ____________________

____

Licensing Office Telephone Number: ____________________

EFFECTS OF LEAD EXPOSURE

Children 1-6 years old are the most at risk for lead poisoning.

- Lead poisoning can harm a child's nervous system and brain when they are still forming, causing learning and behavior problems that may last a lifetime.
- Lead can lead to a low blood count (anemia).
- Even small amounts of lead in the body can make it hard for children to learn, pay attention, and succeed in school.
- Higher amounts of lead exposure can damage the nervous system, kidneys, and other major organs. Very high exposure can lead to seizures or death.

LEAD POISONING FACTS

- Buildup of lead in the body is referred to as lead poisoning.
- Lead is a naturally occurring metal that has been used in many products and is harmful to the human body.
- There is no known safe level of lead in the body.
- Small amounts of lead in the body can cause lifelong learning and behavior problems.
- Lead poisoning is one of the most common environmental illnesses in California children.
- The United States has taken many steps to remove sources of lead, but lead is still around us.

IN THE US:

- Lead in house paint was severely reduced in 1978.
- Lead solder in food cans was banned in the 1980s.
- Lead in gasoline was removed in the early 1990s.

LEAD IN TAP WATER

The only way to know if tap water has lead is to have it tested.

Tap water is more likely to have lead if:

- Plumbing materials, including fixtures, solder (used for joining metals), or service lines have lead in them.
- Water does not come from a public water system (e.g., a private well).

To reduce any potential exposure to lead in tap water:

- **Flush the pipes in your home**
  Let water run at least 30 seconds before using it for cooking, drinking, or baby formula (if used). If water has not been used for 6 hours or longer, let water run until it feels cold (1 to 5 minutes.)*
- **Use only cold tap water for cooking, drinking, or baby formula (if used)**
  If water needs to be heated, use cold water and heat on stove or in microwave.
- **Care for your plumbing**
  Lead solder should not be used for plumbing work. Periodically remove faucet strainers and run water for 3-5 minutes.*

- **Filter your water**
  Consider using a water filter certified to remove lead.

WARNING! Some water crocks have lead. Do not give a child water from a water crock unless you know the crock does not have lead.

(*Water saving tip: Collect your running water and use it to water plants not intended for eating.)

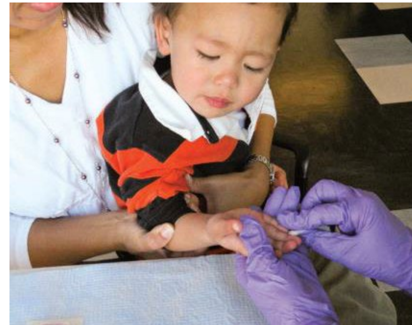
- For information on testing your water for lead, visit the Environmental Protection Agency at their website or call (800) 426-4791. You can also visit the California Department of Public Health's website at www.cdph.ca.gov.

POTENTIAL SOURCES OF LEAD

- Old paint, especially if it is chipped or peeling or if the home has been recently repaired or remodeled
- House dust
- Soil
- Some imported dishes, pots and water crocks. Some older dishware, especially if it is cracked, chipped, or worn
- Work clothes and shoes worn if working with lead
- Some food, candies and spices from other countries
- Some jewelry, toys, and other consumer products
- Some traditional home remedies and traditional make-up
- Lead fishing weights and lead bullets
- Water, especially if plumbing materials contain lead

SYMPTOMS OF LEAD EXPOSURE

Most children who have lead poisoning do not look or act sick. Symptoms, if any, may be confused with common childhood complaints such as stomachache, crankiness, headaches, or loss of appetite.



A blood lead test is free if you have Medi-Cal or if you are in the Child Health and Disability Prevention Program (CHDP). Children on Medi-Cal, CHDP, Head Start, WIC, or at risk for lead poisoning, should be tested at age 1 and 2. Health insurance plans also will pay for this test. Ask your child's doctor about blood lead testing.

For more information, go to the

California Childhood Lead Poisoning Prevention Branch's website, or call them at (510) 620-5600.

The information and images found on this publication are adapted from the California Department of Public Health Childhood Lead Poisoning Prevention Program.

PUB 515 10/2019

Part 2 - ELAP Lab Requirements Verification	Yes	No
1. I will relinquish all water samples and documentation to a laboratory that is accredited by the State of California Environmental Laboratory Accredited Program (ELAP), to perform Environmental Protection Agency Method 200.8 for lead in drinking water as required per chain-of-custody.	☐	☐
2. I will direct the ELAP lab to use a method reporting limit of 1 part per billion (ppb) for lead.	☐	☐
3. I will use 250-mL bottles to collect all water samples.	☐	☐
4. I will direct the lab to provide initial test results to three parties: • Me, the Sampler (via email or paper) • The licensed Child Care Center (via email or paper), if requested • The SWRCB-DDW (electronically)	☐	☐
5. I have reviewed and will follow the CDSS Written Directives for water sampling and lead testing in California's Child Care Centers.	☐	☐
6. I will review the lab results for any errors, verify for accuracy, and inform the Child Care Center of any Action Level Exceedances.	☐	☐

If you are an eligible water sampler (as specified in the written directives) and you would like to share your contact information with child care centers in need of water sampling for required lead testing, please email cccwatertesting@dss.ca.gov, and provide: name of organization, contact name, title, phone, email, and counties that can be serviced.

I, the above-named individual, declare under penalty of perjury under the laws of the State of California, that I have read and understand the information above and that my responses are true and correct.

_________________________________ ________________

Signature of water sampler, Title Date