American Academy of Allergy Asthma & Immunology
www.aaaai.org

# Anaphylaxis Emergency Action Plan

**Patient Name:** _____ **Age:** _____

**Allergies:** _____

**Asthma** ☐ **Yes** ***(high risk for severe reaction)*** ☐ **No**

**Additional health problems besides anaphylaxis:** _____

_____

**Concurrent medications:** _____

_____

**Symptoms of Anaphylaxis**

| | |
|---|---|
| **MOUTH** | **itching, swelling of lips and/or tongue** |
| **THROAT*** | **itching, tightness/closure, hoarseness** |
| **SKIN** | **itching, hives, redness, swelling** |
| **GUT** | **vomiting, diarrhea, cramps** |
| **LUNG*** | **shortness of breath, cough, wheeze** |
| **HEART*** | **weak pulse, dizziness, passing out** |

***Only a few symptoms may be present. Severity of symptoms can change quickly.***
****Some symptoms can be life-threatening. ACT FAST!***

## Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

**1. Inject epinephrine in thigh using (check one):**

☐ **Adrenaclick (0.15 mg)** ☐ **Adrenaclick (0.3 mg)**

☐ **Auvi-Q (0.15 mg)** ☐ **Auvi-Q (0.3 mg)**

☐ **EpiPen Jr (0.15 mg)** ☐ **EpiPen (0.3 mg)**

**Epinephrine Injection, USP Auto-injector- authorized generic**

☐ **(0.15 mg)** ☐ **(0.3 mg)**

☐ **Other (0.15 mg)** ☐ **Other (0.3 mg)**

**Specify others:** _____

**IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.**

**2. Call 911 or rescue squad (before calling contact)**

**3. Emergency contact #1: home**_____ **work**_____ **cell**_____

**Emergency contact #2: home**_____ **work**_____ **cell**_____

**Emergency contact #3: home**_____ **work**_____ **cell**_____

**Comments:** _____

_____

_____

**Doctor's Signature/Date/Phone Number**

_____

**Parent's Signature (for individuals under age 18 yrs)/Date**

# FARE Food Allergy Research & Education

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] **Yes (higher risk for a severe reaction)** [ ] **No**

**PLACE PICTURE HERE**

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following foods:** _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

## **SEVERE** 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, 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 them the child is having anaphylaxis and may need epinephrine when they 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 them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

## **MILD** SYMPTOMS

**NOSE**
Itchy/runny nose, sneezing

**MOUTH**
Itchy mouth

**SKIN**
A few hives, mild itch

**GUT**
Mild nausea/ 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: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

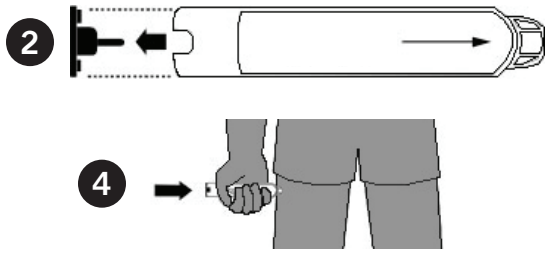
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

FARE
Food Allergy Research & Education

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

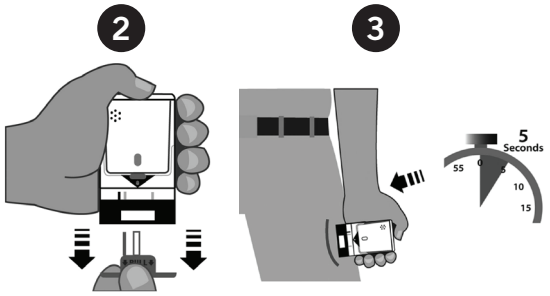
## EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.




## AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.




## ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled “1” and “2”.
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.


**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 get worse quickly.

## EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

## OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

# Asthma Action Plan, for Children 0–5 Years

Name _____

DOB _____

Record # _____

Health Care Provider's Name _____

Health Care Provider's Phone Number _____ Completed by _____ Date _____

| Long-Term Control Medicines (Use every day to stay healthy) | How Much To Take | How Often | Other Instructions (such as spacers/masks, nebulizers |
|---|---|---|---|
| | | ____ times per day EVERY DAY | |
| | | ____ times per day EVERY DAY | |
| | | ____ times per day EVERY DAY | |

| Quick-Relief Medicines | How Much To Take | How Often | Other Instructions |
|---|---|---|---|
| | | Give ONLY as needed | NOTE: If this medicine is needed often ( ____ per week), call physician |

## GREEN ZONE

**Child is WELL and has no asthma symptoms, even during active play**

**Prevent** asthma symptoms every day

- **Give the above long-term control medicines every day**
- Avoid things that make the child's asthma worse

☑ Avoid tobacco smoke, ask people to smoke outside

☐ _____

☐ _____

## YELLOW ZONE

**Child is NOT WELL and has asthma symptoms that may incude:**

- Coughing
- Wheezing
- Runny nose or other cold symptoms
- Breathing harder or faster
- Awakening due to coughing or difficulty breating
- Playing less than usual
- _____
- _____

Other symptoms that could indicate that your child is having trouble breathing may include: difficulty feeding (grunting sounds, poor sucking), changes in sleep patterns, cranky and tired, decreased appetite

**CAUTION:** Take action by continuing to give regular asthma medicines **every day AND:**

☐ Give _____

_____ (include dose and frequency)

If the Child is not in the *Green Zone* and still has symptoms after 1 hour:

☐ Give _____

_____ (include dose and frequency)

☐ Give _____

_____ (include dose and frequency)

☐ Call _____

## RED ZONE

**Child FEELS AWFUL warning signs may incude:**

- Child's wheeze, cough or difficult breathing continues or worsens, even after giving yellow zone medicines
- Child's breathing is so hard that he/she is having trouble walking/talking/eating/playing
- Child is drowsy or less alert than normal

**DANGER!**

**Get help immediately! Call 9-1-1 if:**

**MEDICAL ALERT! Get help!**

☐ Take the child to the hospital or call 9-1-1 immediately!

☐ Give more _____

_____ (include dose and frequency) until you get help

☐ Give more _____

_____ (include dose and frequency) until you get help

- **The child's skin is sucked in around neck and ribs or**
- **Lips and/or fingernails are grey or blue, or**
- **Child doesn't respond to you.**

Source: http://www.calasthma.org/uploads/resources/actionplanpdf.pdf. San Francisco Bay Area Regional Asthma Management Plan. http://www.rampasthma.org

Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention. *Expert Panel Report 3; Guidelines for the Diagnosis and Management of Asthma; Full Report 2007*. Bethesda, MD: NHLBI; 2007:118.

Patient Name _____ DOB _____

# Asthma Action Plan, for Children 0–5 Years, *continued*

## PROVIDER INSTRUCTIONS FOR ASTHMA ACTION PLAN (Children ages 0-5)

- ☐ **Determine the Level of Asthma severity** (see Table 1)
- ☐ **Fill In Medications**
  Fill in medications appropriate to that level (see Table 1) and include instructions, such as "shake well before using" "use with spacer", and "rinse mouth after using".
- ☐ **Address Issues Related To Asthma Severity**
  These can include allergens, smoke, rhinitis, sinusitis, gastro-esophaegeal reflux, sulfite sensitivity, medication interactions, and viral respiratory infections.
- ☐ **Fill in and Review Action Steps**
  Complete the recommendations for action in the different zones, and review the whole plan with the family so they are clear on how to adjust the medications, and when to call for help.
- ☐ **Distribute copies of the plan**
  Give the top copy of the plan to the family, the next one to school, day care, caretaker, or other involved third party as appropriate, and file the last copy in the chart.
- ☐ **Review Action plan Regularly (Step Up/Step Down Therapy)**
  A patient who is always in the green zone for some months may be a candidate to "step down" and be reclassified to a lower level of asthma severity and treatment. A patient frequently in the yellow or red zone should be assessed to make sure inhaler technique is correct, adherence is good, environmental factors are not interfering with treatment, and alternative diagnoses have been considered. If these considerations are met, the patient should "step up" to a higher classification of asthma severity and treatment. Be sure to fill out a new asthma action plan when changes in treatment are made.

## TABLE 1 SEVERITY AND MEDICATION CHART (Classification is based on meeting at least one criterion)

| | Severe Persistent | Moderate Persistent | Mild Persistent | Mild Intermittent |
|---|---|---|---|---|
| **Symptoms/Day** | Consistent symptoms | Daily symptoms | > 2 days/week but < 1 time/day | ≤ 2 days/week |
| **Symptoms/Night** | Frequent | > 1 night/week | > 2 nights/month | ≤ 2 nights/month |
| **Long Term Control[1]** | **Preferred treatment:**<br>• Daily *high-dose* inhaled corticosteroid<br>**AND**<br>• Log acting inhaled $B_2$ – agonist<br>**AND, if needed:**<br>• Corticosteroid tablets or syrup long term (2 mg/kg/day, generally do not exceed 60 mg per day). (Make repeated attempts to reduce systemic corticosteroids and maintain control with high-dose inhaled corticosteroids.)<br>***Consultation With Asthma Specialist Recommended*** | **Preferred treatment:**<br>• Daily *low dose* inhaled corticosteroid and long-acting inhaled $B_2$ – agonist<br>OR<br>• Daily *medium-dose* inhaled corticosteroid<br>**Alternative treatment:**<br>• Daily *low-dose* inhaled corticosteroid and either leukotriene receptor antagonist or theophylline<br>**If needed** (particularly in patients with recurring severe exacerbations):<br>**Preferred treatment:**<br>• Daily *medium dose* inhaled corticosteroid and long-acting inhaled $B_2$ – agonist<br>**Alternative treatment:**<br>• Daily *medium-dose* inhaled corticosteroid and either leukotriene receptor antagonist or theophylline<br>***Consultation With Asthma Specialist Recommended*** | **Preferred treatment:**<br>• Daily *low dose* inhaled corticosteroid (with nebulizer or MDI with holding chamber with or without face mask or DPI)<br>**Alternative treatment:**<br>• Cromolyn (nebulizer is preferred or MDI with holding chamber)<br>**OR**<br>• Leukotriene receptor antagonist<br>**Note:** Initiation of long-term controller therapy should be considered if child has had more then three episodes of wheezing in the past year that lasted more than one day and affected sleep and who have risk factors for the development of asthma[2]<br>***Consultation With Asthma Specialist Recommended*** | **NO** daily medication needed. |
| **Quick Relief[1]** | **Preferred treatment:**<br>• Inhaled short-acting $B_2$ – Agonist<br>**Alternative treatment:**<br>• Oral $B_2$ – agonist | **Preferred treatment:**<br>• Inhaled short-acting $B_2$ – Agonist<br>**Alternative treatment:**<br>• Oral $B_2$ – agonist | **Preferred treatment:**<br>• Inhaled short-acting $B_2$ – Agonist<br>**Alternative treatment:**<br>• Oral $B_2$ – agonist | **Preferred treatment:**<br>• Inhaled short-acting $B_2$ – Agonist<br>**Alternative treatment:**<br>• Oral $B_2$ – agonist |

[1] For infants and children use spacer or spacer AND MASK.

[2] Risk factors for the development of asthma are parental history of asthma, physician-diagnosed etopic dermatitis or two of the following: physician-diagnosed allergic rhinitis, wheezing apart from colds, peripheral blood eosinophilia. With viral respiratory infection, use bronchodilator every 4-6 hours up to 24 hours (longer with physician consult); in general no more than once every six weeks. If patient has seasonal asthma on a predictable basis, long-term anti-inflammatory therapy (inhaled corticosteroids, cromolyn) should be initiated prior to the anticipated onset of symptoms and continued through the season.

This Asthma Plan was developed by a committee facilitated by the Childhood Asthma Initiative, a program funded by the California Children and Families Commission, and the Regional Asthma Management and Prevention (RAMP) Initiative, a program of the Public Health Institute. This plan is based on the recommendations from the National Heart, Lung, and Blood Institute's. "Guidelines for the Diagnosis and Management of Asthma." NIH Publication No. 97-4051 (April 1997) and "Update on Selected Topics 2002." NIH Publication No. 02-5075 (June 2002). The information contained herein is intended for the use and convenience of physicians and other medical personnel, and may not be appropriate for use in all circumstances. Decisions to adopt any particular recommendation must be made by qualified medical personnel in light of available resources and the circumstances presented by individual patients. No entity or individual involved in the funding or development of this plan makes any warranty guarantee, express or implied, of the quality, fitness, performance or results of use of the information or products described in the plan or the Guidelines. For additional information, please contact RAMP at (510) 622-4438, http://www.rampasthma.org.

# Asthma Action Plan, for Children 6 Years or Older

Name _____

DOB _____

Record # _____

Health Care Provider's Name _____

Health Care Provider's Phone Number _____ Completed by _____ Date _____

| Long-Term Control Medicines (Use every day to stay healthy) | How Much To Take | How Often | Other Instructions (such as spacers/masks, nebulizers |
|---|---|---|---|
| | | ____ times per day EVERY DAY | |
| | | ____ times per day EVERY DAY | |
| | | ____ times per day EVERY DAY | |
| | | ____ times per day EVERY DAY | |

| Quick-Relief Medicines | How Much To Take | How Often | Other Instructions |
|---|---|---|---|
| | | Take ONLY as needed | NOTE: If this medicine is needed frequently, call physician to consider increasing long-term-control medications |

Special instructions when I feel ***good*** (green), ***not good*** (yellow), and **awful** (red).

## GREEN ZONE

I feel ***good.***
(My **peak flow** is in the **GREEN** zone.)

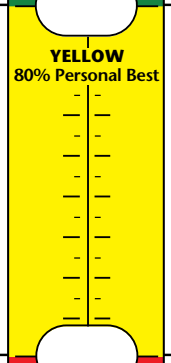

**Prevent** asthma symptoms everyday

- ☐ Take my long-term-control medicines (above) every day
- ☐ Before exercise, take _____ puts of _____
- ☐ Avoid things that make my asthma worse like:_____

## YELLOW ZONE

I do ***not*** feel ***good.***
(My **peak flow** is in the **YELLOW** zone.)
My symptoms may include one or more of the following:

- Wheeze
- Tight chest
- Cough
- Shortness of breath
- Waking up at night with asthma symptoms
- Decreased ability to do usual activities
- _____
- _____




**CAUTION:** I should continue taking my long-term-control asthma medicines every day AND**:**

- ☐ Take _____

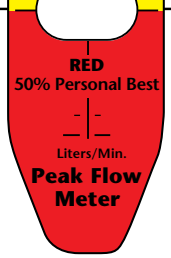
If I do not feel good, or my peak flow is not in the *Green Zone* within 1 hour, then I should:

- ☐ Increase _____
- ☐ Add _____
- ☐ Call _____

## RED ZONE

I feel ***awful***:
(My **peak flow** is in the **RED** zone.)
Warning signs may include one or more of the following:

- It's getting harder and harder to breathe.
- Unable to sleep or do usual activities because of trouble breathing.




**MEDICAL ALERT! Get help!**

- ☐ Take _____ until I get help immediately!
- ☐ Take _____
- ☐ Call _____

**DANGER!**
**Get help immediately!**

**Call 9-1-1 if you have trouble walking or talking due to shortness of breath or lips or fingernails are gray or blue.**

Source: Adapted and reprinted with permission from the Regional Asthma Management and Prevention (RAMP) initiative, a program of the Public Health Institute. http://www.calasthma.org/uploads/resources/actionplanpdf.pdf. San Francisco Bay Area Regional Asthma Management Plan.
Source: http://www.calasthma.org/uploads/resources/actionplanpdf.pdf. San Francisco Bay Area Regional Asthma Management Plan. http://www.rampasthma.org
Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention. *Expert Panel Report 3; Guidelines for the Diagnosis and Management of Asthma; Full Report 2007.* Bethesda, MD: NHLBI; 2007:117.

Patient Name _____ DOB _____

Doctor _____ Doctor's Phone Number _____ .Date _____

Hospital/Emergency Department Phone Number _____

## GREEN ZONE

**Doing Well**

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

**And, if a peak flow meter is used,**

**Peak flow:** more than _____
(80 percent or more of my best peak flow)

My best peak flow is: _____

Take these long-term-control medicines each day (include an anti-inflammatory).

| Medicine | How much to take | When to take it |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Identify and avoid and control the things that make your asthma worse, like (list here):

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Before exercise, if prescribed , take: ☐ 2 or ☐ 4 puffs _____ 5 to 60 minutes before exercise

## YELLOW ZONE

**ASTHMA IS GETTING WORSE.**

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

**–OR–**

**Peak Flow:** _____ to _____
(50 to 79 percent of my best peak flow)

**1** **Add quick-relief medicine — and keep taking your GREEN ZONE medicine.**

_____ (short acting $B_2$ agonist)

☐ 2 or ☐ 4 puffs every 20 minutes for up to 1 hour
☐ Nebulizer, once

**If applicable remove yourself from the thing that made your asthma worse**

**2** **If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:**

☐ Continue monitoring to be sure you stay in the green zone

**–OR –**

**If your symptoms (and peak flow, if used) do NOT return to GREEN ZONE after 1 hour of above treatment:**

☐ Take _____ (short acting $B_2$ agonist) ☐ 2 or ☐ 4 puffs or ☐ Nebulizer

☐ Add _____ (oral corticosteroid) mg per day. For _____ (3-10) days

☐ Call the doctor _____ (phone) ☐ before ☐ within _____ hours after taking the oral corticosteroid

## RED ZONE

**MEDICAL ALERT**

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

**–OR–**

**Peak Flow:** less than _____
(50 percent of my best peak flow)

**Take this medication:**

☐ _____ (short acting $B_2$ agonist) ☐ 4 or ☐ 6 puffs or ☐ Nebulizer

☐ _____ (oral corticosteroid)) mg.

**Then call your doctor NOW.** Go to the hospital or call an ambulance if:

- You are still in the RED ZONE after 15 minutes AND
- You have not reached your doctor

**Danger Signs**

- **Trouble walking and talking due to shortness of breath**
- **Lips or figernails are blue**

- **Take ☐ 4 or ☐ 6 puffs of your quick-relief medication AND**
- **Go to the hospital or call for an ambulance** _____ (phone) **NOW**

Source: National Heart,Lung, and Blood Institute. National Institutes of Health, U.S. Department of Health and Human Services. NIH Publication No 07-5251, October 2006.
Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention. *Expert Panel Report 3; Guidelines for the Diagnosis and Management of Asthma; Full Report 2007.* Bethesda, MD: NHLBI; 2007:119.

# Routine Schedule for Cleaning, Sanitizing, and Disinfecting

| Areas | Before Each Use | After Each Use | Daily (At the End of the Day) | Weekly | Monthly | Comments |
|---|---|---|---|---|---|---|
| **Food Areas** | | | | | | |
| • Food preparation surfaces | Clean, Sanitize | Clean, Sanitize | | | | Use a sanitizer safe for food contact |
| • Eating utensils & dishes | | Clean, Sanitize | | | | If washing the dishes and utensils by hand, use a sanitizer safe for food contact as the final step in the process; Use of an automated dishwasher will sanitize |
| • Tables & highchair trays | Clean, Sanitize | Clean, Sanitize | | | | |
| • Countertops | | Clean | Clean, Sanitize | | | Use a sanitizer safe for food contact |
| • Food preparation appliances | | Clean | Clean, Sanitize | | | |
| • Mixed use tables | Clean, Sanitize | | | | | Before serving food |
| • Refrigerator | | | | | Clean | |
| | | | | | | |
| **Child Care Areas** | | | | | | |
| • Plastic mouthed toys | | Clean | Clean, Sanitize | | | |
| • Pacifiers | | Clean | Clean, Sanitize | | | Reserve for use by only one child; Use dishwasher or boil for one minute |
| • Hats | | | Clean | | | Clean after each use if head lice present |
| • Door & cabinet handles | | | Clean, Disinfect | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| • Floors | | | Clean | | | Sweep or vacuum, then damp mop, (consider micro fiber damp mop to pick up most particles) |
| • Machine washable cloth toys | | | | Clean | | Launder |
| • Dress-up clothes | | | | Clean | | Launder |
| • Play activity centers | | | | Clean | | |
| • Drinking Fountains | | | Clean, Disinfect | | | |
| • Computer keyboards | | Clean, Sanitize | | | | Use sanitizing wipes, do not use spray |
| • Phone receivers | | | Clean | | | |
| | | | | | | |
| **Toilet & Diapering Areas** | | | | | | |
| • Changing tables | | Clean, Disinfect | | | | Clean with detergent, rinse, disinfect |
| • Potty chairs | | Clean, Disinfect | | | | |
| • Handwashing sinks & faucets | | | Clean, Disinfect | | | |
| • Countertops | | | Clean, Disinfect | | | |
| • Toilets | | | Clean, Disinfect | | | |
| • Diaper pails | | | Clean, Disinfect | | | |
| • Floors | | | Clean, Disinfect | | | Damp mop with a floor cleaner/ disinfectant |
| | | | | | | |
| **Sleeping Areas** | | | | | | |
| • Bed sheets & pillow cases | | | | Clean | | Clean before use by another child |
| • Cribs, cots, & mats | | | | Clean | | Clean before use by another child |
| • Blankets | | | | | Clean | |

## **Consent for Release of Information** (to the child care program)

I _____ give permission for
FULL NAME OF PARENT/GUARDIAN
_____ to release to
PROFESSIONAL/FACILITY
_____ the following information
CHILD CARE PROGRAM
_____ .

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

Name of Child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____

_____
PARENT/LEGAL GUARDIAN SIGNATURE DATE

_____
WITNESS SIGNATURE DATE

_____
STAFF MEMBER TO BE CONTACTED FOR ADDITIONAL INFORMATION

# CONSENT FOR RELEASE OF STAFF HEALTH RECORDS

I, _____, hereby authorize _____
*full name of staff person* *full name of Child Care Health Consultant*

to review my health records on file at the child care program: _____.
*full name of program*

Additionally, I authorize communication about these records between _____
*name of Child Care Health Consultant*

and _____ with the understanding that my consent for review of
*full name of the Director of the child care program*

my health records/information and authorization of communication shall be for the limited purpose of understanding and addressing my health needs as they pertain to maintaining and improving child care staff health at _____. Further, _____ is authorized
*name of child care program* *name of Child Care Health Consultant*

to share the information gained with his/her supervisor(s) and/or child care health consulting staff working directly with her/him.

I understand that information regarding my health found in my health record file is generally confidential and may *not* be given to employees of other schools, public agencies or individual professionals in private practice without my consent or other legal requirement.

This consent is given voluntarily and I understand that I can withdraw my consent at any time. Unless I withdraw consent, this authorization will be effective for the period of my employment at _____.
*name of child care program*

By signing below I am confirming that I have read, understood and agree to the above conditions and services.

**Staff Name:** _____
*print full name*

**Staff Signature:** _____

**Date:** _____

*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.***

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

# Child Care Diabetes Medical Management Plan

American Diabetes Association.
YOUR RIGHTS. ONE VOICE.℠

Name of Child: _____ DOB: _____ Dates Plan in Effect: _____

Parent or guardian Name(s)/Number(s): _____

Diabetes Care Provider Name/Number: _____

Diabetes Care Provider Signature:_____ Date:_____

Location of diabetes supplies at child care facility: _____

## Blood Glucose Monitoring

Target range for blood glucose is: ☐ 80-180 ☐ Other _____

When to check blood glucose: ☐ before breakfast ☐ before lunch ☐ before dinner ☐ before snacks

When to do extra blood glucose checks: ☐ before exercise ☐ after exercise ☐ when showing signs of low blood glucose ☐ when showing signs of high blood glucose ☐ other _____

**Insulin Plan:** Please indicate which type of insulin regimen this child uses (check one):

☐ Insulin Pump ☐ Multiple Daily Injections ☐ Fixed Insulin Doses

Specific information related to each insulin regimen/plan is included below for this child.

Type of insulin used at child care (check all that apply): ☐ Regular ☐ Apidra ☐ Humalog ☐ Novolog ☐ NPH ☐ Lantus ☐ Levemir ☐ Mix ☐ Other _____

### Plan A: Insulin Pump*

1. Always use the insulin pump bolus wizard: ☐ Yes ☐ No
   If no, use Insulin:Carbohydrate Ratio and Correction Factor dosage on Plan B.
2. Blood glucose must be checked before the child eats and will (check one):
   ☐ Be sent to the pump by the meter
   ☐ Need to be entered into the pump
3. The insulin pump will calculate the correction dose to be delivered **before** the meal/snack.
4. **After the meal/snack**, enter the total number of carbohydrates eaten at that meal/snack. The insulin pump will calculate the insulin dose for the meal.
5. Contact parent/guardian with any concerns.

For a list of definitions of terms used in this document, please see the *Diabetes Dictionary*.

***Providers should complete Insulin:Carbohydrate ratio and Correction dosage under Plan B section for ALL pump users.**

### Plan B: Multiple Daily Injections

1. Child will receive a fixed dose of _____ long-acting insulin at _____ ☐ **Yes** ☐ **No**
2. Follow blood glucose monitoring plan above.
3. **Use _____ insulin for meals and snacks. Insulin dose for food is** _____ unit(s) for meals **OR** _____ unit(s) for every _____ grams carbohydrate.

Give injection after the child eats.

4. If blood glucose is above target, add correction dose to:
   ☐ **Breakfast** ☐ **Snack**
   ☐ **Lunch** ☐ **Snack**
   ☐ **Other:** _____

Use the following correction factor _____ or this scale:

_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____

**Only add correction dose if it has been 3 hours since the last insulin administration.**

### C: Fixed Insulin Doses

1. Child will receive a fixed dose of long acting insulin? ☐ **Yes** ☐ **No**
   If yes, give child _____ units of _____ insulin at _____.
2. Insulin correction dose at child care ( _____ insulin)?
   ☐ Yes ☐ No
3. If blood glucose is above target, add correction dose to:
   ☐ **Breakfast** ☐ **Snack**
   ☐ **Lunch** ☐ **Snack**
   ☐ **Other:** _____

Use the following correction factor _____ or the following scale:

_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____

**Only add correction dose if it has been 3 hours since the last insulin administration.**

# Managing Very Low Blood Glucose

## Hypoglycemia Plan for Blood Glucose less than _____ mg/dL

1. Give 15 grams of fast acting carbohydrate.
2. Recheck blood glucose in 15 minutes.
3. If still below 70 mg/dL, offer 15 grams of fast acting carbohydrate, check again in 15 minutes.
4. When the child's blood glucose is over 70, provide 15g of carbohydrate as snack. Do not give insulin with this snack.
5. **Contact the parent/guardian** any time blood glucose is less than _____ mg/dL at child care.

**Usual symptoms of hypoglycemia for this child include:**

☐ Shaky ☐ Fast heartbeat ☐ Sweating
☐ Anxious ☐ Hungry ☐ Weakness/Fatigue
☐ Headache ☐ Blurry vision ☐ Irritable/Grouchy
☐ Dizzy ☐ Other _____

1. If you suspect low blood glucose, check blood glucose!
2. If blood glucose is below _____, follow the plan above.
3. If the child is unconscious, having a seizure (convulsion) or unable to swallow:
   - Give glucagon. Mix liquid and powder and draw up to the first hash mark on the syringe. Then inject into the thigh. Turn child on side as vomiting may occur.
   - If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance). After calling 911, contact the parents/guardian. If unable to reach parent, contact diabetes care provider.

# Managing Very High Blood Glucose

## Hyperglycemia Plan for Blood Glucose higher than _____ mg/dL

**Usual symptoms of hyperglycemia for this child include:**

☐ Extreme thirst ☐ Very wet diapers, accidents
☐ Hungry ☐ Warm, dry, flushed skin ☐ Tired or drowsy
☐ Headache ☐ Blurry vision ☐ Vomiting**
☐ Fruity breath ☐ Rapid, shallow breathing
☐ Abdominal pain ☐ Unsteady walk (more than typical)
**If child is vomiting, contact parents immediately

**Treatment of hyperglycemia/very high blood glucose:**

1. Check for ketones in the:
   ☐ urine ☐ blood (parent will provide training)
2. **If ketones are moderate or large**, contact parent. If unable to reach parent, contact diabetes care provider for additional instructions.
   Contact parent if ketones are trace or small: ☐ Yes ☐ No
3. Children with high blood glucose will require additional insulin **if the last dose of insulin was given 3 or more hours earlier**. Consult the insulin plan above for instructions. If still uncertain how to manage high blood glucose, contact the parent.
4. Provide sugar free fluids as tolerated.
5. You may also:
   ☐ Provide carbohydrate free snacks if hungry
   ☐ Delay exercise
   ☐ Change diapers frequently/give frequent access to the bathroom
   ☐ Stay with the child

# Diabetes Dictionary

**Blood glucose** - The main sugar found in the blood and the body's main source of energy. Also called blood sugar. The **blood glucose level** is the amount of glucose in a given amount of blood. It is noted in milligrams in a deciliter, or mg/dL.

**Bolus** - An extra amount of insulin taken to lower the blood glucose or cover a meal or snack.

**Bolus calculator** – A feature of the insulin pump that uses input from a pump user to calculate the insulin dose. The user inputs the blood glucose and amount of carbohydrate to be consumed, and the pump calculates the dose that can be approved by the user.

**Correction Factor** – The drop in blood glucose level, measured in milligrams per deciliter (mg/dl), caused by each unit of insulin taken. Also called **insulin sensitivity factor**.

**Diabetic Ketoacidosis (DKA)** – An emergency condition caused by a severe lack of insulin, that results in the breakdown of body fat for energy and an accumulation of ketones in the blood and urine. Signs of DKA are nausea and vomiting, stomach pain, fruity breath odor and rapid breathing. Untreated DKA can lead to coma and death.

**Fixed dose regimen** – Children with diabetes who use a fixed dose regimen take the same "fixed" doses of insulin at specific times each day. They may also take additional insulin to correct **hyperglycemia**.

**Glucagon** – A hormone produced in the pancreas that raises blood glucose. An injectable form of glucagon, available by prescription, is used to treat severe hypoglycemia or severely low blood glucose.

**Hyperglycemia** - Excessive blood glucose, greater than 240 mg/dL for children using and insulin pump and greater than 300 mg/dL for children on insulin injections. If untreated, the patient is at risk for **diabetic ketoacidosis (DKA)**.

**Hypoglycemia** - A condition that occurs when the blood glucose is lower than normal, usually less than 70 mg/dL. Signs include hunger, nervousness, shakiness, perspiration, dizziness or light-headedness, sleepiness, and confusion. If left untreated, hypoglycemia may lead to unconsciousness.

**Insulin** - A hormone that helps the body use glucose for energy. The beta cells of the pancreas make insulin. When the body cannot make enough insulin, it is taken by injection or through use of an insulin pump.

**Insulin Pump** - An insulin-delivering device about the size of a deck of cards that can be worn on a belt or kept in a pocket. An insulin pump connects to narrow, flexible plastic tubing that ends with a needle inserted just under the skin. Pump users program the pump to give a steady trickle or constant (basal) amount of insulin continuously throughout the day. Then, users set the pump to release bolus doses of insulin at meals and at times when blood glucose is expected to be higher. This is based on programming done by the user.

**Ketones** - A chemical produced when there is a shortage of insulin in the blood and the body breaks down body fat for energy. High levels of ketones can lead to **diabetic ketoacidosis** and coma.

**Multiple Daily Injection Regimen** - Multiple daily insulin regimens typically include a basal, or long acting, insulin given once per day. A short acting insulin is given by injection with meals and to correct hyperglycemia, or elevated blood glucose, multiple times each day.

**Type 1 Diabetes** - Occurs when the body's immune system attacks the insulin-producing beta cells in the pancreas and destroys them. The pancreas then produces little or no insulin. Type 1 diabetes develops most often in young people but can appear in adults. It is one of the most common chronic diseases diagnosed in childhood.

_____
Physician Signature

Safe at School®

## HIGH BLOOD GLUCOSE (HYPERGLYCEMIA) MANAGEMENT ALGORITHM

**Student Name:** _____
**Grade/Teacher:** _____
**School Year/Date & School:** _____

**PICTURE**

**CAUSES**
Too much food
Too little insulin
Decreased activity
Illness, infection
Stress

→ **ONSET**
Over time-hours or days

| **Early Symptoms:** | **Symptoms progressively become worse:** |
|---|---|
| Thirst/dry mouth | Sweet breath |
| Frequent urination | Facial flushing |
| Fatigue/sleepiness | Dry, warm skin |
| Increased hunger | Nausea/stomach pains |
| Blurred vision | Vomiting |
| Lack of concentration | Weakness |
| | Confusion |
| | Labored breathing |
| | Unconsciousness/coma |

**ACTION NEEDED**

**Check student's IHP for order to check blood glucose, check ketones, give insulin.**

**IF STUDENT IS FEELING OK**
- □ Provide water if student is thirsty.
- □ Allow liberal bathroom privileges.
- □ May resume classroom activities.
- □ Communicate with school nurse and parent/guardian.

**IF STUDENT IS NOT FEELING WELL**
- □ Call parent/guardian to pick up student.
- □ Provide water if student is thirsty.
- □ Provide additional treatment per IHP (ketone check, insulin).
- □ Notify school nurse if there are further immediate concerns or questions.
- □ Document action and provide copy to school nurse.

**FOR VOMITING WITH CONFUSION, LABORED BREATHING AND/OR COMA**
- □ Call 911
- □ Contact school nurse
- □ Notify parent/guardian.

School nurse: _____

Date: _____

# LOW BLOOD GLUCOSE (HYPOGLYCEMIA) EMERGENCY CARE PLAN

Student Name: _____ Date: _____

Grade/Teacher: _____

School Year/Date & School: _____

Parent/Guardian Name: _____ Phone: (___) _____

Emergency Contact: _____ Phone: (___) _____

Health Care Provider: _____ Phone: (___) _____

**CAUSES**
Too much insulin
Missed food
Delayed food
Too much exercise
Unscheduled exercise

**ONSET**
Sudden

**PICTURE**

**Never send a child with suspected low blood sugar anywhere alone.**

**SYMPTOMS**
Low blood sugar
Less than 70 mg/dl

**MILD**

| | |
|---|---|
| Hunger | Dizziness |
| Irritable | Shakiness |
| Weak | Anxious |
| Pallor | Headache |
| Crying | |
| Seating | |
| Unable to concentrate | |
| Other _____ | |

**MODERATE**
Sleepiness
Behavior Change
Confusion
Slurred speech
Poor coordination
Other _____

**SEVERE**
Unable to swallow
Combative
Unconscious
Seizures

**ACTION**
- Treat for low blood sugar on the spot
- Check blood sugar if possible
- Notify School Nurse

Name: _____

Contact Number: _____

**MILD**
- ☐ Provide fast-acting sugar source:
  - 3-4 glucose tabs
  - 4 oz juice
  - 6 oz regular soda
  - 3 tsp glucose gel
- ☐ Wait 10-15 minutes
- ☐ Retest blood sugar
- ☐ If blood sugar is less than 70 mg/dl, repeat sugar source
- ☐ Provide snack if no meal for 1 hour
- ☐ If blood sugar within target range, student may return to class if feeling better
- ☐ Communicate school nurse
- ☐ Communicate parent/guardian

**MODERATE**
- ☐ Provide fast-acting sugar source:
  - 3-4 glucose tabs
  - 4 oz juice
  - 6 oz regular soda
  - 3 tsp glucose gel
- ☐ Wait 10-15 minutes
- ☐ Retest blood sugar
- ☐ If blood sugar is less than 70 mg/dl, repeat sugar source
- ☐ Provide snack if no meal for 1 hour
- ☐ If blood sugar within target range, student may return to class if feeling better
- ☐ Notify school nurse
- ☐ Notify parent/guardian

**SEVERE**
- ☐ **Call 911**
- ☐ Don't give anything by mouth
- ☐ Give Glucagon, if ordered
- ☐ Position on side
- ☐ Stay with student
- ☐ Notify school nurse
- ☐ Notify parent/guardian

School Nurse
Signature: _____ Date: _____

## DIABETES MANAGEMENT LOG

STUDENT NAME: _____ SCHOOL: _____ ROOM/GRADE: _____

PARENT/GUARDIAN: _____ PARENT/GUARDIAN PHONE: _____

| Date | Time | Blood Glucose Result | Hypoglycemia Treatment | Ketone Result (Neg, Tr, S, M, L) | Hyperglycemia Treatment | Carbohydrate Intake | Insulin Dose | Comments | Initials |
|---|---|---|---|---|---|---|---|---|---|
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| Signature of staff providing care | Initials | Signature of staff providing care | Initials | Signature of staff providing care | Initials |
|---|---|---|---|---|---|
| | | | | | |
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# Eco-Healthy Child Care® Checklist

30 easy-to-follow steps that will immediately benefit the health and well-being of the children in your care.

**Follow these instructions to get started on creating a healthier environment!**

**1.** Answer all 30 questions on the checklist.

**2.** Comply with at least 24 of 30 items, including #1, #6 and #11, which are required.

**3.** If you can't answer "true" to 24 items, take steps to make improvements. Visit **www.cehn.org/ehcc** for tips and tools.

**4.** Fill out all parts of the Endorsement Form, and obtain both required signatures.

**5.** Send the completed checklist and $25/$50 payment to the address indicated.

**All EHCC checklist items comply with *Caring for Our Children: National Health and Safety Performance Standards, 3rd Edition.***

| TRUE | FALSE | ? | | |
|---|---|---|---|---|
| | | | | **Pesticides and Pest Prevention** |
| ❍ | ❍ | ❍ | **1.** | We use non-toxic techniques inside and outside of the facility to prevent and control pests (both insects and weeds). If a serious threat remains and pesticide application is the only viable option, parents and staff are notified in advance and a licensed professional applies the least toxic, effective product at a time when children will have the least exposure to the application area for at least 12 hours (see manufacturer's instructions to ensure 12 hours is enough time). **REQUIRED** |
| ❍ | ❍ | ❍ | **2.** | We thoroughly wash all fruits and vegetables to avoid possible exposure to pesticides, and we take the opportunity to educate children about the importance of doing so. |
| | | | | **Air Quality** |
| ❍ | ❍ | ❍ | **3.** | We avoid conditions that lead to excess moisture, because moisture contributes to the growth of mold and mildew. We maintain adequate ventilation (which can include exhaust fans and open screened windows). We repair water leaks and keep humidity within a desirable range (30-50%). |
| ❍ | ❍ | ❍ | **4.** | We do not allow vehicles to idle in our designated parking areas. |
| ❍ | ❍ | ❍ | **5.** | We do not use scented or unscented candles or air fresheners. |
| ❍ | ❍ | ❍ | **6.** | During operating hours, we do not permit smoking anywhere on the premises or in sight of children. (Note: For the healthiest environment for children and staff, smoking should not be allowed on the premises at any time). **REQUIRED** |
| | | | | **Household Chemicals** |
| ❍ | ❍ | ❍ | **7.** | We use unscented, biodegradable, non-toxic cleaning products and least-toxic disinfecting and sanitizing products. When disinfectants and sanitizers are required, they are used only for their intended purpose and in strict accordance with all label instructions. |
| ❍ | ❍ | ❍ | **8.** | We use chlorine bleach only when and where it is required or recommended by state and local authorities. We use it prudently and never use more than necessary. |
| ❍ | ❍ | ❍ | **9.** | We do not use aerosol sprays of any kind. |
| ❍ | ❍ | ❍ | **10.** | We use only no-VOC or low-VOC (Volatile Organic Compounds) household paints and do not paint when children are present. |
| | | | | **Lead** |
| ❍ | ❍ | ❍ | **11.** | We use only cold water for drinking, cooking and making baby formula; we flush all cooking and drinking outlets after long periods of non-use; and we clean debris from our outlet screens or aerators on a regular basis. If we suspect that there could be lead in our drinking water, we have our water tested and, if appropriate, use water filtration devices that have been certified to remove lead for additional treatment of drinking water at the outlet. **REQUIRED** |

over

| TRUE | FALSE | ? | | |
|---|---|---|---|---|
| ❍ | ❍ | ❍ | **12.** | Our building was built after 1978 OR 1) We maintain our facility to minimize lead hazards AND 2) We follow the Federal requirements in EPA's *Renovate Right* brochure before painting, remodeling, renovating, or making repairs that disturb paint. We have reviewed how to meet these requirements at **www.cehn.org/files/leadpaint.pdf**. |
| ❍ | ❍ | ❍ | **13.** | To avoid possible lead exposure, we do not use imported, old or handmade pottery to cook, store or serve food or drinks. |
| ❍ | ❍ | ❍ | **14.** | To reduce possible exposure to lead-contaminated dirt, we supply a rough mat at the entrance of our facility and encourage the wiping of shoes before entering — or — we are a shoe-free facility. |
| ❍ | ❍ | ❍ | **15.** | We screen our toys for lead by searching **www.cpsc.gov** or **www.healthystuff.org**. |
| | | | | **Mercury** |
| ❍ | ❍ | ❍ | **16.** | We do not use any mercury-containing thermometers or thermostats. Instead we use digital options. |
| ❍ | ❍ | ❍ | **17.** | We securely store and recycle all used batteries and fluorescent and compact fluorescent light bulbs. |
| | | | | **Furniture and Carpets** |
| ❍ | ❍ | ❍ | **18.** | To avoid possible exposure to flame retardants, we ensure furniture is in good condition without foam or inside stuffing exposed. Stuffed animals, matting, pillows and other foam items are also intact. |
| ❍ | ❍ | ❍ | **19.** | Furniture is made of solid wood or low-VOC (Volatile Organic Compounds) products, with few items made of particleboard. When purchasing furniture or renovating, we choose either solid wood (new or used) or products that have low VOCs. |
| ❍ | ❍ | ❍ | **20.** | We do not have wall-to-wall carpeting where children are present. |
| ❍ | ❍ | ❍ | **21.** | Area rugs are vacuumed daily and cleaned at least twice a year and as needed using biodegradable cleaners. |
| | | | | **Art Supplies** |
| ❍ | ❍ | ❍ | **22.** | We use only non-toxic art supplies approved by the Art and Creative Materials Institute (ACMI). Look for ACMI non-toxic seal 'AP' at **www.acminet.org**. |
| | | | | **Plastics and Plastic Toys** |
| ❍ | ❍ | ❍ | **23.** | We avoid toys made out of soft plastic vinyl (such as vinyl dolls, beach balls, and "rubber ducky" chew toys). We buy only those labeled "PVC-free" and "phthalate-free". |
| ❍ | ❍ | ❍ | **24.** | When using a microwave, we never heat children's food in plastic containers, plastic wrap or plastic bags. |
| ❍ | ❍ | ❍ | **25.** | We never use baby bottles, sippy cups or drinking cups made with BPA (Bisphenol A). Instead, we choose products made of glass, or plastic that is labeled 'BPA free'. |
| | | | | **Treated Playground Equipment** |
| ❍ | ❍ | ❍ | **26.** | We do not have playground equipment made of CCA treated wood (pre-2006) — or — if we do, we apply 2 coats of waterproof stain or sealant at least once a year. |
| | | | | **Radon** |
| ❍ | ❍ | ❍ | **27.** | We have tested our facility for radon. If elevated levels of radon are found, we take action to mitigate. We have visited **www.epa.gov/radon** for resources, and have researched state requirements and guidelines to learn more. |
| | | | | **Recycling and Garbage Storage** |
| ❍ | ❍ | ❍ | **28.** | We recycle all paper, cardboard, glass, aluminum and plastic bottles. |
| ❍ | ❍ | ❍ | **29.** | We keep our garbage covered at all times to avoid attracting pests and to minimize odors. |
| | | | | **Education and Awareness** |
| ❍ | ❍ | ❍ | **30.** | We create opportunities to educate the families we serve on eco-healthy practices. |

For more information on any checklist items, visit **www.cehn.org/ehcc/resources** For more information on any checklist items, visit **www.cehn.org/ehcc/resources**

EHCC is a program of Children's Environmental Health Network created by Oregon Environmental Council.
For more information, please visit us online at **www.cehn.org/ehcc**

Eco-Healthy Child Care®

# Endorsement Form

**Thank you for working to make your child care Eco-Healthy!**

**1 Verify your responses** (both signatures required):

"The information provided on this Eco-Healthy Child Care® Endorsement Checklist is true to the best of my knowledge."

1. FACILITY OWNER OR DIRECTOR ..... date

2. PARENT OR NON-EMPLOYEE WITNESS ..... date

**2 Please record your facility information:**

Facility name ..... # of children served

Street address or P.O. Box

City ..... State ..... Zip code

Contact name ..... Phone

Contact email ..... Facility website

Choose one: ❍ Family Child Care ❍ Center-based

❍ Please **do not** post my facility information on the website

❍ I **do not** want to receive EHCC's bi-monthly email tips

**3 Provide fee and confirmation of EHCC participation**

As part of EHCC quality control, a limited number of endorsed sites are randomly selected for a free site assessment; selected sites receive at least 48 hours notice. By submitting this endorsement form and payment, you also agree to a possible site assessment conducted by EHCC staff. Please visit **www.cehn.org/onsite** to find out more.

By meeting the criteria outlined above, including the necessary signatures, and submitting the $25/$50 endorsement fee, your facility will receive the 2-year Eco-Healthy Child Care® endorsement, including certificate, Eco-Healthy Tips, inclusion on the EHCC website, and other EHCC support for 2 years.

**Fees**

The 2-year endorsement processing fee:

- facilities licensed to care for 1-20 children is **$25**
- facilities licensed to care for 21+ children is **$50**

**Please indicate method of payment**

❍ Enclosed is our $25/$50 check or money order made out to EHCC/CEHN

❍ We've paid our $25/$50 payment via credit card at **www.cehn.org/ehcc/payment**
Our payment confirmation number _____

**Renewal Incentive:** Previously-endorsed facilities that renew their endorsement on time (both checklist AND payment received by CEHN before one's current endorsement expires) may deduct $10 from their endorsement fee. (The dates of endorsement are listed on the EHCC endorsement certificate.)

**4 Mail form and payment to:**

EHCC/CEHN
110 Maryland Avenue NE, Suite 402
Washington DC, 20002

FOR VERIFICATION • OFFICE USE ONLY

Approved by (signature) ..... Date ..... Center #

# Be Eco-Healthy!

life are critical to shaping their future health and development. As a child care provider, small changes you make can have a big impact on the children in your care. By reducing toxins, you help prevent illnesses like asthma, certain learning disabilities and even some forms of cancer. Learn more at **www.cehn.org/ehcc**.

**Thank you for taking steps to make your child care program Eco-Healthy!**

**www.cehn.org/ehcc**
EHCC is a program of Children's Environmental Health Network created by Oregon Environmental Council.

# Emergency Drill Log

Plan and conduct emergency drills for fire, tornado, lockdown, relocation, earthquake, etc., record on form and sign.

| Date | Time | Type and Location of Drill | Length of Time to Evacuate or Prepare | Number of Children in Attendance | Signature of Director or Person in Charge |
|---|---|---|---|---|---|
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# Health and Safety Checklist for Early Care and Education Programs:

## Based on *Caring for Our Children* National Health and Safety Performance Standards, Third Edition

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CALIFORNIA CHILDCARE HEALTH PROGRAM

*Developed by the California Childcare Health Program*
*Funded by the UCSF School of Nursing*
*2014*

# Health and Safety Checklist for Early Care and Education Programs: Based on *Caring for Our Children National Health and Safety Performance Standards, Third Edition*

Developed by the California Childcare Health Program (CCHP)
University of California San Francisco (UCSF) School of Nursing
2014

The UCSF CCHP Health and Safety Checklist Development Team is grateful to the many individuals who shared their expertise and spent considerable time developing this Checklist.

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**PILOT STUDY**
We would like to thank the many ECE programs in Arizona, North Carolina and California for their participation in the pilot testing of the Checklist.

**PILOT STUDY CHILD CARE HEALTH CONSULTANTS:**
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# Health and Safety Checklist for Early Care and Education Programs:

## Based on *Caring for Our Children* National Health and Safety Performance Standards, Third Edition

Child Care Center: _____

Classroom: _____

Classroom type (infant/toddler, preschool): _____

Date: (month/day/year) __ __/ __ __ / __ __ __ __

Observer Name: _____

Time Begin: __ __:__ __AM/PM

Time End: __ __:__ __AM/PM

**Ratings:**

| Code | Meaning | Definition |
|---|---|---|
| 1 | Never | None of the components of the item are met. |
| 2 | Sometimes | Less than or 50% (≤50%) of the components in the item are met. |
| 3 | Usually | More than 50% (>50%) but less than 100% of the components in the item are met. |
| 4 | Always | Every component in the item is met (100%). |
| NA | Not Applicable | The item is not applicable (NA) to the classroom/program. Explain why it is rated NA in the 'notes' section. |
| N Op | No Opportunity to Observe | There was no opportunity (N Op) to observe this item. Explain why it is rated N Op in the 'notes' section. |

**Notes:**

- An asterisk (*) means you may need to talk to the director or a staff member to ask where to find an item or product.
- At the end of each subscale there is a space to list and rate other related standards and/or regulations that may apply.
- When a field/box is shaded grey, the rating choice is not an option.

*This checklist does not cover all health and safety concerns or replace each child care program's responsibility to meet local, state, and federal health and safety requirements.*

## FACILITIES: Emergencies, Medications, Equipment and Furnishings

Emergencies

| | Never | Sometimes | Usually | Always | Not Applicable | No Opportunity |
|---|---|---|---|---|---|---|
| 1. A sign-in/sign-out system tracks who (other than children) enters and exits the facility. It includes name, contact number, purpose of visit (for example, parent/guardian, vendor, guest, consultant) and time in and out. (Std. 9.2.4.7) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 2. Phone numbers to report child abuse and neglect (Child Protective Services) are clearly posted where any adult can easily see them. (Std. 3.4.4.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 3. Phone number for the Poison Center is posted where it can be seen in an emergency (for example, next to the phone). (Stds. 5.2.9.1, 5.2.9.2) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 4. Fire extinguishers are inspected annually. Check date on fire extinguisher tag. (Std. 5.1.1.3) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 5. Each building or structure has at least two unobstructed exits leading to an open space at the ground floor. (Std. 5.1.4.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 6. A smoke detector system or alarm in working order is in each room or place where children spend time. (Std. 5.2.5.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 7. Carbon monoxide detectors are outside of sleeping areas. (Std. 5.2.9.5) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | |
| **NOTES** | | | | | | |
| 8. *First aid supplies are well-stocked in each location where children spend time. (Std. 5.6.0.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 9. *First aid supplies are kept in a closed container, cabinet or drawer that is labeled. They are stored out of children's reach and within easy reach of staff. (Std. 5.6.0.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 10. *A well-stocked first aid kit is ready for staff to take along when they leave the facility with children (for example, when going on a walk, a field trip or to another location). (Std. 5.6.0.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | |
| **NOTES** | | | | | | |
| List and rate other federal, state, local and/or accreditation standards/regulations that may apply: | | | | | | |
| | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | N Op ○ |
| **NOTES** | | | | | | |

## Medications

| | Never | Sometimes | Usually | Always | Not Applicable | No Opportunity |
|---|---|---|---|---|---|---|
| 11. *Medications are stored in an organized fashion and are not expired. They are stored at the proper temperature, (for example, in the refrigerator or at room temperature according to instructions) out of children's reach and separated from food. (Std. 3.6.3.2) | 1 | 2 | 3 | 4 | NA | |
| **NOTES** | | | | | | |
| 12. *Over-the-counter medications are in the original containers. They are labeled with the child's name. Clear written instructions from the child's health care provider are with the medication. (Stds. 3.6.3.1, 3.6.3.2) | 1 | 2 | 3 | 4 | NA | N Op |
| **NOTES** | | | | | | |
| 13. *Prescription medications are in their original, child resistant container, labeled with child's name, date filled, prescribing health care provider's name, pharmacy name and phone number, dosage, instructions, and warnings. (Stds. 3.6.3.1, 3.6.3.2) | 1 | 2 | 3 | 4 | NA | N Op |
| **NOTES** | | | | | | |
| List and rate other federal, state, local and/or accreditation standards/regulations that may apply: | | | | | | |
| | 1 | 2 | 3 | 4 | | N Op |
| **NOTES** | | | | | | |

## Equipment and Furnishings — Indoors and Outdoors

| | | | | | | |
|---|---|---|---|---|---|---|
| 14. There is fresh air provided by windows or a ventilation system. There are no odors or fumes (for example, mold, urine, excrement, air fresheners, chemicals, pesticides.) (Stds. 5.2.1.1, 3.3.0.1, 5.2.8.1) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |
| 15. Windows accessible to children open less than 4 inches or have window guards so that children cannot climb out. (Std. 5.1.3.2) | 1 | 2 | 3 | 4 | NA | |
| **NOTES** | | | | | | |
| 16. There are no unvented gas or oil heaters or portable kerosene space heaters. (Std. 5.2.1.10) | 1 | | | 4 | | |
| **NOTES** | | | | | | |
| 17. Gas cooking appliances are not used for heating purposes. Charcoal grills are not used indoors. (Std. 5.2.1.10) | 1 | | | 4 | NA | |
| **NOTES** | | | | | | |
| 18. Portable electric space heaters are not used with an extension cord and are not left on when unattended. They are placed on the floor at least three feet from curtains, papers, furniture and/or any flammable object and are out of children's reach. (Std. 5.2.1.11) | 1 | 2 | 3 | 4 | NA | N Op |
| **NOTES** | | | | | | |
| 19. All electrical outlets within children's reach are tamper resistant or have safety covers attached by a screw or other means that cannot be removed by a child. (Std. 5.2.4.2) | 1 | 2 | 3 | 4 | NA | |
| **NOTES** | | | | | | |
| 20. All cords from electrical devices or appliances are out of children's reach. (Stds. 4.5.0.9, 5.2.4.4) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |
| | | | | | | |

| | Never | Sometimes | Usually | Always | Not Applicable | No Opportunity |
|---|---|---|---|---|---|---|
| 21. *There are no firearms, pellet or BB guns, darts, bows and arrows, cap pistols, stun guns, paint ball guns or objects manufactured for play as toy guns visible. (Std. 5.5.0.8) | 1 | | | 4 | | |
| **NOTES** | | | | | | |
| 22. Plastic bags, matches, candles and lighters are stored out of children's reach. (Stds. 5.5.0.7, 5.5.0.6) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |
| 23. There are no latex balloons (inflated, underinflated, or not inflated) or inflated objects that are treated as balloons, (for example, inflated latex gloves) on site. (Stds. 6.4.1.5, 6.4.1.2) | 1 | | | 4 | | |
| **NOTES** | | | | | | |
| 24. Bathtubs, buckets, diaper pails and other open containers of water are emptied immediately after use. (Std. 6.3.5.2) | 1 | 2 | 3 | 4 | NA | |
| **NOTES** | | | | | | |
| 25. Children do not play in areas where there is a body of water unless a caregiver/teacher is within an arm's length providing "touch supervision". Bodies of water include tubs, pails, sinks, toilets, swimming pools, ponds, irrigation ditches, and built-in wading pools. (Std. 2.2.0.4) | 1 | | | 4 | NA | N Op |
| **NOTES** | | | | | | |
| 26. Hot liquids and food (more than 120°F) are kept out of children's reach. Adults do not consume hot liquids in child care areas. (Std. 4.5.0.9) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |
| 27. Equipment and play areas (including water play areas) do not have sharp points or corners, splinters, glass, protrusions that may catch a child's clothing (for example, nails, pipes, wood ends, long bolts) flaking paint, loose or rusty parts, small parts that may become detached or present a choking, aspiration, or ingestion hazard, strangulation hazards (for example, straps or strings), or components that can snag skin, pinch, sheer, or crush body tissues. (Stds. 5.3.1.1, 6.2.1.9, 6.3.1.1) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |
| 28. All openings in play or other equipment are smaller than 3.5 inches or larger than 9 inches. There are no rings on long chains. (Stds. 6.2.1.9, 5.3.1.1) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |
| 29. All openings in play or other equipment are smaller than 3/8 of an inch or larger than 1 inch. (Std. 6.2.1.9) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |
| 30. Climbing equipment is placed over and surrounded by a shock-absorbing surface. Loose fill materials (for example, sand, wood chips) are raked to maintain proper depth/distribution. Unitary shock-absorbing surfaces meet current ASTM International standards and/or CPSC Standards. http://www.astm.org/Standards/F2223.htm, http://www.cpsc.gov//PageFiles/122149/325.pdf (Std. 6.2.3.1, Appendix Z) | 1 | 2 | 3 | 4 | NA | N Op |
| **NOTES** | | | | | | |
| 31. Fall zones extend at least 6 feet beyond the perimeter of stationary climbing equipment. (Std. 6.2.3.1) | 1 | 2 | 3 | 4 | NA | N Op |
| **NOTES** | | | | | | |
| 32. Equipment and furnishings are sturdy and in good repair. There are no tip-over or tripping hazards. (Std. 5.3.1.1) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |

## Equipment and Furnishings — Indoors and Outdoors — *Continued*

| | Never | Sometimes | Usually | Always | Not Applicable | No Opportunity |
|---|---|---|---|---|---|---|
| 33. There is no hazardous equipment (for example, broken equipment, lawn mowers, tools, tractors, trampolines) accessible to children. (Std. 5.7.0.4, 6.2.4.4) | 1 ○ | | | 4 ○ | | |
| **NOTES** | | | | | | |
| 34. Open sides of stairs, ramps, porches, balconies and other walking surfaces, with more than 30 inches to fall, have guardrails or protective barriers. The guardrails are at least 36 inches high. (Std. 5.1.6.6) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | |
| **NOTES** | | | | | | |
| 35. Children one year of age and older wear helmets when riding toys with wheels (for example, tricycles, bikes) or using any wheeled equipment (for example, rollerblades, skateboards). Helmets fit properly and meet CPSC standards. Children take off helmets after riding or using wheeled toys or equipment. (Std. 6.4.2.2) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | N Op ○ |
| **NOTES** | | | | | | |

## Equipment and Furnishings — Outdoors Only

| | | | | | | |
|---|---|---|---|---|---|---|
| 36. Children play outdoors each day. Children stay inside only if weather poses a health risk (for example, wind chill factor at or below minus 15°F, heat index at or above 90°F). (Std. 3.1.3.2) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | N Op ○ |
| **NOTES** | | | | | | |
| 37. Outdoor play areas are enclosed with a fence or natural barriers that allow caregivers/teachers to see children. Openings in fences and gates are no larger than 3.5 inches. (Std. 6.1.0.8) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | N Op ○ |
| **NOTES** | | | | | | |
| 38. Enclosures outside have at least two exits, one being remote from the building. (Std. 6.1.0.8) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | N Op ○ |
| **NOTES** | | | | | | |
| 39. Each gate has a latch that cannot be opened by children. Outdoor exit gates are equipped with self-closing, positive latching closure mechanisms that cannot be opened by children. (Std. 6.1.0.8) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | N Op ○ |
| **NOTES** | | | | | | |
| 40. Shade is provided outside (for example, trees, tarps, umbrellas). Children wear hats or caps with a brim to protect their faces from the sun if they are not in a shaded area. (Std. 3.4.5.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | N Op ○ |
| **NOTES** | | | | | | |
| 41. Broad spectrum sun screen with SPF of 15 or higher is available for use. (Std. 3.4.5.1) | 1 ○ | | | 4 ○ | | |
| **NOTES** | | | | | | |
| List and rate other federal, state, local and/or accreditation standards/regulations that may apply: | | | | | | |
| | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | N Op ○ |
| **NOTES** | | | | | | |

## SUPERVISION, INTERACTION and ACTIVITY

Interaction and Physical Activity

| Age | Maximum Child: Staff Ratio | Maximum Group Size |
|---|---|---|
| ≤12 months | 3:1 | 6 |
| 13-35 months | 4:1 | 8 |
| 3-year-olds | 7:1 | 14 |
| 4-year-olds | 8:1 | 16 |
| 5-year-olds | 8:1 | 16 |

| | Never | Sometimes | Usually | Always | Not Applicable | No Opportunity |
|---|---|---|---|---|---|---|
| 42. Ratios: Indoors: Time (hour/min): ____ /____<br>Ages of children observed: (check all that apply)<br>☐12 months ☐years ☐years ☐years ☐5+ years<br># of children ____ # of staff ____ child/staff ratio: ____:____ (Std. 1.1.1.2)<br>For Family Child Care Programs, see CFOC3 Stds. 1.1.1.1, 1.1.1.2 | 1 ○ | | | 4 ○ | | |
| **NOTES** | | | | | | |
| 43. Ratios: Outdoors: Time (hour/min): ____ /____<br>Ages of children observed: (check all that apply)<br>☐12 months ☐years ☐years ☐years ☐5+ years<br># of children ____ # of staff ____ child/staff ratio: ____:____ (Std. 1.1.1.2)<br>For Family Child Care Programs, see CFOC3 Stds. 1.1.1.1, 1.1.1.2 | 1 ○ | | | 4 ○ | | N Op ○ |
| **NOTES** | | | | | | |
| 44. Caregivers/Teachers directly supervise children by sight and hearing at all times. This includes indoors, outdoors and when children are sleeping, going to sleep or waking up. (Std. 2.2.0.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 45. Caregivers/Teachers encourage positive behavior and guide children to develop self-control. Caregivers/Teachers model desired behavior. "Time out" is only used for persistent, unacceptable behavior. (Std. 2.2.0.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 46. Caregivers/Teachers support children to learn appropriate social skills and emotional responses. There are daily routines and schedules. (Std. 2.2.0.6) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 47. There is no physical or emotional abuse or maltreatment of a child. There is no physical punishment or threat of physical punishment of a child. (Std. 2.2.0.9) | 1 ○ | | | 4 ○ | | |
| **NOTES** | | | | | | |
| 48. Caregivers/Teachers do not use threats or humiliation (public or private). There is no profane or sarcastic language. There are no derogatory remarks made about a child or a child's family. (Std. 2.2.0.9) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 49. Children are not physically restrained unless their safety or that of others is at risk. (Std. 2.2.0.10) | 1 ○ | | | 4 ○ | | |
| **NOTES** | | | | | | |
| 50. Physical activity/outdoor time are not taken away as punishment. (Std. 2.2.0.9) | 1 ○ | | | 4 ○ | | |
| **NOTES** | | | | | | |
| 51. Children engage in moderate to vigorous physical activities such as running, climbing, dancing, skipping and jumping. All children (including infants) have opportunities to develop and practice gross motor and movement skills. (Std. 3.1.3.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |

Interaction and Physical Activity — *Continued*

| | Never | Sometimes | Usually | Always | Not Applicable | No Opportunity |
|---|---|---|---|---|---|---|
| 52. There are structured or adult-led physical activities and games that promote movement for children. (Std. 3.1.3.1) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |
| List and rate other federal, state, local and/or accreditation standards/regulations that may apply: | | | | | | |
| | 1 | 2 | 3 | 4 | | N Op |
| **NOTES** | | | | | | |

Nutrition: Eating and Drinking

| | | | | | | |
|---|---|---|---|---|---|---|
| 53. Individual children's food allergies are posted where they can be seen in the classroom and wherever food is served. (Std. 4.2.0.10) | 1 | 2 | 3 | 4 | NA | |
| **NOTES** | | | | | | |
| 54. Children two years of age and older are served skim or 1% milk. (Std. 4.9.0.3) | 1 | 2 | 3 | 4 | NA | N Op |
| **NOTES** | | | | | | |
| 55. Drinking water is available, indoors and outdoors, throughout the day for children over 6 months of age. (Std. 4.2.0.6) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |
| 56. A variety of nourishing foods is served at meals and snacks. Nourishing foods include fruits, vegetables, whole and enriched grains, protein and dairy. (Std. 4.2.0.3) | 1 | 2 | 3 | 4 | NA | N Op |
| **NOTES** | | | | | | |
| 57. Foods that are choking hazards are not served to children under 4 years of age. This includes hot dogs and other meat sticks (whole or sliced into rounds), raw carrot rounds, whole grapes, hard candy, nuts, seeds, raw peas, hard pretzels, chips, peanuts, popcorn, rice cakes, marshmallows, spoonfuls of peanut butter or chunks of meat larger than can be swallowed whole. (Std. 4.5.0.10) | 1 | | | 4 | | |
| **NOTES** | | | | | | |
| 58. Children are always seated while eating. (Std. 4.5.0.10) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |
| 59. Food is not used or withheld as a bribe, reward, or punishment. (Std.2.2.0.9) | 1 | | | 4 | | |
| **NOTES** | | | | | | |
| List and rate other federal, state, local and/or accreditation standards/regulations that may apply: | | | | | | |
| | 1 | 2 | 3 | 4 | | N Op |
| **NOTES** | | | | | | |

## SANITATION: Personal Hygiene, Environmental Health

Personal Hygiene — Handwashing

| | Never | Sometimes | Usually | Always | Not Applicable | No Opportunity |
|---|---|---|---|---|---|---|
| 60. Situations or times that children and staff should perform hand hygiene are posted in all food preparation, hand hygiene, diapering, and toileting areas. (Std.3.2.2.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 61. Handwashing Procedures — *Staff*<br>– Moisten hands with water and apply soap (not antibacterial).<br>– Rub hands together into a soapy lather for 20 seconds.<br>– All hand surfaces are washed including fronts and backs and between fingers from wrists to finger tips.<br>– Hands are rinsed with running water and dried with a paper or single use cloth towel. (Std. 3.2.2.2) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 62. Handwashing Procedures — *Children*<br>Children wash their hands or have their hands washed.<br>– Moisten hands with water and apply soap (not antibacterial).<br>– Rub hands together into a soapy lather for 10 to 20 seconds.<br>– All hand surfaces are washed including fronts and backs and between fingers from wrists to finger tips.<br>– Hands are rinsed with running water and dried with a paper or single use cloth towel. (Std. 3.2.2.2) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 63. Caregivers/Teachers help children wash their hands when children can stand but cannot wash their hands by themselves. Children's hands hang freely under the running water either at a child level sink or at a sink with a safety step. (Std. 3.2.2.3) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 64. Adults and children only use alcohol-based sanitizers as an alternative to handwashing with soap and water, if hands are not visibly soiled. Hand sanitizers are only used for children over 24 months with adult supervision. (Stds. 3.2.2.2, 3.2.2.3) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | N Op ○ |
| **NOTES** | | | | | | |

## Personal Hygiene — Toothbrushing

| | Never | Sometimes | Usually | Always | Not Applicable | No Opportunity |
|---|---|---|---|---|---|---|
| 65. When toothbrushes are present, they are not worn or frayed. Fluoride toothpaste is present. (Std. 3.1.5.1) | 1 | 2 | 3 | 4 | NA | |
| **NOTES** | | | | | | |
| 66. *Except in the case of children who are known to brush their teeth twice a day at home, caregivers/ teachers brush children's teeth or monitor tooth brushing activities at least once during the hours that the child is in child care. (Std. 3.1.5.1) | 1 | 2 | 3 | 4 | NA | N Op |
| **NOTES** | | | | | | |

## Food Safety/Food Handling

| | | | | | | |
|---|---|---|---|---|---|---|
| 67. The food preparation area of the kitchen is separate from eating, play, laundry, toilet, bathroom, and diapering areas. No animals are allowed in the food preparation area. (Std. 4.8.0.1) | 1 | 2 | 3 | 4 | NA | |
| **NOTES** | | | | | | |
| 68. The food preparation area is separated from child care areas by a door, gate, counter, or room divider. (Std. 4.8.0.1) | 1 | | | 4 | NA | |
| **NOTES** | | | | | | |
| 69. There is no home-canned food or food in cans without labels. Food from dented, rusted, bulging or leaking cans is not used. (Std. 4.9.0.3) | 1 | 2 | 3 | 4 | NA | |
| **NOTES** | | | | | | |
| 70. Meat, fish, poultry, milk, and egg products are refrigerated or frozen before use. Refrigerators have a thermometer and are kept at 41°F or lower. (Std. 4.9.0.3) | 1 | 2 | 3 | 4 | NA | |
| **NOTES** | | | | | | |
| 71. Meat product labels state they are from government-inspected sources and/or dairy product labels state that they are pasteurized. (Std. 4.9.0.3) | 1 | 2 | 3 | 4 | NA | N Op |
| **NOTES** | | | | | | |
| 72. All fruits and vegetables are washed thoroughly with water prior to use. (Std. 4.9.0.3) | 1 | 2 | 3 | 4 | NA | N Op |
| **NOTES** | | | | | | |
| 73. Store bought fruit juice labels state the juice is pasteurized. Fruit and vegetable juices squeezed on-site are squeezed just prior to serving. (Std. 4.9.0.3) | 1 | 2 | 3 | 4 | NA | |
| **NOTES** | | | | | | |
| 74. Food surfaces (for example, dishes, utensils, dining tables, high chair trays, cutting boards) and/or objects intended for the mouth (for example, pacifiers and teething toys) are sanitized. A dishwasher is used or an EPA registered sanitizer is used according to label instructions for sanitizing. (Std. 3.3.0.1) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |

| | Never | Sometimes | Usually | Always | Not Applicable | No Opportunity |
|---|---|---|---|---|---|---|
| 75. Kitchen equipment is clean and in working order. Food surfaces are in good repair and free of cracks and crevices. Food surfaces are made of non-porous, smooth material and are kept clean and sanitized. (Std. 4.8.0.3) | 1 | 2 | 3 | 4 | NA | N Op |
| **NOTES** | | | | | | |
| 76. There are no cracks or holes in walls, ceilings, floors or screens. (Std. 5.2.8.1) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |
| 77. There is no clutter, trash, water damage, standing water or leaking pipes. Pest breeding areas are not on site. (Std. 5.2.8.1) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |
| 78. Objects and surfaces are kept clean of dirt, debris and sticky films. (Std. 3.3.0.1) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |
| 79. Hard, non-porous surfaces soiled with potentially infectious body fluid (for example, toilets, diaper changing tables, blood spills) are disinfected. An EPA registered disinfectant is used according to label instructions. (Std. 3.3.0.1) | 1 | 2 | 3 | 4 | | N Op |
| **NOTES** | | | | | | |
| 80. There are disposable gloves available for handling blood and blood containing body fluids. (Std. 3.2.3.4) | 1 | | | 4 | | |
| **NOTES** | | | | | | |
| 81. *Infectious waste (for example soiled diapers, blood) and toxic waste (for example, used batteries, fluorescent light bulbs) are stored separately from other waste. (Stds. 5.2.7.6, 5.2.9.1) | 1 | 2 | 3 | 4 | | N Op |
| **NOTES** | | | | | | |
| 82. Sanitizing and disinfecting are not done when children are nearby. (Std. 3.3.0.1) | 1 | 2 | 3 | 4 | | N Op |
| **NOTES** | | | | | | |
| 83.*Pesticides are not applied when children are present. (Std. 5.2.8.1) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |
| 84. *Toxic substances are stored in the original, labeled containers. Material Safety Data Sheets (MSDS) are on site for each toxic substance/chemical. (Std. 5.2.9.1) | 1 | 2 | 3 | 4 | NA | N Op |
| **NOTES** | | | | | | |
| 85. *Toxic substances are inaccessible to children and in a locked room or cabinet. Bleach solutions are labeled with contents and date mixed. (Stds. 5.2.9.1, 5.2.8.1, 3.2.3.4, Appendix J) | 1 | 2 | 3 | 4 | | |
| **NOTES** | | | | | | |
| List and rate other federal, state, local and/or accreditation standards/regulations that may apply: | | | | | | |
| | 1 | 2 | 3 | 4 | | N Op |
| **NOTES** | | | | | | |

## POOLS, SPAS and HOT TUBS

Does this program have a pool, spa or hot tub or other water hazard?
Yes: ◯ If yes, complete the items below. No: ◯ If no, go to the Infants and Toddlers Section.
This facility has the following water hazards: (check all that apply)
☐ Swimming Pool ☐ Hot Tub ☐ Stationary Wading Pool ☐ Pond ☐ Other_____

| Developmental Levels | Child: Staff Ratios |
|---|---|
| Infants | 1:1 |
| Toddlers | 1:1 |
| Preschoolers | 4:1 |
| School-age Children | 6:1 |

| | Never | Sometimes | Usually | Always | Not Applicable | No Opportunity |
|---|---|---|---|---|---|---|
| 86. Ratios: Ages of children observed: (check all that apply)<br>☐ ≤12 months ☐ 1 year ☐ 2 years ☐ 3 years ☐ 4 years ☐ 5+ years<br>Location_____ Time of Day (hour/min): ____ /____<br># of children ____ # of staff ____ child/staff ratio: ____:____ (Std. 1.1.1.5) | 1 ◯ | | | 4 ◯ | | N Op ◯ |
| **NOTES** | | | | | | |
| 87. All outdoor water hazards are enclosed with a fence at least 4-6 feet high that comes within 3½ inches from the ground. Exits and entrances around bodies of water have self-closing, positive latching gates or doors. The locking devices are a minimum of 55 inches from the ground or floor. (Stds. 6.1.0.6, 6.3.1.1) | 1 ◯ | 2 ◯ | 3 ◯ | 4 ◯ | | N Op ◯ |
| **NOTES** | | | | | | |
| 88. When not in use, in-ground and above-ground swimming pools, spas, hot tubs or wading pools are covered with a safety cover. The cover meets the ASTM International standards. (Std. 6.3.1.4) | 1 ◯ | | | 4 ◯ | NA ◯ | N Op ◯ |
| **NOTES** | | | | | | |
| List and rate other federal, state, local and/or accreditation standards/regulations that may apply: | | | | | | |
| | 1 ◯ | 2 ◯ | 3 ◯ | 4 ◯ | | N Op ◯ |
| **NOTES** | | | | | | |

## INFANTS and TODDLERS: Personal Relationships, Diapering, Injury Prevention

Are there children under 36 months of age in this program?
Yes: ◯ If yes, complete the items below. No: ◯ If no, you have completed the Checklist.

### Infants and Toddlers — Personal Relationships

| | | | | | | |
|---|---|---|---|---|---|---|
| 89. Caregivers/Teachers smile, talk, touch, hold, sing and/or play with children during daily routines, such as diapering, feeding and eating. (Std. 2.1.2.1) | 1 ◯ | 2 ◯ | 3 ◯ | 4 ◯ | | |
| **NOTES** | | | | | | |
| 90. Caregivers/Teachers comfort children who are upset. Caregivers/Teachers are aware of and respond to children's feelings. (Std. 2.1.2.1) | 1 ◯ | 2 ◯ | 3 ◯ | 4 ◯ | | |
| **NOTES** | | | | | | |

## Infants and Toddlers — Diapering

| | Never | Sometimes | Usually | Always | Not Applicable | No Opportunity |
|---|---|---|---|---|---|---|
| 91. Caregivers/Teachers follow diaper changing procedures below:<br>– Caregiver/Teacher has one hand on the child at all times.<br>– Non-absorbent paper liner, large enough to cover the changing surface from the child's shoulders to beyond the child's feet, is used.<br>– Clothing is removed or otherwise kept from contact with the contents of the diaper during the change.<br>– Child is cleaned of stool and urine, front to back, with a fresh wipe for each swipe.<br>– Soiled diapers placed in a plastic-lined, covered, hands-free can.<br>– If reusable cloth diapers are used, soiled diaper is put in a plastic bag or into a plastic-lined, hands-free covered can.<br>– A fresh wipe is used to clean the hands of the caregiver and another fresh wipe to clean the hands of the child before putting on a new diaper and dressing the child.<br>– The child's hands are washed according to the procedure in item #62 before returning the child to a supervised area.<br>– Diaper changing surface is cleaned and disinfected with an EPA registered disinfectant after each diaper change.<br>– Disinfectant is put away, out of children's reach.<br>– Caregivers'/Teachers' hands are washed after diapering procedure is complete according to the procedure in item #61. (Stds. 3.2.1.4, 3.2.3.4) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | N Op ○ |
| **NOTES** | | | | | | |
| 92. Current diaper changing procedures as listed in item #91 are posted in the diaper changing area(s). (Std. 3.2.1.4) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | N Op ○ |
| **NOTES** | | | | | | |

## Infants and/or Toddlers — Injury Prevention

| | | | | | | |
|---|---|---|---|---|---|---|
| 93. Strings, cords, ribbons, ties and straps long enough to encircle a child's neck are out of children's reach. (Std. 3.4.6.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 94. The following are not within children's reach: small objects, toys, and toy parts that have a diameter less than 1¼ inch and a length between 1 inch and 2¼ inches; balls and toys with spherical, egg shaped, or elliptical parts that are smaller than 1¾ inches in diameter; toys with sharp points and edges; plastic bags; Styrofoam® objects; coins; rubber or latex balloons; safety pins; marbles; magnets; foam blocks, books, or objects; latex gloves; bulletin board tacks or glitter. (Std. 6.4.1.2) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 95. Securely installed, guards (for example, gates) are at the top and bottom of each open stairway where infants and toddlers are in care. (Std. 5.1.5.4) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | |
| **NOTES** | | | | | | |
| 96. Children over 12 months of age who can feed themselves are actively supervised by a caregiver/teacher. The caregiver/teacher is within arm's reach of the child's high chair or feeding table or is seated at the same table. (Std. 4.5.0.6) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | |
| **NOTES** | | | | | | |
| 97. Foods that are choking hazards are not served to toddlers. Food for toddlers is served in pieces ½ inches or smaller. (Std. 4.5.0.10) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | |
| **NOTES** | | | | | | |

| | Never | Sometimes | Usually | Always | Not Applicable | No Opportunity |
|---|---|---|---|---|---|---|
| List and rate other federal, state, local and/or accreditation standards/regulations that may apply: | | | | | | |
| | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | N Op ○ |
| **NOTES** | | | | | | |

## INFANTS ONLY: Activity, Sleep, Safety, Nutrition

Are there infants under 12 months of age in this program?
Yes: ○ If yes, complete items below No: ○ If no, you have completed the Checklist.

Infants Only — Activity, Sleep, Safety

| | | | | | | |
|---|---|---|---|---|---|---|
| 98. Sunscreen is not applied to infants 6 months of age or younger. Infants less than 6 months of age are not in direct sunlight. (Std. 3.4.5.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | N Op ○ |
| **NOTES** | | | | | | |
| 99. Infants have supervised tummy time while awake at least once each day. (Std. 3.1.3.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | N Op ○ |
| **NOTES** | | | | | | |
| 100. Infants are not seated more than 15 minutes at a time except during meals. (Std. 3.1.3.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 101. All infants are placed to sleep on their backs, in a crib, on a firm mattress, with a tightly fitting sheet. Only one infant is placed in each crib. (Std. 3.1.4.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | N Op ○ |
| **NOTES** | | | | | | |
| 102. Soft or loose bedding and other objects are kept away from sleeping infants and are not in safe sleep environments (for example, not in cribs). This includes bumpers, pillows, positioners, blankets, quilts, bibs, diapers, flat sheets, sheepskins, toys and stuffed animals. One-piece blanket sleepers may be used for warmth. (Std. 3.1.4.1) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 103. The room temperature where infants sleep is comfortable for a lightly clothed adult. (Std. 3.1.4.1) | 1 ○ | | | 4 ○ | | |
| **NOTES** | | | | | | |
| 104. Infants who fall asleep any place that is not a crib are moved and placed to sleep on their backs in a crib. Examples of places where infants may not be left to sleep are car seats, high chairs, swings, infant seats, beanbag chairs, and futons. (Std. 3.1.4.1) | 1 ○ | | | 4 ○ | | N Op ○ |
| **NOTES** | | | | | | |
| 105. *Cribs meet the current guidelines approved by CPSC and ASTM International standards. Crib slats are spaced no more than 2 3/8 inches apart. The crib has a firm mattress that is fitted so that no more than two fingers can fit between the mattress and the crib side in the lowest position. Cribs with drop sides are not used. Cribs are placed away from window blinds or draperies. (Std. 5.4.5.2) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | |
| **NOTES** | | | | | | |
| 106. Infants mobile enough to potentially climb out of a crib sleep on cots or mats. (Std. 5.4.5.2) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | N Op ○ |
| **NOTES** | | | | | | |

| | Never | Sometimes | Usually | Always | Not Applicable | No Opportunity |
|---|---|---|---|---|---|---|
| 107. Bottles or containers with mother's milk are labeled with the infant's full name, date and time the milk was expressed. Mother's milk is stored in the refrigerator or freezer. (Std. 4.3.1.3) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | |
| **NOTES** | | | | | | |
| 108. Bottles of formula prepared from powder or concentrate or ready-to-feed formula are labeled with the child's full name and the time and date of preparation. (Std. 4.3.1.5) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | NA ○ | |
| **NOTES** | | | | | | |
| 109. If caregivers/teachers warm bottles and infant foods, bottles are warmed under running warm tap water or by placing in a container of water no warmer than 120°F. Bottles and infant foods are not thawed or warmed in microwave ovens. The temperature of warmed milk does not exceed 98.6 F. (Stds. 4.3.1.3, 4.3.1.9) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | |
| **NOTES** | | | | | | |
| 110. Infants are not fed solid foods sooner than 4 months (preferably 6 months). Introductory foods are single ingredient. (Std. 4.3.1.11) | 1 ○ | | | 4 ○ | NA ○ | N Op ○ |
| **NOTES** | | | | | | |
| 111. Infants who are learning to feed themselves are actively supervised by a caregiver/teacher. Infants are seated within arm's reach of caregiver/teacher at all times while being fed or eating. (Std. 4.5.0.6) | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | N Op ○ |
| **NOTES** | | | | | | |
| 112. Foods that are choking hazards are not served to infants. Food for infants is served in pieces ¼ inch or smaller. (Std. 4.5.0.10) | 1 ○ | | | 4 ○ | | N Op ○ |
| **NOTES** | | | | | | |
| List and rate other federal, state, local and/or accreditation standards/regulations that may apply: | | | | | | |
| | 1 ○ | 2 ○ | 3 ○ | 4 ○ | | N Op ○ |
| **NOTES** | | | | | | |

# Incident Report Form

Fill in all blanks and boxes that apply.

Name of Program: _____ Date of Incident: __/__/__

Address of program: _____

Child's Name: _____ Sex: M F Birthdate: __/__/__

Time of Incident: _____ am/pm Witnesses: _____

Details of Incident:
_____
_____
_____
_____

Location where incident occurred:

___ Playground ___ Classroom ___ Bathroom ___ Hallway

___ Kitchen ___ Doorway ___ Large muscle room or gym

___ Unknown ___ Other (specify) _____

Injury received, or severe illness that occurred: _____

Type of injury or illness: _____

First aid or care provided by: _____

Further treatment provided by: _____

EMS (911) or other medical professional notified? _____ If so, time notified: _____ am/pm

Parent of guardian notified? _____ If so, time notified: _____ am/pm

Number of days of limited activity from this incident: ____ Follow-up plan for care for the child:
_____

Corrective action needed to prevent reoccurrence:
_____
_____

Signature of staff member: _____ Date: _____

# *Let's Move!* Child Care Checklist Quiz

The *Let's Move!* Child Care best practices are listed on the left. Please check the box under the statement that best describes your current situation.

| Best Practices | Yes, fully meeting this best practice | Making progress on meeting this best practice | Ready to get started on meeting this best practice | Unable to work on meeting this best practice right now |
|---|---|---|---|---|
| **Answer if you serve TODDLERS or PRESCHOOLERS** | | | | |
| Drinking water is visible and available inside and outside for self-serve | ☐ | ☐ | ☐ | ☐ |
| 100% fruit juice is limited to no more than 4-6 oz. per day per child and parents are encouraged to support this limit | ☐ | ☐ | ☐ | ☐ |
| Sugary drinks, including fruit drinks, sports drinks, sweet tea, and soda, are never offered | ☐ | ☐ | ☐ | ☐ |
| Children 2 years and older are served only 1% or skim/non-fat milk (unless otherwise directed by the child's health provider) | ☐ | ☐ | ☐ | ☐ |
| Fruit (not juice) and/or a vegetable is served to toddlers and preschoolers at every meal<br><br>(French fries, tator tots, and hash browns don't count as vegetables) | ☐ | ☐ | ☐ | ☐ |
| French fries, tator tots, hash browns, potato chips, or other fried or pre-fried potatoes are offered to toddlers and preschoolers no more than once a month<br><br>(Baked fries are okay) | ☐ | ☐ | ☐ | ☐ |
| Chicken nuggets, fish sticks, and other fried or pre-fried forms of frozen and breaded meats or fish are offered to toddlers and preschoolers no more than once a month | ☐ | ☐ | ☐ | ☐ |
| **Answer if you serve PRESCHOOLERS** | | | | |
| All meals to preschoolers are served family style so that children are encouraged to serve themselves with limited help | ☐ | ☐ | ☐ | ☐ |

| Best Practices | Yes, fully meeting this best practice | Making progress on meeting this best practice | Ready to get started on meeting this best practice | Unable to work on meeting this best practice right now |
|---|---|---|---|---|
| **Answer if you serve PRESCHOOLERS** | | | | |
| Preschoolers, including children with special needs, are provided with 120 minutes or more of active play time every day, both indoor and outdoor<br><br>(for half-day programs, 60 minutes or more is provided for active play every day) | ☐ | ☐ | ☐ | ☐ |
| We strive to limit total screen time (e.g., TV and DVD viewing, computer use) to no more than 30 minutes for preschoolers at child care per week or never, and we work with parents/caregivers to ensure that children have no more than 1-2 hours per day<br><br>(for half-day programs, we strive to limit total screen time to no more than 15 minutes per week or never) | ☐ | ☐ | ☐ | ☐ |
| Parents of preschoolers are provided screen time reduction and/or media literacy education such as special programs, newsletters, or information sheets, 2 or more times per year | ☐ | ☐ | ☐ | ☐ |
| **Answer if you serve TODDLERS** | | | | |
| Toddlers, including children with special needs, are provided with 60-90 minutes or more of active play time every day, both indoor and outdoor<br>(for half-day programs, 30 minutes or more is provided for active play every day) | ☐ | ☐ | ☐ | ☐ |
| **Answer if you serve INFANTS or TODDLERS** | | | | |
| Screen time for toddlers and infants is limited to no more than 3-4 times per year or is never allowed | ☐ | ☐ | ☐ | ☐ |
| **Answer if you serve INFANTS** | | | | |
| Breastfeeding mothers are provided access to a private room for breastfeeding or pumping, other than a bathroom, with appropriate seating and privacy | ☐ | ☐ | ☐ | ☐ |
| Short supervised periods of tummy time are provided for all infants, including those with special needs several times each day | ☐ | ☐ | ☐ | ☐ |

# Medication Administration Packet

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

## CHILD'S INFORMATION

_____ ____/____/____
Name of Facility/School Today's Date

_____ ____/____/____
Name of Child (First and Last) Date of Birth

Name of Medicine _____

Reason medicine is needed during school hours _____

Dose _____ Route _____

Time to give medicine _____

Additional instructions _____

Date to start medicine _____/_____/_____ Stop date _____/_____/_____

Known side effects of medicine _____

Plan of management of side effects _____

Child allergies _____

## PRESCRIBER'S INFORMATION

_____
Prescribing Health Professional's Name

_____
Phone Number

## PERMISSION TO GIVE MEDICINE

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

_____
Parent or Guardian Name (Print)

_____
Parent or Guardian Signature

_____
Address

_____
Home Phone Number Work Phone Number Cell Phone Number

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

# Receiving Medication

**PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER**

Name of child _____

Name of medicine _____

Date medicine was received _____/_____/_____

**Safety Check**

☐ 1. Child-resistant container.

☐ 2. Original prescription or manufacturer's label with the name and strength of the medicine.

☐ 3. Name of child on container is correct (first and last names).

☐ 4. Current date on prescription/expiration label covers period when medicine is to be given.

☐ 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.

☐ 6. Copy of Child Health Record is on file.

☐ 7. Instructions are clear for dose, route, and time to give medicine.

☐ 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.

☐ 9. Child has had a previous trial dose.

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

_____

Caregiver/Teacher Name (Print)

_____

Caregiver/Teacher Signature

# Medication Log

**PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER**

Name of child _____ Weight of child_____

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

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

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

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

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

# Medication Incident Report

Date of report _____ School/center _____

Name of person completing this report _____

Signature of person completing this report _____

Child's name _____

Date of birth _____ Classroom/grade _____

Date incident occurred _____ Time noted _____

Person administering medication _____

Prescribing health care provider _____

Name of medication _____

Dose _____ Scheduled time _____

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

_____

_____

_____

Action taken/intervention _____

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

Name of the parent/guardian that was notified _____

Follow-up and outcome _____

Administrator's signature _____

Adapted with permission from Healthy Child Care Colorado.

## Permission to Apply Sunscreen to Child

(Name of Child) _____

As the parent of the above child, I recognize that too much sunlight may cause sunburn and increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at: (Child Care Program name) _____ to apply sunscreen of SPF-30 or higher to my child before going outdoors.

I understand the sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose and bare shoulders, arms, and legs.

I have checked applicable information regarding the type and use of sunscreen for my child:

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

___ Staff may use the sunscreen of their choice following the directions or recommendations printed on the bottle.

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

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

Parent's full name (print): _____

Parent's signature: _____

Date: _____

## Permission to Apply Sunscreen to Child

(Name of Child) _____

As the parent of the above child, I recognize that too much sunlight may cause sunburn and increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at: (Child Care Program name) _____ to apply sunscreen of SPF-30 or higher to my child before going outdoors.

I understand the sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose and bare shoulders, arms, and legs.

I have checked applicable information regarding the type and use of sunscreen for my child:

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

___ Staff may use the sunscreen of their choice following the directions or recommendations printed on the bottle.

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

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

Parent's full name (print): _____

Parent's signature: _____

Date: _____

# Permission to Photograph

I, _____, give permission for _____ to
(Parent or Guardian name) (Child Care Provider)

photograph my child, _____, for the following purposes:
(Child's name)

| Type of Use: | (Please check one) Grant Permission | Decline Permission |
|---|---|---|
| **Still Photographs:** | | |
| Display in my personal scrapbook | ☐ | ☐ |
| Give photographs possibly containing your child to current clients | ☐ | ☐ |
| Display in facility's scrapbook or bulletin boards, shown to current and prospective clients | ☐ | ☐ |
| Display still photos on child care website* | ☐ | ☐ |
| Post photos on child care's Facebook page | ☐ | ☐ |
| Other: | ☐ | ☐ |
| **Videos:** | | |
| Give video to current parents | ☐ | ☐ |
| YouTube™ promotional video | ☐ | ☐ |
| Other: | ☐ | ☐ |
| **Other (please list):** | | |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |

*Only first names and possibly last initials (in the event of two or more children with the same first name) will be displayed on the facility website.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Signed:

_____ _____
(Parent or Guardian signature) (Date)

## Permission to Transport

I give permission for (name of program) _____

to transport (name of child) _____

for the purpose of _____

on the following dates _____

Parent name (Print): _____

Parent signature: _____

Date: _____

## Permission to Transport

I give permission for (name of program) _____

to transport (name of child) _____

for the purpose of _____

on the following dates _____

Parent name (Print): _____

Parent signature: _____

Date: _____

CALIFORNIA CHILDCARE HEALTH PROGRAM

Model Health & Safety Policies

# Safe Sleep Policy for Infants in Child Care Programs

All childcare providers at _____ [program name] will follow safe sleep recommendations for infants to reduce the risk of Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death (SUID), and the spread of contagious diseases:

1. Infants will always be put to sleep on their backs.
2. Infants will be placed on a firm mattress, with a fitted crib sheet, in a crib that meets the Consumer Product Safety Commission safety standards.
3. No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, positioning devices or extra bedding will be in the crib or draped over the side of the crib.
4. 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.
5. If additional warmth is needed, a one-piece blanket sleeper or sleep sack may be used.
6. The infant's head will remain uncovered for sleep. Bibs and hoods will be removed.
7. Sleeping infants will be actively observed by sight and sound.
8. Infants will not be allowed to sleep on a couch, chair cushion, bed, pillow, or in a car seat, swing or bouncy chair. If an infant falls asleep anyplace other than a crib, the infant will be moved to a crib right away.
9. An infant who arrives asleep in a car seat will be moved to a crib.
10. Infants will not share cribs, and cribs will be spaced 3 feet apart.
11. Infants may be offered a pacifier for sleep, if provided by the parent.
12. 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.
13. When able to roll back and forth from back to front, the infant will be put to sleep on his back and allowed to assume a preferred sleep position.
14. In the rare case of a medical condition requiring a sleep position other than on the back, the parent must provide a signed waiver from the infant's physician.
15. Our child care program is a smoke-free environment.
16. Our child care program supports breastfeeding.
17. Awake infants will have supervised "Tummy Time".

*This policy reflects the safe sleep research as of November, 2011.

Courtesy of the Back to Sleep Campaign, NICHD, NIH, DHHS

## Resources

Caring for Our Children, National Health and Safety Performance Standards, 3rd Edition.
http://nrckids.org/CFOC3/index.html

SIDS and Other Sleep Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment, Pediatrics, AAP Policy. http://pediatrics.aappublications.org/content/128/5/e1341.full

CCHP Tummy Time. http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/tummy_time_0209.pdf

Safe Sleep for Infants in Child Care Programs: Reducing the Risk of SIDS and SUID Health and Safety Note.
http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/SIDS_EN_1111.pdf

# SEIZURE ACTIVITY LOG

NOTE: This should be accompanied by a *Seizure Care Plan* established and on-file for this child.

Name of Child: _____ Room: _____

| DATE | TIME | CIRCUMSTANCES PRECEEDING (activity participating in) | DESCRIBE SEIZURE* | LENGTH OF SEIZURE | ACTIONS TAKEN BY STAFF | CHILD'S BEHAVIOR AFTER SEIZURE | STAFF INITIALS |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
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***What To Look For and Note Above:**

- *How did the seizure start? Did the seizure start in just one part of the body and then spread, or did it involve the whole body from the beginning?*
- *Was there smacking or licking of the lips? Eyelid fluttering? Picking or fumbling movements of the hands?*
- *Was the child able to respond to any outside stimulus* (for example, name called, gently shaking shoulder)*? Was the response normal/confused/no response?*
- *Were there stiff and/or jerking movements?*
- *Was the jaw clenched or the tongue bitten?*
- *Was there any color change or breathing problem?*
- *How long did the actual seizure last?*

# Seizure Care Plan

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

Name of Child: _____ Date: _____

Facility Name: _____

**Description of seizure condition/disorder**: _____

_____

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

_____

_____

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

_____

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

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

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

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

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

_____

_____

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

**Planned strategies to support the child's needs and safety issues when the child has a seizure**:

(e.g., diapering/toileting, outdoor play, nap/sleeping, etc) _____

_____

_____

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

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

**Communication**

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

_____

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

Date and time specifics: _____

**Other Professionals Involved** **Telephone**

Health Care Provider (MD, NP, etc.): _____ _____

Occupational Therapist: _____ _____

Physical Therapist: _____ _____

Neurology Specialist: _____ _____

Other: _____ _____

**Specific Medical Information**

❖ Medical documentation provided & attached: ❑ Yes ❑ No

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

Any known allergies to food and/or medications: _____

❖ Medication to be administered: ❑ Yes ❑ No

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

**Special Staff Training Needs**

Type (be specific): _____

Training done by: _____ Date of Training: _____

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

_____

_____

_____

**Support Program the Child is Involved With Outside of Child Care**

Name of program: _____

Address and telephone: _____

Contact person: _____

**Emergency Procedures**

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

_____

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

❑ Other: _____

Emergency contact: _____ Telephone: _____

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**Follow-up: Updates/Revisions**

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

Date for revision and team meeting: _____

# Special Health Care Plan

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

**Name of Child:** _____ **Date:** _____

**Facility Name:** _____

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

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

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

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

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

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

**Communication**

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

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

Date and time specifics: _____

## Specific Medical Information

❖ Medical documentation provided and attached: ❑ Yes ❑ No

❑ **Information Exchange Form** completed by health care provider is in child,s file on site.

❖ Medication to be administered: ❑ Yes ❑ No

❑ **Medication Administration Form** completed by health care provider and parents are in child's file on site (including: type of medications, method, amount, time schedule, potential side effects, etc.)

Any known allergies to foods and/or medications: _____

Specific health-related needs: _____

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

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

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

## Special Staff Training Needs

Training monitored by: _____

1) Type (be specific): _____

Training done by: _____ Date of Training: _____

2) Type (be specific): _____

Training done by: _____ Date of Training: _____

3) Type (be specific): _____

Training done by: _____ Date of Training: _____

## Equipment/Positioning

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

Special equipment needed/to be used: _____

Positioning requirements (attach additional documentation as necessary): _____

Equipment care/maintenance notes: _____

## Nutrition and Feeding Needs

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

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

_____

_____

_____

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

_____

_____

_____

## Support Programs the Child Is Involved with Outside of Child Care

1. Name of program: _____ Contact person: _____
   Address and telephone: _____
   Frequency of attendance: _____

2. Name of program: _____ Contact person: _____
   Address and telephone: _____
   Frequency of attendance: _____

3. Name of program: _____ Contact person: _____
   Address and telephone: _____
   Frequency of attendance: _____

## Emergency Procedures

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

Emergency instructions: _____

_____

_____

Emergency contact: _____ Telephone: _____

## Follow-up: Updates/Revisions

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

Due date for revision and team meeting: _____

# Symptom Record

Child's Name _____ Date _____

**Symptoms:**
Circle or write in other symptoms:

runny nose sore throat cough vomiting diarrhea wheezing

trouble breathing stiff neck rash trouble urinating pain

itching trouble sleeping earache headache stomachache

**Other Symptoms**:
_____
_____

When did symptoms begin? _____

How long are the symptoms lasting? _____

How severe and how often are the symptoms? _____
_____

**Changes in the child's behavior**: _____
_____

Child's temperature: _____ Time taken: _____
Circle method used: armpit oral ear canal

Type and quantity of food and fluid the child ingested in the past 12 hours: _____
_____

Frequency of urine and bowel movement, in the past 12 hours? Any abnormalities?
_____
_____

Exposure to medications, animals, insects, soaps, new foods:
_____
_____

Exposure to other people with similar symptoms: Yes No Unsure

If yes, type of illness or symptoms: _____

Child's other conditions that might affect this illness (for example: asthma or diabetes)
_____
_____

Should child be excluded from child care? YES NO

If yes, when can child return to care? _____

Action taken and/or treatment given:
_____
_____

Time of action or treatment: _____

Name of person taking action or providing treatment: _____

Name and title of person completing this form: _____

Adapted from Model Child Care Health Policies, PA Chapter-American Academy of Pediatrics. 4th Ed.