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Caring for Our Children Basics Health and Safety Foundations for Early Care and Education



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Abbey Alkon, RN, Ph.D.
School of Nursing
University of California, San Francisco

Judy Collins
Consultant

Richard Fiene, Ph.D.
Research Institute for Key Indicators

Walter Gilliam, Ph.D.
Edward Zigler Center in Child Development
and Social Policy
Yale University Child Study Center

Barbara Hamilton, MA
Maternal and Child Health Bureau
Health Resources and Services
Administration
U.S. Department of Health and Human
Services

Pauline D. Koch
Koch Consulting

Marilyn Krajicek, Ed.D., RN, FAAN
National Resource Center for Health and
Safety in Child Care and Early Education
College of Nursing
University of Colorado Denver

Beverly Schmalzreid, Ph.D.
Department of Child Development
South Texas College

Danette Swanson Glassy, MD, FAAP
American Academy of Pediatrics

Nancy Von Barga, MS
Office of Child Care National Center for
Child Care Quality Improvement

Jeanne VanOrsdal, M. Ed.
Early Education and Child Care Initiatives
American Academy of Pediatrics

Marcus Williams
National Association for Regulatory
Administration

Introduction

Evidence continues to mount that demonstrates the profound influence children's earliest experiences have on later success. Nurturing and stimulating care given in the early years builds optimal brain architecture that allows children to maximize their potential for learning. Interventions in the first years of life are capable of altering the course of development and shift the odds for those at risk of poor outcomes toward more adaptive ones.

To meet the needs of our nation's most vulnerable children and families, the early care and education programs administered by the Administration for Children and Families (ACF) are designed to both provide enriching early childhood experiences that promote the long-term success of children and assist low-income working parents with the cost of child care. In partnership with families, all early care and education programs should support children's needs and age-appropriate progress across domains of language and literacy development; cognition and general knowledge; approaches to learning; physical health and well-being and motor development, and social and emotional development that will improve readiness for kindergarten. Head Start, Early Head Start, pre-Kindergarten, and child care programs aim to support the ability of parents, teachers, child care providers and other community members to interact positively with children in stable and stimulating environments to help create a sturdy foundation for later school achievement, economic productivity, and responsible citizenship.

ACF strives to achieve the following goals in all early childhood programs:

- Build successful Early Learning and Development Systems across Early Head Start, Head Start, child care, and pre-Kindergarten.
- Promote high quality and accountable early learning and development programs for all children.
- Ensure an effective early childhood workforce.
- Improve the physical, developmental, mental health, and social well-being of children in early learning and development settings.
- Promote family engagement and support in a child's development with the recognition that parents are their children's primary teachers and advocates.
- Build on the strengths and address the needs of culturally and linguistically diverse children and families.
- Improve the health and safety of early learning and development settings

While high quality early care and education settings can have significant developmental benefits and other positive long term effects for children well into their adult years, poor quality settings can result in unsafe environments that disregard children's basic physical and emotional needs leading to neglect, toxic stress, injury, or even death. As a result, it is not surprising that health and safety has been identified in multiple parent surveys as one of the most important factors to consider when evaluating child care options (Shlay, 2010). Health and

safety practices provide the foundation on which states and communities build quality early care and education settings.

Licensing of center-based care and family child care homes is a process that establishes the minimum requirements necessary to protect the health and safety of children in care. State licensing requirements are regulatory requirements, including registration or certification requirements, established under State law necessary for a provider to legally operate and provide child care services.

From 2009 to 2011, more than half of states made changes to licensing regulations for center-based care and family child care homes. For example, states increased the pre-service training requirements for center directors, and increased the number of ongoing training hours for all center staff roles, as well as family child care providers. Specifically, 47 States require center staff and 37 States require family child care providers to complete first aid training. With respect to CPR, 46 States require training of center staff and 36 require it of family child care providers. More than half of States require center staff to complete training on child abuse and neglect (27 States) or the prevention of communicable diseases (25 States). The number of States requiring fingerprint checks of federal records and checks of sex offender registries has increased since 2007. All States that license centers and more than 85% that license family child care homes have requirements about the nutritional content of meals and snacks served to children. States have added requirements about fences for outdoor space, transportation, and emergency preparedness, and more States prohibit firearms in child care centers (Office of Child Care National Center on Child Care Quality Improvement and National Association for Regulatory Administration, 2013).

Great progress has been made in States to safeguard children in out of home care, yet more work must be done to ensure children can learn, play, and grow in settings that are safe and secure. States vary widely in the number and content of health and safety standards as well as the means by which they monitor compliance. Some early care and education programs may receive no monitoring while others receive multiple visits. Further, some programs who receive funding from multiple sources may receive repeated monitoring visits that evaluate programs against complicated, and sometimes conflicting, standards. While there are differences in health and safety requirements by funding stream (e.g. Head Start, Child Care Development Fund, Individuals with Disabilities Education Act, and Title I), early childhood program type (e.g. center-based, family child care homes) and length of time in care, there are basic standards that must be in place to protect children no matter what type of variation in program. Until now, there has been no federal guidance that supports States in creating basic, consistent health and safety standards across early care and education settings.

ACF is pleased to announce *Caring for Our Children Basics: Health and Safety Foundations for Early Care and Education*. *Caring for our Children Basics* represents the **minimum** health and safety standards experts believe should be in place where children are cared for outside of their homes. *Caring for our Children Basics* seeks to reduce the conflicts and redundancy found in program standards linked to multiple funding streams. *Caring for our Children Basics* should not

be construed to represent all standards that should be present to achieve the highest quality of care and early learning. For example, the caregiver training requirements outlined in these standards are designed only to prevent harm to children, not to ensure their optimal development and learning.

Caring for our Children Basics is the result of work from both federal and non-federal experts and is founded on [*Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Early Care and Education Programs, Third Edition*](#), created by the American Academy of Pediatrics; American Public Health Association; and National Resource Center for Health and Safety in Child Care and Early Education with funding from the Maternal and Child Health Bureau. The Office of Child Care, Office of Head Start, Office of the Deputy Assistant Secretary for Early Childhood, and the Maternal and Child Health Bureau were instrumental in this effort. Although use of *Caring for our Children Basics* is not federally required, the set of standards was posted for public comment in the Federal Register to provide ACF with practical guidance to aid in refinement and application. The standards, regulations, and guidance with which *Caring for our Children Basics* was produced are located at the end of this document.

Quality care can be achieved with consistent, basic health and safety practices in place. Though **voluntary**, ACF hopes *Caring for Our Children Basics* will be a helpful resource for states and other entities as they work to improve health and safety standards in both licensing and quality rating improvement systems (QRIS). As more states build their QRIS, it is hoped that *Caring for Our Children Basics* will support continuous quality improvement in programs as they move to higher levels of quality and improve the overall health and well-being of **all** children in out-of-home settings. In addition, ACF anticipates *Caring for Our Children Basics* will support efficiency and effectiveness of monitoring systems for early care and education settings. A common framework will assist the Nation in working towards and achieving a more consistent foundation for quality upon which families can rely.

Staffing

1.1.1.1-1.1.1.5 Ratios for Centers and Family Child Care Homes

Appropriate ratios should be kept during all hours of program operation. Children with special health care needs or who require more attention due to certain disabilities may require additional staff on-site, depending on their needs and the extent of their disabilities.

In center-based care, child-provider ratios should be determined by the age of the majority of children and the needs of children present.

	Child Care Centers
Age	Maximum Child: Provider Ratio
≤ 12 months	4:1
13-23 months	4:1
24-35 months	4:1-6:1
3-year-olds	9:1
4- to 5-year-olds	10:1

In family child care homes, the provider's own children under the age of 6, as well as any other children in the home temporarily requiring supervision, should be included in the child: provider ratio. In family child care settings where there are mixed age groups that include infants and toddlers, a maximum ratio of 6:1 should be maintained and no more than two of these children should be 24 months or younger. If all children in care are under 36 months, a maximum ratio of 4:1 should be maintained and no more than two of these children should be 18 months or younger. If all children in care are 3 years old, a maximum ratio of 7:1 should be preserved. If all children in care are 4 to 5 years of age, a maximum ratio of 8:1 should be maintained.

1.2.0.2 Background Screening

All caregivers/teachers and staff in early care and education settings (in addition to any individual age 18 and older, or a minor over age 12 if allowed under State law and if a registry/database includes minors, residing in a family child care home) should undergo a complete background screening upon employment and once at least every five years thereafter. Screening should be conducted as expeditiously as possible and should be completed within 45 days after hiring. Caregivers/teachers and staff should not have unsupervised access to children until screening has been completed. Consent to the background investigation should be required for employment consideration. The comprehensive background screening should include the following:

- a) A search of the State criminal and sex offender registry or repository in the State where the child care staff member resides, and each State where such staff member resided during the preceding 5 years;

- b) A search of State-based child abuse and neglect registries and databases in the State where the child care staff member resides, and each State where such staff member resided during the preceding 5 years; and
- c) A Federal Bureau of Investigation fingerprint check using Next Generation Identification.

Directors/programs should review each employment application to assess the relevancy of any issue uncovered by the complete background screening, including any arrest, pending criminal charge, or conviction, and should use this information in employment decisions in accordance with state laws.

1.4.1.1/1.4.2.3 Pre-service Training/Orientation

Before or during the first three months of employment, training and orientation should detail health and safety issues for early care and education settings including, but not limited to, typical and atypical child development; pediatric first aid and CPR; safe sleep practices, including risk reduction of Sudden Infant Death Syndrome/Sudden Unexplained Infant Death (SIDS/SUID); poison prevention; shaken baby syndrome and abusive head trauma; standard precautions; emergency preparedness; nutrition and age-appropriate feeding; medication administration; and care plan implementation for children with special health care needs. Caregivers/teachers should complete training before administering medication to children. See Standard 3.6.3.3 for more information. All directors or program administrators and caregivers/teachers should document receipt of training.

Providers should not care for children unsupervised until they have completed training in pediatric first aid and CPR; safe sleep practices, including risk reduction of Sudden Infant Death Syndrome/Sudden Unexplained Infant Death (SIDS/SUID); standard precautions for the prevention of communicable disease; poison prevention; and shaken baby syndrome/abusive head trauma.

1.4.3.1 First Aid and CPR Training for Staff

All staff members involved in providing direct care to children should have up-to-date documentation of satisfactory completion of training in pediatric first aid and current certification in pediatric CPR. Records of successful completion of training in pediatric first aid and CPR should be maintained in the personnel files of the facility.

1.4.4.1/1.4.4.2 Continuing Education for Directors, Caregivers/Teachers in Centers, and Family Child Care Homes

Directors and caregivers/teachers should successfully complete intentional and sequential education/professional development in child development programming and child health, safety, and staff health based on individual competency and any special needs of the children in their care.

1.4.5.2 Child Abuse and Neglect Education

Caregivers/teachers should be educated on child abuse and neglect to establish child abuse and neglect prevention and recognition strategies for children, caregivers/teachers, and parents/guardians. The education should address physical, sexual, and psychological or

emotional abuse and neglect. Caregivers/teachers are mandatory reporters of child abuse or neglect. Caregivers/teachers should be trained in compliance with their state's child abuse reporting laws.

Program Activities for Healthy Development

2.1.1.4 Monitoring Children's Development/Obtaining Consent for Screening

Programs should have a process in place for age-appropriate developmental and behavioral screenings for all children at the beginning of a child's enrollment in the program, at least yearly thereafter, and as developmental concerns become apparent to staff and/or parents/guardians. Providers may choose to conduct screenings, themselves; partner with a local agency/health care provider/specialist who would conduct the screening; or work with parents in connecting them to resources to ensure that screening occurs. This process should consist of parental/guardian education, consent, and participation as well as connection to resources and support, including the primary health care provider, as needed. Results of screenings should be documented in child records.

2.1.2.1/2.1.3.1 Personal Caregiver/Teacher Relationships for Birth to Five-Year-Olds

Programs should implement relationship-based policies and program practices that promote consistency and continuity of care, especially for infants and toddlers. Early care and education programs should provide opportunities for each child to build emotionally secure relationships with a limited number of caregivers/teachers. Children with special health care needs may require additional specialists to promote health and safety and to support learning.

2.2.0.1 Methods of Supervision of Children

In center-based programs, caregivers/teachers should directly supervise children under age 6 by sight and sound at all times. In family child care settings, caregivers should directly supervise children by sight or sound. When children are sleeping, caregivers may supervise by sound with frequent visual checks.

Developmentally appropriate child-to-staff ratios should be met during all hours of operation, and safety precautions for specific areas and equipment should be followed. Children under the age of 6 should never be inside or outside by themselves.

2.2.0.4 Supervision near Water

Constant and active supervision should be maintained when any child is in or around water. During swimming and/or bathing where an infant or toddler is present, the ratio should always be one adult to one infant/toddler. During wading and/or water play activities, the supervising adult should be within an arm's length providing "touch supervision." Programs should ensure that all pools have drain covers that are used in compliance with the Virginia Graeme Baker Pool and Spa Safety Act.

2.2.0.8 Preventing Expulsions, Suspensions, and Other Limitations in Services

Programs should have a comprehensive discipline policy that includes developmentally appropriate social-emotional and behavioral health promotion practices as well as discipline and intervention procedures that provide specific guidance on what caregivers/teachers and programs should do to prevent and respond to challenging behaviors. Programs should ensure all caregivers/teachers have access to pre- and in-service training on such practices and procedures. Practices and procedures should be clearly communicated to all staff, families, and community partners, and implemented consistently and without bias or discrimination. Preventive and discipline practices should be used as learning opportunities to guide children's appropriate behavioral development.

Programs should establish policies that eliminate or severely limit expulsion, suspension, or other exclusionary discipline (including limiting services); these exclusionary measures should be used only in extraordinary circumstances where there are serious safety concerns¹ that cannot otherwise be reduced or eliminated by the provision of reasonable modifications.

2.2.0.9 Prohibited Caregiver/Teacher Behaviors

The following behaviors should be prohibited in all early care and education settings:

- a) The use of corporal punishment\ including, but not limited to:
 - i. Hitting, spanking, shaking, slapping, twisting, pulling, squeezing, or biting;
 - ii. Demanding excessive physical exercise, excessive rest, or strenuous or bizarre postures;
 - iii. Compelling a child to eat or have in his/her mouth soap, food, spices, or foreign substances;
 - iv. Exposing a child to extremes of temperature.
- b) Isolating a child in an adjacent room, hallway, closet, darkened area, play area, or any other area where a child cannot be seen or supervised;
- c) Binding, tying to restrict movement, or taping the mouth;
- d) Using or withholding food or beverages as a punishment;
- e) Toilet learning/training methods that punish, demean, or humiliate a child;
- f) Any form of emotional abuse, including rejecting, terrorizing, extended ignoring, isolating, or corrupting a child;
- g) Any abuse or maltreatment of a child;;
- h) Abusive, profane, or sarcastic language or verbal abuse, threats, or derogatory remarks about the child or child's family;
- i) Any form of public or private humiliation, including threats of physical punishment (1);
- j) Physical activity/outdoor time taken away as punishment;
- k) Placing a child in a crib for a time-out or for disciplinary reasons.

¹ Determinations of safety concerns must be based on actual risks, best available objective evidence, and cannot be based on stereotypes or generalizations.

Health Promotion and Protection

3.1.3.1 Active Opportunities for Physical Activity

Programs should promote developmentally appropriate active play for all children, including infants and toddlers, every day. Children should have opportunities to engage in moderate to vigorous activities indoors and outdoors, weather permitting.

3.1.4.1 Safe Sleep Practices and SIDS Risk Reduction

All staff, parents/guardians, volunteers, and others who care for infants in the early care and education setting should follow safe sleep practices as recommended by the American Academy of Pediatrics (AAP). Cribs must be in compliance with current U.S. Consumer Product Safety Commission (CPSC) and ASTM International safety standards. See Standard 5.4.5.2 for more information.

3.1.5.1 Routine Oral Hygiene Activities

Caregivers/teachers should promote good oral hygiene through learning activities including the habit of regular tooth brushing.

3.2.1.4 Diaper Changing Procedure

The following diaper changing procedure should be posted in the changing area and followed to protect the health and safety of children and staff:

- Step 1: Before bringing the child to the diaper changing area, perform hand hygiene and bring supplies to the diaper changing area.
- Step 2: Carry/bring the child to the changing table/surface, keeping soiled clothing away from you and any surfaces you cannot easily clean and sanitize after the change. Always keep a hand on the child.
- Step 3: Clean the child's diaper area.
- Step 4: Remove the soiled diaper and clothing without contaminating any surface not already in contact with stool or urine.
- Step 5: Put on a clean diaper and dress the child.
- Step 6: Wash the child's hands and return the child to a supervised area.
- Step 7: Clean and disinfect the diaper-changing surface. Dispose of the disposable paper liner if used on the diaper changing surface in a plastic-lined, hands-free, covered can. If clothing was soiled, securely tie the plastic bag used to store the clothing and send home.
- Step 8: Perform hand hygiene and record the diaper change, diaper contents, and/or any problems.

Caregivers/teachers should never leave a child unattended on a table or countertop. A safety strap or harness should not be used on the diaper changing table/surface.

3.2.2.1 Situations that Require Hand Hygiene²

All staff, volunteers, and children should abide by the following procedures for hand washing, as defined by the U.S. Centers for Disease Control and Prevention (CDC):

- a) Upon arrival for the day, after breaks, or when moving from one group to another.
- b) Before and after:
 - Preparing food or beverages;
 - Eating, handling food, or feeding a child;
 - Brushing or helping a child brush teeth;
 - Giving medication or applying a medical ointment or cream in which a break in the skin (e.g., sores, cuts, or scrapes) may be encountered;
 - Playing in water (including swimming) that is used by more than one person; and
 - Diapering.
- c) After:
 - Using the toilet or helping a child use a toilet;
 - Handling bodily fluid (mucus, blood, vomit);
 - Handling animals or cleaning up animal waste;
 - Playing in sand, on wooden play sets, and outdoors; and
 - Cleaning or handling the garbage.

Situations or times that children and staff should perform hand hygiene should be posted in all food preparation, diapering, and toileting areas.

3.3.0.1 Routine Cleaning, Sanitizing, and Disinfecting

Programs should follow a routine schedule of cleaning, sanitizing, and disinfecting. Cleaning, sanitizing, and disinfecting products should not be used in close proximity to children, and adequate ventilation should be maintained during use.

3.2.3.4 Prevention of Exposure to Blood and Body Fluids

Early care and education programs should adopt the use of Standard Precautions, developed by the Centers for Disease Control and Prevention (CDC), to handle potential exposure to blood and other potentially infectious fluids. Caregivers and teachers are required to be educated regarding Standard Precautions before beginning to work in the program and annually thereafter. For center-based care, training should comply with requirements of the Occupational Safety and Health Administration (OSHA).

3.4.1.1 Use of Tobacco, Alcohol, and Illegal Drugs

Directors, caregivers, volunteers, and staff should not be impaired due to the use of alcohol, illegal drugs or prescription medication during program hours. Tobacco, alcohol, and illegal drug use should be prohibited on the premises (both indoor and outdoor environments) and in any vehicles used by the program at all times. In family child care settings, tobacco and alcohol should be inaccessible to children.

² Family child care homes are exempt from posting procedures for hand washing but should follow all other aspects of this standard.

3.4.3.1 Emergency Procedures

Programs should have a procedure for responding to situations when an immediate emergency medical response is required. Emergency procedures should be posted and readily accessible. Child-to-provider ratios should be maintained, and additional adults may need to be called in to maintain the required ratio. Programs should develop contingency plans for emergencies or disaster situations when it may not be possible to follow standard emergency procedures. All providers and/or staff should be trained to manage an emergency until emergency medical care becomes available

3.4.4.1 Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation

Because caregivers/teachers are mandated reporters of child abuse and neglect, each program should have a written policy for reporting child abuse and neglect. The written policy should specify that in any instance where there is reasonable cause to believe that child abuse or neglect has occurred, the individual who suspects child abuse or neglect should report directly to the child abuse reporting hotline, child protective services, or the police, as required by state and local laws.

3.4.4.3 Preventing and Identifying Shaken Baby Syndrome and Abusive Head Trauma

All programs should have a policy and procedure to identify and prevent shaken baby syndrome and abusive head trauma. All caregivers/teachers who are in direct contact with children, including substitute caregivers/teachers and volunteers, should receive training on preventing shaken baby syndrome and abusive head trauma; recognition of potential signs and symptoms of shaken baby syndrome and abusive head trauma; strategies for coping with a crying, fussing, or distraught child; and the development and vulnerabilities of the brain in infancy and early childhood.

3.4.5.1 Sun Safety Including Sunscreen

Caregivers/teachers should ensure sun safety for themselves and children under their supervision by keeping infants younger than six months out of direct sunlight, limiting sun exposure when ultraviolet rays are strongest and applying sunscreen with written permission of parents/guardians. Manufacturer instructions should be followed.

3.4.6.1 Strangulation Hazards

Strings and cords long enough to encircle a child's neck, such as those on toys and window coverings, should not be accessible to children in early care and education programs.

3.5.0.1 Care Plan for Children with Special Health Care Needs

Children with special health care needs are defined as “. . . those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally” (McPherson, 1998).

Any child who meets these criteria in an early care and education setting should have an up-to-date Routine and Emergent Care Plan, completed by their primary health care provider with input from parents/guardians, included in their on-site health record and readily accessible to

those caring for the child. Community resources should be used to ensure adequate information, training, and monitoring is available for early care and education staff. Caregivers should undergo training in pediatric first aid and CPR that includes responding to an emergency for any child with a special health care need.

3.6.1.1 Inclusion/Exclusion/Dismissal of Children

The program should notify parents/guardians when children develop new signs or symptoms of illness. Parent/guardian notification should be immediate for emergency or urgent issues. Staff should notify parents/guardians of children who have symptoms that require exclusion, and parents/guardians should remove children from the early care and education setting as soon as possible. For children whose symptoms do not require exclusion, verbal or written notification to the parent/guardian at the end of the day is acceptable. Most conditions that require exclusion do not require a primary health care provider visit before re-entering care.

When a child becomes ill but does not require immediate medical help, a determination should be made regarding whether the child should be sent home. The caregiver/teacher should determine if the illness:

- a) Prevents the child from participating comfortably in activities;
- b) Results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;
- c) Poses a risk of spread of harmful diseases to others;
- d) Causes a fever and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, and diarrhea). An unexplained temperature above 100 °F (37.8 °C) (armpit) in a child younger than 6 months should be medically evaluated. Any infant younger than 2 months of age with fever should get immediate medical attention.

If any of the above criteria are met, the child should be removed from direct contact with other children and monitored and supervised by a staff member known to the child until dismissed to the care of a parent/guardian, primary health care provider, or other person designated by the parent. The local or state health department will be able to provide specific guidelines for exclusion.

3.6.1.4 Infectious Disease Outbreak Control

During the course of an identified outbreak of any reportable illness at the program, a child or staff member should be excluded if the local health department official or primary health care provider suspects that the child or staff member is contributing to transmission of the illness, is not adequately immunized when there is an outbreak of a vaccine-preventable disease, or the circulating pathogen poses an increased risk to the individual. The child or staff member should be readmitted when the health department official or primary health care provider who made the initial determination decides that the risk of transmission is no longer present. Parents/guardians should be notified of any determination.

3.6.3.1/3.6.3.2 Medication Administration and Storage

The administration of medicines at the facility should be limited to:

- a) Prescription or non-prescription medication (over-the-counter) ordered by the prescribing health professional for a specific child with written permission of the parent/guardian. Prescription medication should be labeled with the child's name; date the prescription was filled; name and contact information of the prescribing health professional; expiration date; medical need; instructions for administration, storage, and disposal; and name and strength of the medication.
- b) Labeled medications (over-the-counter) brought to the early care and education facility by the parent/guardian in the original container. The label should include the child's name; dosage; relevant warnings as well as specific; and legible instructions for administration, storage; and disposal.

Programs should never administer a medication that is prescribed for one child to another child. Documentation that the medicine/agent is administered to the child as prescribed is required. Medication should not be used beyond the date of expiration. Unused medications should be returned to the parent/guardian for disposal.

All medications, refrigerated or unrefrigerated, should have child-resistant caps; be stored away from food at the proper temperature, and be inaccessible to children.

3.6.3.3 Training of Caregivers/Teachers to Administer Medication

Any caregiver/teacher who administers medication should complete a standardized training course that includes skill and competency assessment in medication administration. The course should be repeated according to state and/or local regulation and taught by a trained professional. Skill and competency should be monitored whenever an administration error occurs.

Nutrition and Food Service

4.2.0.3 Use of U.S. Department of Agriculture (USDA), Child and Adult Care Food Program (CACFP) Guidelines

Programs should serve nutritious and sufficient foods that meet the requirements for meals of the child care component of the USDA CACFP as referenced in 7 CFR 226.20.

4.2.0.6 Availability of Drinking Water

Clean, sanitary drinking water should be readily accessible in indoor and outdoor areas, throughout the day. On hot days, infants receiving human milk in a bottle may be given additional human milk, and those receiving formula mixed with water may be given additional formula mixed with water. Infants should not be given water, especially in the first six months of life.

4.2.0.10 Care for Children with Food Allergies

Each child with a food allergy should have a written care plan that includes:

- a) Instructions regarding the food(s) to which the child is allergic and steps to be taken to avoid that food;

- b) A detailed treatment plan to be implemented in the event of an allergic reaction, including the names, doses, and methods of prompt administration of any medications. The plan should include specific symptoms that would indicate the need to administer one or more medications.

Based on the child's care plan and prior to caring for the child, caregivers/teachers should receive training for, demonstrate competence in, and implement measures for:

- a) Preventing exposure to the specific food(s) to which the child is allergic;
- b) Recognizing the symptoms of an allergic reaction;
- c) Treating allergic reactions.

The written child care plan, a mobile phone, and the proper medications for appropriate treatment if the child develops an acute allergic reaction should be routinely carried on field trips or transport out of the early care and education setting.

The program should notify the parents/guardians immediately of any suspected allergic reactions, as well as the ingestion of or contact with the problem food even if a reaction did not occur. The program should contact the emergency medical services system immediately whenever epinephrine has been administered.

Each child's food allergies should be posted prominently in the classroom and/or wherever food is served with permission of the parent/guardian.

4.3.1.3 Preparing, Feeding, and Storing Human Milk

Programs should develop and follow procedures for the preparation and storage of expressed human milk that ensures the health and safety of all infants, as outlined by the Academy of Breastfeeding Medicine Protocol #8; Revision 2010, and prohibits the use of infant formula for a breastfed infant without parental consent. The bottle or container should be properly labeled with the infant's full name and date; and should only be given to the specified child. Unused breast milk should be returned to parent in the bottle or container.

4.3.1.5 Preparing, Feeding, and Storing Infant Formula

Programs should develop and follow procedures for the preparation and storage of infant formula that ensures the health and safety of all infants. Formula provided by parents/guardians or programs should come in sealed containers. The caregiver/teacher should always follow the parent or manufacturer's instructions for mixing and storing of any formula preparation. If instructions are not readily available, caregivers/teachers should obtain information from the World Health Organization's Safe Preparation, Storage and Handling of Powdered Infant Formula Guidelines. Bottles of prepared or ready-to-feed formula should be labeled with the child's full name, time, and date of preparation. Prepared formula should be discarded daily if not used.

4.3.1.9 Warming Bottles and Infant Foods

Bottles and infant foods can be served cold from the refrigerator and do not have to be warmed. If a caregiver/teacher chooses to warm them, or a parent requests they be warmed, bottles should be warmed under running, warm tap water; using a commercial bottle warmer, stove top warming methods, or slow-cooking device; or by placing them in container of warm water. Bottles should never be warmed in microwaves. Warming devices should not be accessible to children.

4.5.0.10 Foods that Are Choking Hazards

Caregivers/teachers should not offer foods that are associated with young children's choking incidents to children under 4 years of age. Food for infants should be cut into pieces $\frac{1}{4}$ inch or smaller, food for toddlers should be cut into pieces $\frac{1}{2}$ inch or smaller to prevent choking. Children should be supervised while eating, to monitor the size of food and that they are eating appropriately.

4.8.0.1 Food Preparation Area Access

Access to areas where hot food is prepared should only be permitted when children are supervised by adults who are qualified to follow sanitation and safety procedures.

4.9.0.1 Compliance with U.S. Food and Drug Administration (FDA) Food Code and State and Local Rules

The program should conform to applicable portions of the FDA Food Code and all applicable state and local food service rules and regulations for centers and family child care homes regarding safe food protection and sanitation practices.

Facilities, Supplies, Equipment, and Environmental Health

5.1.1.2 Inspection of Buildings

Existing and/or newly constructed, renovated, remodeled, or altered buildings should be inspected by a building inspector to ensure compliance with applicable state and local building and fire codes before the building can be used for the purpose of early care and education.

5.1.1.3 Compliance with Fire Prevention Code

Programs should comply with a state-approved or nationally recognized fire prevention code, such as the National Fire Protection Association (NFPA) 101: Life Safety Code.

5.1.1.5 Environmental Audit of Site Location

An environmental audit should be conducted before construction of a new building; renovation or occupation of an older building; or after a natural disaster to properly evaluate and, where necessary, remediate or avoid sites where children's health could be compromised. A written report that includes any remedial action taken should be kept on file. The audit should include assessments of:

- a) Potential air, soil, and water contamination on program sites and outdoor play spaces;

- b) Potential toxic or hazardous materials in building construction, such as lead and asbestos; and
- c) Potential safety hazards in the community surrounding the site.

5.1.6.6 Guardrails and Protective Barriers

Guardrails or protective barriers, such as baby gates, should be provided at open sides of stairs, ramps, and other walking surfaces (e.g., landings, balconies, porches) from which there is more than a 30 inch vertical distance to fall.

5.2.4.2 Safety Covers and Shock Protection Devices for Electrical Outlets

All accessible electrical outlets should be “tamper-resistant electrical outlets” that contain internal shutter mechanisms to prevent children from sticking objects into receptacles. In settings that do not have “tamper-resistant electrical outlets,” outlets should have “safety covers” that are attached to the electrical outlet by a screw or other means to prevent easy removal by a child. “Safety plugs” may also be used if they cannot be easily removed from outlets by children and do not pose a choking risk.

5.2.4.4 Location of Electrical Devices near Water

No electrical device or apparatus accessible to children should be located so it could be plugged into an electrical outlet while a person is in contact with a water source, such as a sink, tub, shower area, water table, or swimming pool.

5.2.8.1 Integrated Pest Management

Programs should adopt an integrated pest management program to ensure long-term, environmentally sound pest suppression through a range of practices including pest exclusion, sanitation and clutter control, and elimination of conditions that are conducive to pest infestations.

5.2.9.1 Use and Storage of Toxic Substances

All toxic substances should be inaccessible to children and should not be used when children are present. Toxic substances should be used as recommended by the manufacturer and stored in the original labeled containers. The telephone number for the poison control center should be posted and readily accessible in emergency situations.

5.2.9.5 Carbon Monoxide Detectors

Programs should meet state or local laws regarding carbon monoxide detectors, including circumstances when detectors are necessary. Detectors should be tested monthly, and testing should be documented. Batteries should be changed at least yearly. Detectors should be replaced according to the manufacturer’s instructions.

5.3.1.1/5.5.0.6/5.5.0.7 Safety of Equipment, Materials, and Furnishings

Equipment, materials, furnishings, and play areas should be sturdy, safe, in good repair, and meet the recommendations of the CPSC. Programs should attend to, including, but not limited to, the following safety hazards:

- a) Openings that could entrap a child's head or limbs;

- b) Elevated surfaces that are inadequately guarded;
- c) Lack of specified surfacing and fall zones under and around climbable equipment;
- d) Mismatched size and design of equipment for the intended users;
- e) Insufficient spacing between equipment;
- f) Tripping hazards;
- g) Components that can pinch, shear, or crush body tissues;
- h) Equipment that is known to be of a hazardous type;
- i) Sharp points or corners;
- j) Splinters;
- k) Protruding nails, bolts, or other parts that could entangle clothing or snag skin;
- l) Loose, rusty parts;
- m) Hazardous small parts that may become detached during normal use or reasonably foreseeable abuse of the equipment and that present a choking, aspiration, or ingestion hazard to a child;
- n) Strangulation hazards (e.g., straps, strings, etc.);
- o) Flaking paint;
- p) Paint that contains lead or other hazardous materials; and
- q) Tip-over hazards, such as chests, bookshelves, and televisions.

Plastic bags that are large enough to pose a suffocation risk as well as matches, candles, and lighters should not be accessible to children.

5.3.1.12 Availability and Use of a Telephone or Wireless Communication Device

The facility should provide at all times at least one working non-pay telephone or wireless communication device for general and emergency use on the premises of the child care program, in each vehicle used when transporting children, and on field trips. While transporting children, drivers should not operate a motor vehicle while using a mobile telephone or wireless communications device when the vehicle is in motion or traffic.

5.4.5.2 Cribs and Play Yards

Before purchase and use, cribs and play yards should be in compliance with current CPSC and ASTM International safety standards that include ASTM F1169-10a Standard Consumer Safety Specification for Full-Size Baby Cribs, ASTM F406-13, Standard Consumer Safety Specification for Non-Full-Size Baby Cribs/Play Yards, , or the CPSC 16 CFR 1219, 1220, and 1500—Safety Standards for Full-Size Baby Cribs and Non-Full-Size Baby Cribs; Final Rule.

Programs should only use cribs for sleep purposes and ensure that each crib is a safe sleep environment as defined by the American Academy of Pediatrics. Each crib should be labeled and used for the infant's exclusive use. Cribs and mattresses should be thoroughly cleaned and sanitized before assignment for use by another child. Infants should not be placed in the cribs with items that could pose a strangulation or suffocation risk. Cribs should be placed away from window blinds or draperies.

5.5.0.8 Firearms

Center-based programs should not have firearms or any other weapon on the premises at any time. If present in a family child care home, parents should be notified and these items should be unloaded, equipped with child protective devices, and kept under lock and key with the ammunition locked separately in areas inaccessible to the children. Parents/guardians should be informed about this policy.

5.6.0.1: First Aid and Emergency Supplies

The facility should maintain up-to-date first aid and emergency supplies in each location in which children are cared. The first aid kit or supplies should be kept in a closed container, cabinet, or drawer that is labeled and stored in a location known to all staff, accessible to staff at all times, but locked or otherwise inaccessible to children. When children leave the facility for a walk or to be transported, a designated staff member should bring a transportable first aid kit. In addition, a transportable first aid kit should be in each vehicle that is used to transport children to and from the program. First aid kits or supplies should be restocked after each use.

Play Areas/Playgrounds and Transportation

6.1.0.6/6.1.0.8/6.3.1.1 Location of Play Areas near Bodies of Water/ Enclosures for Outdoor Play Areas/Enclosure of Bodies of Water

The outdoor play area should be enclosed with a fence or natural barriers. Fences and barriers should not prevent the supervision of children by caregivers/teachers. If a fence is used, it should be in good condition and conform to applicable local building codes in height and construction. These areas should have at least two exits, with at least one being remote from the buildings.

Gates should be equipped with self-closing and positive self-latching closure mechanisms that are high enough or of a type such that children cannot open it. The openings in the fence and gates should be no larger than 3 ½ inches. The fence and gates should be constructed to discourage climbing. Outside play areas should be free from unsecured bodies of water. If present, all water hazards should be inaccessible to unsupervised children and enclosed with a fence that is 4 to 6 feet high or higher and comes within 3 ½ inches of the ground.

6.2.3.1 Prohibited Surfaces for Placing Climbing Equipment

Equipment used for climbing should not be placed over, or immediately next to, hard surfaces not intended for use as surfacing for climbing equipment. All pieces of playground equipment should be placed over a shock-absorbing material that is either the unitary or the loose-fill type extending beyond the perimeter of the stationary equipment. Organic materials that support colonization of molds and bacteria should not be used. This standard applies whether the equipment is installed outdoors or indoors. Programs should follow CPSC guidelines and ASTM International Standards F1292-13 and F2223-10.

6.2.5.1 Inspection of Indoor and Outdoor Play Areas and Equipment

The indoor and outdoor play areas and equipment should be inspected daily for basic health and safety, including, but not limited to:

- a) Missing or broken parts;
- b) Protrusion of nuts and bolts;
- c) Rust and chipping or peeling paint;
- d) Sharp edges, splinters, and rough surfaces;
- e) Stability of handholds;
- f) Visible cracks;
- g) Stability of non-anchored large play equipment (*e.g.*, playhouses);
- h) Wear and deterioration
- i) Vandalism or trash

Any problems should be corrected before the playground is used by children.

6.3.2.1 Lifesaving Equipment

Each swimming pool more than six feet in width, length, or diameter should be provided with a ring buoy and rope, a rescue tube, or a throwing line and a shepherd's hook that will not conduct electricity. This equipment should be long enough to reach the center of the pool from the edge of the pool, kept in good repair, and stored safely and conveniently for immediate access. Caregivers/teachers should be trained on the proper use of this equipment. Children should be familiarized with the use of the equipment based on their developmental level.

6.3.5.2 Water in Containers

Bathtubs, buckets, diaper pails, and other open containers of water should be emptied immediately after use.

6.5.1.2 Qualifications for Drivers

In addition to meeting the general staff background check standards, any driver or transportation staff member who transports children for any purpose should have:

- a) A valid driver's license that authorizes the driver to operate the type of vehicle being driven;
- b) A safe driving record for more than 5 years, with no crashes where a citation was issued, as evidenced by the state Department of Motor Vehicles records;
- c) No use of alcohol, drugs, or any substance that could impair abilities before or while driving;
- d) No tobacco use while driving;
- e) No medical condition that would compromise driving, supervision, or evacuation capability;
- f) Valid pediatric CPR and first aid certificate if transporting children alone.

The driver's license number and date of expiration, vehicle insurance information, and verification of current state vehicle inspection should be on file in the facility.

6.5.2.2 Child Passenger Safety

When children are driven in a motor vehicle other than a bus, all children should be transported only if they are restrained in a developmentally appropriate car safety seat, booster seat, seat belt, or harness that is suited to the child's weight and age in accordance with state and federal laws and regulations. The child should be securely fastened, according to the manufacturer's instructions. The child passenger restraint system should meet the federal motor vehicle safety standards contained in 49 CFR 571.213 and carry notice of compliance. Child passenger restraint systems should be installed and used in accordance with the manufacturer's instructions and should be secured in back seats only.

Car safety seats should be replaced if they have been recalled, are past the manufacturer's "date of use" expiration date, or have been involved in a crash that meets the U.S. Department of Transportation crash severity criteria or the manufacturer's criteria for replacement of seats after a crash.

If the program uses a vehicle that meets the definition of a school bus and the school bus has safety restraints, the following should apply:

- a) The school bus should accommodate the placement of wheelchairs with four tie-downs affixed according to the manufactures' instructions in a forward-facing direction;
- b) The wheelchair occupant should be secured by a three-point tie restraint during transport;
- c) At all times, school buses should be ready to transport children who must ride in wheelchairs;
- d) Manufacturers' specifications should be followed to assure that safety requirements are met.

6.5.2.4 Interior Temperature of Vehicles

The interior of vehicles used to transport children for field trips and out-of-program activities should be maintained at a temperature comfortable to children. All vehicles should be locked when not in use, head counts of children should be taken before and after transporting to prevent a child from being left in a vehicle, and children should never be left in a vehicle unattended.

6.5.3.1 Passenger Vans

Early care and education programs that provide transportation for any purpose to children, parents/guardians, staff, and others should not use 15-passenger vans when avoidable.

Infectious Disease

7.2.0.1 Immunization Documentation

Programs should require that all parents/guardians of enrolled children provide written documentation of receipt of immunizations appropriate for each child's age. Infants, children, and adolescents should be immunized as specified in the "Recommended Immunization Schedules for Persons Aged 0 Through 18 Years," developed by the Advisory Committee on

Immunization Practices of the CDC, the American Academy of Pediatrics, and the American Academy of Family Physicians. Children whose immunizations are not up-to-date or have not been administered according to the recommended schedule should receive the required immunizations, unless contraindicated or for legal exemptions.

7.2.0.2 Unimmunized Children

If immunizations have not been or are not to be administered because of a medical condition, a statement from the child's primary health care provider documenting the reason why the child is temporarily or permanently medically exempt from the immunization requirements should be on file. If immunizations are not to be administered because of the parents'/guardians' religious or philosophical beliefs, a legal exemption with notarization, waiver, or other state-specific required documentation signed by the parent/guardian should be on file.

Parents/guardians of an enrolling or enrolled infant who has not been immunized due to the child's age should be informed if/when there are children in care who have not had routine immunizations due to exemption.

The parent/guardian of a child who has not received the age-appropriate immunizations prior to enrollment and who does not have documented medical, religious, or philosophical exemptions from routine childhood immunizations should provide documentation of a scheduled appointment or arrangement to receive immunizations. Children who are in foster care or experiencing homelessness as defined by the McKinney-Vento Act should receive services while parents/guardians are taking necessary actions to comply with immunization requirements of the program. An immunization plan and catch-up immunizations should be initiated upon enrollment and completed as soon as possible.

If a vaccine-preventable disease to which children are susceptible occurs and potentially exposes the unimmunized children who are susceptible to that disease, the health department should be consulted to determine whether these children should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.

7.2.0.3 Immunization of Caregivers/Teachers

Caregivers/teachers should be current with all immunizations routinely recommended for adults by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) as shown in the "Recommended Adult Immunization Schedule" in the following categories:

- a) Vaccines recommended for all adults who meet the age requirements and who lack evidence of immunity (i.e., lack documentation of vaccination or have no evidence of prior infection); and
- b) Recommended if a specific risk factor is present.

If a staff member is not appropriately immunized for medical, religious, or philosophical reasons, the program should require written documentation of the reason. If a vaccine-preventable disease to which adults are susceptible occurs in the facility and potentially exposes the unimmunized adults who are susceptible to that disease, the health department

should be consulted to determine whether these adults should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.

Policies

9.2.4.1 Written Plan and Training for Handling Urgent Medical Care or Threatening Incidents

The program should have a written plan for reporting and managing any incident or unusual occurrence that is threatening to the health, safety, or welfare of the children, staff, or volunteers. Caregiver/teacher and staff training procedures should also be included. The management, documentation, and reporting of the following types of incidents should be addressed:

- a) Lost or missing child;
- b) Suspected maltreatment of a child (also see state's mandates for reporting);
- c) Suspected sexual, physical, or emotional abuse of staff, volunteers, or family members occurring while they are on the premises of the program;
- d) Injuries to children requiring medical or dental care;
- e) Illness or injuries requiring hospitalization or emergency treatment;
- f) Mental health emergencies;
- g) Health and safety emergencies involving parents/guardians and visitors to the program;
- h) Death of a child or staff member, including a death that was the result of serious illness or injury that occurred on the premises of the early care and education program, even if the death occurred outside of early care and education hours;
- i) The presence of a threatening individual who attempts or succeeds in gaining entrance to the facility.

9.2.4.3/9.2.4.5 Disaster Planning, Training and Communication/Emergency and Evacuation Drills

Early care and education programs should consider how to prepare for and respond to emergency situations or natural disasters that may require evacuation, lock-down, or shelter-in-place and have written plans, accordingly. Written plans should be posted in each classroom and areas used by children. The following topics should be addressed, including but not limited to regularly scheduled practice drills, procedures for notifying and updating parents, and the use of the daily class roster(s) to check attendance of children and staff during an emergency or drill when gathered in a safe space after exit and upon return to the program. All drills/exercises should be recorded.

9.2.4.7 Sign-In/Sign-Out System³

Programs should have a sign-in/sign-out system to track those who enter and exit the facility. The system should include name, contact number, relationship to facility (*e.g.*, parent/guardian, vendor, guest, etc.), and recorded time in and out.

³ Family Child Care is exempt.

9.2.4.8 Authorized Persons to Pick Up Child

Children may only be released to adults authorized by parents or legal guardians whose identity has been verified by photo identification. Names, addresses, and telephone numbers of persons authorized to pick up child should be obtained during the enrollment process and regularly reviewed, along with clarification/documentation of any custody issues/court orders. The legal guardian(s) of the child should be established and documented at this time.

9.4.1.12 Record of Valid License, Certificate, or Registration of Facility or Family Child Care Home

Every facility and/or child care home should hold a valid license, certificate, or documentation of registration prior to operation as required by the local and/or state statute.

9.4.2.1 Contents of Child Records

Programs should maintain a confidential file for each child in one central location on-site and should be immediately available to the child's caregivers/teachers (who should have parental/guardian consent for access to records), the child's parents/guardians, and the licensing authority upon request. The file for each child should include the following:

- a) Pre-admission enrollment information;
- b) Admission agreement signed by the parent/guardian at enrollment;
- c) Initial and updated health care assessments, completed and signed by the child's primary care provider, based on the child's most recent well care visit;
- d) Health history completed by the parent/guardian at admission;
- e) Medication record;
- f) Authorization form for emergency medical care;
- g) Results of developmental and behavioral screenings;
- h) Record of persons authorized to pick up child;
- i) Written informed consent forms signed by the parent/guardian allowing the facility to share the child's health records with other service providers.

10.4.2.1 Frequency of Inspections for Child Care Centers and Family Child Care Homes

Licensing inspectors or monitoring staff should make on-site inspections to measure program compliance with health, safety, and fire standards prior to issuing an initial license and no less than one, unannounced inspection each year thereafter to ensure compliance with regulations. Additional inspections should take place if needed for the program to achieve satisfactory compliance or if the program is closed at any time. The number of inspections should not include those inspections conducted for the purpose of investigating complaints. Complaints should be investigated promptly, based on severity of the complaint. States should post results of licensing inspections, including complaints, on the internet for parent and public review. Parents/guardians should have easy access to licensing rules and made aware of how to report complaints to the licensing agency.

Sufficient numbers of licensing inspectors should be qualified to inspect early care and education programs and trained in related health and safety requirements among other requirements of the State licensure.

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