

13 Key Indicators of Child Care Quality
Child Care Quality Indicators (CCQI – CDPES2 PC1) Scale

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13 Key Indicator of Child Care Quality

1. Child Abuse Indicator
2. Immunization Indicator
3. Staff Child Ratio and Group Size Indicator
4. Staff (Director and Teacher) Qualifications Indicators (2 Indicators)
5. Staff Training Indicator
6. Supervision/Discipline Indicator
7. Fire Drills Indicator
8. Medication Indicator
9. Emergency Plan/Contact Indicator
10. Outdoor Playground Indicator
11. Toxic Substances Indicator
12. Handwashing/Diapering Indicator

Note: Each of the following items includes a series of numbers and letters in parenthesis. The first number listed refers to which of the 13 Indicators the item relates to. The remaining series of numbers and letters relates to the resource and standard the item is drawn from.

The purpose of this tool/Scale is to provide guidance for state child care agencies as they think about revising their state child care regulations and the need for national child care standards. The tool is based upon a synthesis of literature around the health and safety standards for out-of-home child care found in *Stepping Stones to Using Caring for Our Children*, using 13 predictor/indicator topics to provide focus. The tool examines evidence that exists to support how these standards protect children from harm. The audiences for this research brief are state administrators and policymakers, child care providers, and early childhood researchers. It combines two licensing measurement methodologies (Fiene & Kroh, 2000): 1) Licensing weighting and 2) indicator systems.

Licensing weighting and indicator systems are two licensing measurement tools that have been utilized in the licensing literature for the past 20 years. These two methodologies are part of the *Licensing Curriculum* developed by the National Association for Regulatory Administration. These methodologies constitute the most researched tools for conducting inferential inspections by licensing agencies. The National Resource Center for Health and Safety in Child Care utilized the two licensing measurement methodologies to develop a user-friendly, shortened assistance tool based upon *Caring for Our Children: National Health and Safety Performance Standards for Out-of-Home Child Care*, a comprehensive standards document containing over 900 standards. The shortened publication, *Stepping Stones to Using Caring for Our Children*, is a statistically determined version of *Caring for Our Children*, based upon the most critical standards to protect children from harm in out-of-home child care. Employing the indicator system methodology, this tool builds upon *Stepping Stones* by focusing on those standards that protect children from harm in child care. These standards are also key predictors regarding children's positive outcomes while in child care and are statistical indicators of overall compliance with child care regulations. The indicators in this tool contain a reduced number of standards from those presented in *Stepping Stones*. These standards have gone through a weighting consensus based on risk factors as well as an indicator methodology that selects standards on the basis of being able to predict overall compliance with standards and positive outcomes for children. As state regulations are rewritten, this tool will constitute a major step forward in support of state child care agencies as they attempt to ascertain which standards are the keys to protecting children. This tool is the final product of a lengthy process that started in 1979, when the Federal Interagency Day Care Requirements (FIDCR) were being drafted and the Department of Health, Education and Welfare (HEW) was looking for a streamlined tool for conducting monitoring reviews.

The weighted licensing indicator system was just being developed in Pennsylvania (Fiene & Nixon, 1981) and this new methodology looked like a potential solution for the FIDCR standards. Although the FIDCR standards went through several drafts, the standards were never finished and implemented. However, the interest of HEW (became the Department of Health and Human Services (HHS) in 1980) in the weighted licensing indicator system methodology never wavered. A federal demonstration grant was given to Pennsylvania to further develop this methodology and begin pilot testing it in a consortium of states from 1980-1985 (Fiene, 1988). After 1980 it became clear that the monitoring focus for child care programs was shifting from the federal government to the states. HHS wanted to assist states in their monitoring efforts and felt that the weighted licensing indicator system was an innovative means for doing this.

During 1980's and early 1990's, many states utilized this methodology to help streamline their licensing enforcement systems. In 1994, a study from the U.S. General Accounting Office (GAO) estimated that 30 states were using the methodology in one form or another. The methodology has been used in child care and in other human services areas as well, including: mental health, early intervention, child welfare, and youth services (Fiene, 1988). During this time, a national data base was established at the Pennsylvania State University in order to track the various state regulations that constituted respective states' weighted licensing indicator systems. The remarkable aspect of this data collection effort and data base was that a core set of indicators began to appear. Although the wording was not exact from state to state, every state had the same indicators appearing on their indicator checklists in some fashion. Thirteen key indicators consistently appeared.

The 13 indicators are the following: child abuse reporting and clearances, proper immunizations, staff child ratio and group size, director and teacher qualifications, staff training, supervision/discipline, fire drills, administration of medication, emergency plan/contact, outdoor playground safety, inaccessibility of toxic substances, and hand washing/diapering. From the early 1990's, the methodology began to gain the attention of national organizations that were interested in utilizing it outside of the licensing domain. For example, the National Child Care Association was interested in using it for their newly developing accreditation system (Fiene, 1992). In 1994, the Maternal and Child Health Bureau and the National Resource Center for Health and Safety in Child Care became interested in exploring a means for targeting certain standards in *Caring for Our Children* based upon the methodology. *Stepping Stones* is the product of that endeavor. However, only the weighting consensus portion of the methodology was utilized in the development of *Stepping Stones*. This tool completes that process by incorporating the key indicator portion of the methodology.

This tool updates reviews of recent research that is related to the 13 indicators that form the basis of the national database maintained at the Pennsylvania State University. It also lists the standards from *Caring for Our Children* that correspond to the 13 indicators. In many of the indicators, several standards are listed because the indicator was represented by different wording or emphases in the various state regulations. Therefore, when the comparison between the *Caring for Our Children* standards and the national data base of the state child care regulations was completed, many variations on each specific indicator were included. The research brief then summarizes the research that has been completed in the 1990's and identifies gaps where additional research is needed. Following that, a summary table gives additional detail in an annotated bibliographic fashion on key studies that demonstrate the importance of the particular indicator. This research base and review clearly documents the importance of the 13 indicators when determining the health and safety of young children in child care and the overall quality of a program. These key indicators support and embrace the overall research literature related to child care quality. Many of the indicators have been identified as key surrogates of child care quality that have an impact on young children and as being a reliable tool for identifying high compliant versus low compliant programs. The research literature over the past 20 years has demonstrated that these indicators accomplish two things. One, they statistically predict overall compliance with regulations in particular states. And two, a significant relationship exists between compliance with these indicators and positive outcomes for young children (Fiene, 1994).

A. Observation: Caregiver

1. Caregivers are allowed 15 minute break time every 4 hours AND a lunch break of 30 minutes (1:HP 102).

Yes No

2. Child:staff ratios are maintained at all times (3:ST002).

Yes No

Age	Child-staff ratio	Maximum group size
Birth-12 months	3:1	6
13-24 months	3:1	6
25-30 months	4:1	8
31-35 months	5:1	10
3 year olds	7:1	14
4 year olds	8:1	16
5 year olds	8:1	16
6-8 year olds	10:1	20
9-12 year olds	12:1	24

3. Does the caregiver have an undergraduate degree in early childhood education, child development, social work, nursing, or other child-related field, or a combination of college course work and experience under qualified supervision? (4:ST012)

Yes No

4. Does the caregiver have at least 1 year's experience caring for children? (4:ST012)

Yes No

5. Is the caregiver in charge of a group licensed/certified as lead teacher, teacher, or associate teachers, **with education in child development and early childhood education specific to this age group, as well as supervised experience with the age group of children in care?** (4:ST014 and ST016)

Yes

No

6. Do the caregivers who work with infants and toddlers, when asked, report their job function is to foster interactions, diapering, bathing, feeding, holding, comforting and responding? (4:ST015)

Yes

No

7. Do the caregivers who work with 3 to 5 year olds demonstrate knowledge and understanding of these children's independence and social competence, more complex inner lives, and increasing ability to adapt to their environment and cope with stress (4:ST017)?

Yes

No

8. Does the caregiver demonstrate knowledge about the social and emotional needs and developmental tasks of 5 to 12 year old children, and how to implement a nonacademic, enriching program (4:ST019)?

Yes

No

9. Is supervision of children maintained at all times as specified in Supervision Policy (AD 009)(6: PR 028)?

Yes

No

10. Does discipline include positive guidance, redirection, and the setting of clear-cut limits that foster the child's ability to become self-disciplined? Disciplinary measures shall be clear and understandable to the child, shall be consistent, and shall be explained to the child before and at the time of any disciplinary action (6: PR 031).

Yes No

11. Do caregivers guide the child to develop self-control and orderly conduct in his/her relationships with peers and adults? (6:PR 032)

Yes No

12. Do caregivers show children positive alternatives rather than just telling children "no."? (6:PR 032)

Yes No

13. Is good behavior rewarded? (6:PR 032)

Yes No

14. Do caregivers work with children without recourse to physical punishment or abusive language? (6:PR 032)

Yes No

15. Do caregivers use the teaching method described in standard PR 032(Indicator # 14) immediately when it is important to show that aggressive physical behavior toward staff or children is unacceptable? (6:PR033)

Yes No

16. Do caregivers intervene immediately when children become physically aggressive? (6:PR033)

Yes No

17. Are established disciplinary practices designed to encourage the child to be fair, to respect property, and to assume personal responsibility and responsibility for others? (6:PR034).

Yes No

18. Are the following behaviors prohibited in all child care settings and by all caregivers? (6:PR035)

A. Corporal punishment, including hitting, spanking, beating, shaking, pinching, and other measures that produce physical pain.

Yes No

B. Withdrawal or the threat of withdrawal of food, rest, or bathroom opportunities.

Yes No

C. Abusive or profane language.

Yes No

D. Any form of public or private humiliation, including threats of physical punishment.

Yes No

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

Yes No

19. Caregiver never physically restrains children except as necessary to ensure their own safety or that of others, and then only for as long as is necessary for control of the situation (6:PR036).

Yes No

20. Children are not given medicines or drugs that will affect their behavior except as prescribed by their health care provider and with specific written instructions from their health care provider for the use of the medicine (6:PR036).

Yes

No

21. "Time out" that enables the child to regain control of himself or herself and that keeps the child in visual contact with a caregiver is used selectively, taking into account the child's developmental stage and the usefulness of "time out" for the particular child (6:PR03y).

Yes

No

22. Is the fire evacuation procedure maintained by the caregiver and practiced at least monthly from all exit locations at varied times of the day and during varied activities, including naptime (7: AD 035)?

Yes

No

23. Do staff and children wash their hands at least at the following times, and whenever hands are contaminated with body fluids: (12:HP 029)?

- | | | |
|--|-----|----|
| A. Before food preparation, handling, or serving. | Yes | No |
| B. After toileting or changing diapers. | Yes | No |
| C. After assisting a child with toilet use. | Yes | No |
| D. Before handling food. | Yes | No |
| E. Before any food service activity (including setting the table). | Yes | No |
| F. Before and after eating meals or snacks. | Yes | No |
| G. After handling pets or other animals. | Yes | No |

Place checkmark for Yes. Place X for No. Notate for each incidence observed.

	Adult	Children
A.		
B.		
C.		
D.		
E.		
F.		
G.		

NOTE: Children and staff must wash and scrub their hands for at least 20 seconds with soap and warm running water to receive credit (12:HP 030).

Observation: Environment

24. The physical layout of the facility is arranged to ensure all areas can be viewed by at least two adults (caregiver and another). The purpose of this is to ensure each caregiver can be observed while interacting with children. This includes areas where the child may be undressed or have their genitals exposed (bathroom)(1:HP104).

Yes No

Outdoor Playground

25. Are sunlit areas and shaded areas provided by means of open space and tree plantings or other cover in outdoor spaces (10: FA 234)?

Yes No

26. Is the outdoor play area enclosed with a fence or natural barriers and includes the following (10: FA 235):

A. The barrier is at least 4 feet in height and the bottom edge shall be no more than 3 1/2 inches off the ground.

Yes No

B. There are at least two exits from such areas, with at least one remote from the buildings.

Yes No

C. Gates are equipped with self-closing and positive self-latching closure mechanisms.

Yes No

D. The latch or securing device is high enough or of such a type that it cannot be opened by small children.

Yes No

E. The openings in the fence are no greater than 3 1/2 inches.

Yes No

F. The fence is constructed to discourage climbing.

Yes No

27. If soil is used in the play areas,

A. It does not contain hazardous levels of any toxic chemical or substances. The facility shall have soil samples and analyses performed by the local health department, extension service, or environmental control testing laboratory, as required, where there is good reason to believe a problem may exist. (10:FA 236)

Yes

No

B. The soil in play areas shall be analyzed for lead content initially. It shall be analyzed at least once every 2 years where the exteriors of adjacent buildings and structures are painted with lead containing paint. Lead in soil shall not exceed 500 ppm. Testing and analyses shall be in accord with procedures specified by the regulating health authority. (10:FA 237)

Yes

No

28. If sandboxes are used, are they:

A. constructed to permit drainage?

Yes

No

B. covered tightly and securely when not in use?

Yes

No

C. kept free from cat or other animal excrement? (10:FA 238)

Yes

No

D. Sand used in sandboxes does not contain toxic or harmful materials? (10: FA 239)

Yes

No

29. Is outdoor storage available for equipment not secured to the ground, unless indoor storage space is available? (10:FA 240)

Yes

No

30. No anchored play equipment is placed over, or immediately adjacent to, hard surfaces.
(10:FA 241)

Yes No

31. Is all outdoor play equipment of safe design and in good repair?

Yes No

32. Are climbing equipment and swings set in concrete footings located below ground surface (at least 6 inches)?

Yes No

33. Do swings have soft and, or flexible seats?

Yes No

34. Is access to play equipment limited to age groups for which the equipment is developmentally appropriate? (10: FA 242)

Yes No

35. Are all pieces of playground equipment designed to match the body dimensions of children (10: FA 243)?

Yes No

36. Are all pieces of playground equipment installed so that an average adult will not be able to cause a fixed structure to wobble or tip (10:FA 244)?

Yes No

37. Are all paved surfaces well drained to avoid water accumulation and ice formation?(10:FA 252:

Yes No

38. Are all pieces of playground equipment?

A. Surrounded by a resilient surface (e.g., fine, loose sand; wood chips; wood mulch) of an acceptable depth (9 inches), or by rubber mats manufactured for such use, consistent with the guidelines of the Consumer Product Safety Commission and the standard of the American Society for Testing and Materials,

Yes

No

B. Extend beyond the external limits of the piece of equipment for at least 4 feet beyond the fall zone of the equipment. These resilient surfaces must conform to the standard stating that the impact from falling from the height of the structure will be less than or equal to peak deceleration 200G(63). Organic materials that support colonization of molds and bacteria shall not be used. (10:FA 245).

Yes

No

C. Designed so that moving parts (swing components, teeter totter mechanism, spring ride springs, etc.) will be shielded or enclosed (10:FA 246).

Yes

No

D. Free of sharp edges, protruding parts, weaknesses, and flaws in material construction. Sharp edges in wood, metal, or concrete shall be rounded to a minimum of 1/2 inch wide on all edges. Wood materials shall be sanded smooth and shall be inspected regularly for splintering. (10:FA 247).

Yes

No

E. All pieces of playground equipment shall be designed to guard against entrapment or situations that may cause strangulation by being made too large for a child's head to get stuck or too small for a child's head to fit into. Openings in exercise rings shall be smaller than 4, inches or larger than 9 inches in diameter. There shall be no openings in a play structure with a dimension between 4 and 5/8 inches and 9 and 1/8 inches. In particular, side railings, stairs, and other locations where a child might slip or try to climb through shall be checked for appropriate dimensions. Protrusions such as pipes or wood ends that may catch a child's clothing are prohibited. Distances between vertical infill, where used, must be 4 and 5/8 inches or less to prevent entrapment of a child's head. No opening shall have a vertical angle of less than 55 degrees. To prevent finger entrapment, no opening larger than 3/8 inch and smaller than 1 inch shall be present. (10:FA 248).

Yes

No

F. All bolts, hooks, eyes, shackles, rungs, and other connecting and linking devices of all pieces of playground equipment shall be designed and secured to prevent loosening or unfastening except by authorized individuals with special tools. (10:FA 249)

Yes No

G. Crawl spaces of all pieces of playground equipment, such as pipes or tunnels, shall be securely anchored to the ground to prevent movement, and shall have a minimum diameter that permits easy access to the space by adults in an emergency or for maintenance. (10:FA 250)

Yes No

H. The maximum height of any piece of playground equipment shall be no greater than 5 and 1/2 feet if children up to the age of 6 are given access to it, and no higher than 3 feet if the maximum age of children is 3 years. (10:FA 251)

Yes No

39. Are do all walking surfaces, such as walkways, ramps, and decks, have a nonslip finish (10: FA 253)?

Yes No

40. Are all walking surfaces and other play surfaces free of holes and sudden irregularities in the surface (10: FA 254)?

Yes No

41. Does space used for wheeled vehicles (10:FA255)

A. Have a flat, smooth, and nonslippery surface?

Yes No

B. Have a physical barrier separating this space from traffic, streets, parking, delivery areas, driveways, stairs, hallways used as fire exits, balconies, and pools and other areas containing water?

Yes No

42. Are all outdoor activity areas maintained in a clean and safe condition by removing debris, dilapidated structures, broken or worn play equipment, building supplies, glass, sharp rocks, twigs, toxic plants, and other injurious material?

Yes No

43. Are play areas free from anthills, unprotected ditches, wells, holes, grease traps, cisterns, cesspools, and unprotected utility equipment? Holes or abandoned wells within the site shall be properly filled or sealed. The area shall be well drained with no standing water. (10:FA 256)

Yes No

44. Is outdoor play equipment not coated or treated with, nor does it contain, toxic materials in hazardous amounts that are accessible to children. (10:FA 257)

Yes No

45. Is the general playground surfaces checked every day for broken glass, trash, and other foreign materials (e.g., animal excrement) (10: FA 259)?

Yes No

46. Is the playground area checked on a daily basis for areas of poor drainage and accumulation of water and ice (10: FA 260)?

Yes No

47. Is any particulate resilient material beneath playground equipment checked at least monthly for packing due to rain or ice and, if found compressed, turned over or raked up to increase resilience capacity? All particulate resilient material, particularly sand, shall be inspected daily for glass and other debris, animal excrement, and other foreign material. Loose fill surfaces shall be hosed down for cleaning and raked or sifted to remove hazardous debris as often as needed to keep the surface free of dangerous, unsanitary materials. (10:FA 261)

Yes No

48. Is the playground equipment checked on a monthly basis for the following: (10:FA 262)

A. Visible cracks, bending or warping, rusting, or breakage of any equipment.	Yes	No
B. Deformation of open hooks, shackles, rings, links, and so forth.	Yes	No
C. Worn swings hangers and chains.	Yes	No
D. Missing, damaged, or loose swing seats.	Yes	No
E. Broken supports or anchors.	Yes	No
F. Cement support footings that are exposed, cracked, or loose in the ground.	Yes	No
G. Accessible sharp edges or points.	Yes	No
H. Exposed ends of tubing that require covering with plugs or caps.	Yes	No
I. Protruding bolt ends that have lost caps or covers.	Yes	No
J. Loose bolts, nuts, and so forth that require tightening.	Yes	No
K. Splintered, cracked, or otherwise deteriorating wood.	Yes	No
L. Lack of lubrication on moving parts.	Yes	No
M. Worn bearings or other mechanical parts.	Yes	No
N. Broken or missing rails, steps, rungs, or seats.	Yes	No
O. Worn or scattered surfacing material.	Yes	No
P. Hard surfaces, especially under swings, slides, and so forth (e.g., places where resilient material has been shifted away from any surface underneath play equipment).	Yes	No
Q. Chipped or peeling paint.	Yes	No
R. Pinch or crush points, exposed mechanisms, juncture, and moving components.	Yes	No

49. Are all cleaning materials, detergents, aerosol cans, pesticides, health and beauty aids, poisons, and other toxic materials stored in their original labeled containers and used according to the manufacturer's instructions and for the intended purpose?

Yes No

50. Are all cleaning materials used only in a manner that will not contaminate play surfaces, food, or food preparation areas, and that will not constitute a hazard to the children?

Yes No

51. When not in actual use, are all cleaning materials kept in a place inaccessible to children and separate from stored medications and food? (11:FA120)

Yes No

52. Are toilets and sinks, easily accessible for use and supervision, and provided in the following ratios:

A. Toilets, urinals, and hand sinks are apportioned at a ratio of 1:10 for toddlers and preschool-age children and 1:15 for school-age children.

Yes No

B. Maximum toilet height is 11 inches and maximum hand sink height is 22 inches.

Yes No

C. Urinals do not exceed 30 percent of the total required toilet fixtures.

Yes No

D. When the number of children in the ratio is exceeded by one, an additional fixture is required. These numbers are subject to the following minimums: (12:FA 144)

A. A minimum of one sink and one flush toilet for 10 or fewer toddlers and pre-school age children using toilets.

Yes No

B. A minimum of one sink and one flush toilet for 15 or fewer school age children using toilets.

Yes No

- C. A minimum of two sinks and two flush toilets for 16 to 30 children using toilets.
- Yes No
- D. A minimum of one sink and one flush toilet for each additional 15 children.
- Yes No
53. The changing area is not located in food preparation areas and is never be used for temporary placement or serving of food. (12:FA 154)
- Yes No
54. Changing tables (12:FA 156)
- A. have impervious, nonabsorbent surfaces? Yes No
- B. are sturdy? Yes No
- C. are adult height? Yes No
- D. are equipped with railings? Yes No
- E. do not have safety straps? Yes No
55. If cloth diapers are used, is a toilet easily accessible so that waste contents may be disposed of by dumping before placing the diapers in the waste receptacle?(12:FA 158)
- Yes No
56. Are conveniently located, washable, plastic lined, tightly covered receptacles, operated by a foot pedal used for and soiled burping cloths and linen. (12:FA 159)?
- Yes No

C. Policy

57. Caregivers who report child abuse are protected from any disciplinary action, unless the report is found to be malicious (1:HP097).

Yes No

58. Symptoms and indicators of child abuse are included in written policies (1:HP100)

Yes No

59. Caregivers must report suspected sexually transmitted disease in children to a health care provider as well as the parent in order to make certain the child is taken for care (1:HP104).

Yes No

60. Any staff who will be alone with children shall have their references checked and employment history examined before employment (1:ST034).

Yes No

61. All children in care are required to be up to date on the current American Academy of Pediatrics (AAP) immunization schedule (2:APP 26).

Yes No

62. All staff involved with direct care are certified in pediatric first aid that includes rescue breathing and first aid for choking (5:ST044).

Yes No

63. At least one person who is certified in pediatric first aid that includes rescue breathing and first aid for choking is in attendance at all times and in all places that children are in care (5:ST044).

Yes

No

64. Does the facility's supervision policy specify:

A. That no child shall be left alone or unsupervised while under the care of the child care staff.

Yes

No

B. Caregivers shall supervise children at all times, even when the children are sleeping (a caregiver must be able to both see and hear infants while they are sleeping).

Yes

No

C. Caregivers shall not be on one floor while children are on another floor.

Yes

No

D. School-age children shall be permitted to participate in activities and visit friends off premises as approved by their parents and by the caregiver(s)

Yes

No

E. That developmentally appropriate child:staff ratios shall be met during all hours of operating, including field trips.

Yes

No

F. The policy shall include specific procedures governing supervision of the indoor and outdoor play spaces that describe the child:staff ratio, precautions to be followed for specific areas and equipment, and staff assignments for high-risk areas.

Yes

No

G. The supervision policies of centers are written policies. (6:AD 009)

Yes

No

65. Is there a written policy for the use of any commonly used, nonprescription medication as specified in medication administration indicators in the Director/Center Administration section?

Yes

No

66. Does RCL provide child care workers with hazard information, as required by the Occupational Safety and Health Administration (OSHA), about the presence of toxic substances such as asbestos or formaldehyde? Such information shall include the identification of the ingredients of art materials and disinfectants. (11:FA 122)

Yes

No

67. When the manufacturer's Material Data Safety Sheet shows the presence of any toxic effects, are these materials replaced with nontoxic substitutes? If no substitute is available, the product shall be eliminated (11:FA 123).

Yes

No

D. Training

68. Caregivers are aware of the common behaviors shown by abused children (1:HP96).

Yes No

69. Employees receive an instruction sheet about child abuse reporting (1:HP098)

Yes No

70. All caregivers in all settings and levels of employment know the definitions of the four forms of child abuse (physical, sexual, emotional and neglect) and can provide examples (1:HP099).

Yes No

71. Caregivers with a year of experience in child care know the symptoms and indicators of abuse that abused children may show (1:HP100).

Yes No

72. Caregivers know the common factors, both chronic and situational, that lead to abuse (1:HP100).

Yes No

73. Documented training is provided to all caregivers on the signs and symptoms of sexually transmitted diseases in children (1:HP104)

Yes No

74. Does the center require Director to provide documentation of one course or 26-30 clock hours of training in health and safety issues? This training is in addition to other educational qualifications required upon employment. The training shall include at least the following content (4:ST009):

- | | | | |
|----|--|-----|----|
| A. | Mechanisms of the spread of communicable diseases. | Yes | No |
| B. | Procedures for preventing the spread of communicable diseases, including handwashing, sanitation, diaper changing; required notification to the health department relating to communicable diseases; equipment, toy selection and proper washing and disinfecting to reduce disease and injury risk, and health related aspects of pets in the facility. | Yes | No |
| C. | Immunization requirements for children and staff | Yes | No |
| D. | Common childhood illnesses and their management, including child care exclusion policies. | Yes | No |
| E. | Organization of the facility to reduce illness and injury risks. | Yes | No |
| F. | Training child care staff and children on infection and injury control. | Yes | No |
| G. | Emergency procedures. | Yes | No |
| H. | Promotion of health in the child care setting. | Yes | No |

75. Does all new staff (both full and part time) shall receive **documented** orientation **during the week immediately following hire**, that includes, at a minimum, the following:
(5:ST040; 5(ST041)

- | | | |
|--|-----|----|
| A. The goals and philosophy of the facility. | Yes | No |
| B. The names and ages of the children for whom the caregiver will be responsible, and their specific developmental needs. | Yes | No |
| C. Any special adaptation(s) of the facility required for a child with special needs. | Yes | No |
| D. Any special health or nutrition need(s) of the children assigned to the caregiver. | Yes | No |
| E. The planned program of activities at the facility. | Yes | No |
| F. Routines and transitions. | Yes | No |
| G. Acceptable methods of discipline. | Yes | No |
| H. Policies of the facility about relating to parents. | Yes | No |
| I. Meal patterns and food-handling policies of the facility. | Yes | No |
| J. Occupational health hazards for caregivers. | Yes | No |
| K. Emergency health and safety procedures. | Yes | No |
| L. General health policies and procedures, including but not limited to the following: | | |
| a. Handwashing techniques, including indications for handwashing. | Yes | No |
| b. Diapering technique and toileting, if care is provided to children in diapers and/or needing help with toileting, including appropriate diaper disposal and diaper-changing techniques. | Yes | No |

- | | | |
|---|-----|----|
| c. Correct food preparation, serving, and storage techniques if employee prepares food. | Yes | No |
| d. Formula preparation, if formula is handled. | Yes | No |
| M. Child abuse detection, prevention, and reporting. | Yes | No |
| N. Teaching health promotion concepts to children and parents as part of the daily care provided to children. | Yes | No |
| O. Recognizing symptoms of illness. | Yes | No |

76. Within the first three months of employment, does all full and part time staff receive additional orientation on the following topics? (5:ST042)

- | | | |
|--|-----|----|
| A. Recognition of symptoms of illness and correct documentation procedures for recording illness symptoms. | Yes | No |
| B. Exclusion and readmission procedures. | Yes | No |
| C. Cleaning, sanitation, and disinfection procedures. | Yes | No |
| D. Procedures for administering medication to children and for documenting medication administered to children. | Yes | No |
| E. Procedures for notifying parents or legal guardians of communicable disease occurring in children or staff within the facility. | Yes | No |
| F. Procedures for performing the daily health assessment of children to determine whether they are ill and whether they need to be excluded from the facility. | Yes | No |

77. Is any caregiver who administers medication trained to check for the following (8:HP 087)

A. Name of the child Yes No

B. To read the label/prescription directions in relation to the measured dose, frequency, and other circumstances relative to administration (e.g., relation to meals); Yes No

C. To document properly that the medication was administered. Yes No

78. Are staff expected to take responsibility for aspects of care ONLY after they have been oriented and trained? (5:ST043)

Yes No

79. Is the pediatric aid training, including rescue breathing and first aid for choking, consistent with pediatric first aid training developed by the American Red Cross, the American Heart Association, or the National Safety Council for First Aid Training Institute, or the equivalent of one of the three? The offered first aid instruction shall include, but not be limited to, the emergency management of: (5:ST046)

A. Bleeding.	Yes	No
B. Burns.	Yes	No
C. Poisoning.	Yes	No
D. Choking.	Yes	No
E. Injuries, including insect, animal, and human bites.	Yes	No
F. Shock.	Yes	No
G. Convulsions or nonconvulsive seizures.	Yes	No
H. Musculoskeletal injury (e.g., sprains, fractures).	Yes	No
I. Dental emergencies.	Yes	No
J. Head injuries.	Yes	No
K. Allergic reactions.	Yes	No
L. Eye injuries.	Yes	No
M. Loss of consciousness.	Yes	No
N. Electric shock.	Yes	No
O. Drowning.	Yes	No

80. Are there current records of certification of pediatric first aid including rescue breathing and first aid for choking (and infant and child CPR) (5:ST049)?

Yes No

81. When providing care in a facility that has a swimming pool or wading pool, are caregivers required to have infant and child CPR training (5:ST047)?

Yes No

82. When providing care in a facility that has a swimming pool or wading pool, does at least one caregiver who is counted in the child:staff ratio trained in basic water safety and certified in infant and child CPR each year by a person certified as an instructor in water safety and in CPR? (Requires written verification kept on file) (5:ST047).

Yes No

83. When providing care for children with special needs in a facility that has a swimming pool or wading pool, is at least one caregiver certified in infant and child CPR (written verification must be kept on file) (5:ST047)

Yes No

84. Are the Director and all caregivers required to have at least 30 hours of continuing education the first year of employment? (5:ST050)

Yes No

85. Does this training include the following: (5:ST050)

A. 16 hours in child development programming? Yes No

B. 14 hours in child health, safety and staff health? Yes No

86. Are the Director and all caregivers required to have at least 24 hours of continuing education in the second and subsequent years of employment? (5:ST050)

Yes No

87. Does this training include the following: (5:ST050)
- | | | |
|--|-----|----|
| A. 16 hours in child development programming? | Yes | No |
| B. 8 hours in child health, safety and staff health? | Yes | No |
-
88. Does the facility have a staff training plan for reporting and evacuating in case of fire, flood, tornado, earthquake, hurricane, blizzard, power failure, or other disaster that could create structural damages to the facility or pose health hazards (7: AD 031).
- | | |
|-----|----|
| Yes | No |
|-----|----|
-
89. Is staff training provided on the emergency plan that is outlined in the Director/Center Administration section?
- | | |
|-----|----|
| Yes | No |
|-----|----|

E. Administration (Center Based/Director)

90. The facility reports suspected child abuse, neglect, or exploitation (1:HP094)

Yes No

91. A health care professional is available for consultation for suspected abuse. These names are available for inspection (1:HP095)

Yes No

92. Center director knows methods of reducing the risk, how to recognize common symptoms and signs of child abuse (1:HP101).

Yes No

93. Is the Director at least 21 years of age? (4:ST006)

Yes No

94. **For programs ONLY offering infant through preschool care:** Does the director of the program have an undergraduate degree in early childhood education, child development, social work, nursing, or other child-related field, or a combination of college course work and experience under qualified supervision? (4:ST006)

Yes No

95. **For programs ONLY offering school aged care:** Does the director have an undergraduate degree in early childhood education, elementary education, child development, recreation, or other child related field, or a combination of college course work and experience under qualified supervision? (4:ST011).

Yes No

96. Does the education of the director include: (4:ST006)
- | | | | |
|----|--|-----|----|
| A. | College course work in business and/or education administration or an Administrator Credential | Yes | No |
| B. | At least four college courses in child development and early childhood education | Yes | No |
| C. | Two or more years experience as a teacher of children of the age group(s) in care. (Select all that apply) (4:ST010) | | |
| | 0-35 months | Yes | No |
| | 3 to 5 years | Yes | No |
| | 6 years and up (school aged care) | Yes | No |

97. Does the Director have teaching duties in addition to his/her administrative role? (4:ST008)
- | | |
|-----|----|
| Yes | No |
|-----|----|

98. Does the director have a valid certificate in pediatric first aid, including management of a blocked airway, and rescue breathing?
- | | |
|-----|----|
| Yes | No |
|-----|----|

99. Does the director have at least one year experience as the administrator of an early childhood program?
- | | |
|-----|----|
| Yes | No |
|-----|----|

100. Prior to employment, does the director (4:ST034):
- | | | | |
|----|-------------------------------------|-----|----|
| A. | Check the applicant's references | Yes | No |
| B. | Verify past employment | Yes | No |
| C. | Complete criminal background checks | Yes | No |

101. Does the center, have at least one licensed/certified lead teacher (or mentor teacher) who has a Bachelor of Arts, Bachelor of Science, Bachelor of Education, or Master of Education degree in early childhood education, child development, social work, nursing, or other child-related field, as well as at least 1 year of experience working in child care with this age group? (4:ST 016 and ST018)

Yes

No

102. Does the facility have a written plan for reporting and evacuating in case of fire, flood, tornado, earthquake, hurricane, blizzard, power failure, or other disaster that could create structural damages to the facility or pose health hazards (7: AD 031).

Yes

No

103. Are evacuation drills practiced as follows in areas where natural disasters occur: for tornadoes, on a monthly basis in tornado season; for earthquakes, every 6 months; and for hurricanes, annually (7: AD 032)?

No

Yes

104. Does the Center Director use a daily class roster in checking the evacuation and return to a safe indoor space of all children in attendance during an evacuation drill (7: AD 033)?

Yes

No

105. Is the fire evacuation procedure approved by a fire inspector and practiced at least monthly from all exit locations at varied times of the day and during varied activities, including naptime (7:AD 034)?

No

Yes

106. Is the administration of medicines at the facility limited to (8:HP082):

A. Those prescribed medications ordered by a health care provider for a specific child.

Yes No

B. Those nonprescription medications recommended by a health care provider for a specific child, with written permission of the parent or legal guardian referencing a written or telephone instruction received by the facility from the health care provider.

Yes No

107. Do the requirements of prescription medication brought into the facility by the parent, legal guardian, or responsible relative of a child include (8:HP083):

A. Be kept in the original container labeled by a pharmacist with the child's first and last names;

Yes No

B. the date the prescription was filled;

Yes No

C. the name of the health care provider who wrote the prescription;

Yes No

D. the medication's expiration date; and

Yes No

E. specific, legible instructions for administration, storage, and disposal (i.e., the manufacturer's instructions or prescription label).

Yes No

108. Do any over-the-counter medication brought into the facility for use by a specific child include the following:(8:HP084)?

A. In the original, labeled container

Yes No

B. The date; the child's first and last names;

Yes No

C. specific, legible instructions for administration and storage (i.e., manufacturer's instructions);

Yes No

D. the name of the health care provider who made the recommendation.

Yes No

109. Are/do all medications, refrigerated or unrefrigerated (8: HP085):

- | | | |
|---|-----|----|
| A. have child protective caps? | Yes | No |
| B. kept in an orderly fashion? | Yes | No |
| C. stored away from food at the proper temperature? | Yes | No |
| D. inaccessible to children? | Yes | No |
| E. not used beyond the date of expiration? | Yes | No |

110. Does the facility shall 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 or staff (9:APP28)

Yes No

111. Are the following incidents, at a minimum, addressed in the emergency plan:

- | | | |
|--|-----|----|
| A. lost or missing child; | Yes | No |
| B. sexual or physical abuse or neglect of a child; | Yes | No |
| C. injuries requiring medical or dental care; | Yes | No |
| D. serious illness requiring hospitalization, death of a child enrolled in the facility, or death of a caregiver, including deaths that occur outside of child care hours. | | |

Yes No

112. Are the following procedures, at a minimum, addressed in the emergency plan:

- A. Provision for a caregiver to accompany a child to the emergency care source and remain with the child until the parent or legal guardian assumes responsibility for the child. Child:staff ratios must be maintained at the facility during the emergency;

Yes No

- B. The source of emergency medical care—a hospital emergency room, clinic, or other constantly staffed facility known to caregivers and acceptable to parents;

Yes No

C. Ensure that first aid kits are resupplied following each first aid incident, and that required contents are maintained in a serviceable condition, by a periodic review of the contents;

Yes No

D. The names and addresses of a least three licensed providers of dental services who have agreed to accept emergency dental referrals of children and to give advice regarding a dental emergency.

Yes No

113. Does the Center Director conduct inspections of the playground area and the playground as specified in the Environment Section (10:FA 258)?

Yes No

114. Does the facility ensure that staff and children are instructed in, and monitored on, the use of running water, soap, and single-use or disposable towels in handwashing as specified in this chapter (11:HP 031)?

Yes No

115. Is the poison control center and or physician called for advice about safe use of any toxic products (e.g., pesticides, plants, rat poison) or in any ingestion emergency, and their advice documented in the facility's files? The poison information specialist and or physician shall be told the child's age and sex, the substance swallowed and the estimated amount, and the condition of the child. (11:FA 121)

Yes No

116. Are Radon concentrations less than 4 picocuries per liter of air (11:FA 124)?

Yes No

117. Has any asbestos that is friable or in a dangerous condition found within a facility been removed by a contractor certified to remove asbestos, encapsulated, or enclosed in

accordance with existing regulations of the Environmental Protection Agency, the federal agency responsible for asbestos abatement. (11:FA 125)?

Yes No

118. Are pipe and boiler insulation sampled and examined in an accredited laboratory for the presence of asbestos in a friable or potentially dangerous condition (11:FA 126)?

Yes No

119. Is nonfriable asbestos identified to prevent disturbance and or exposure during remodeling or future activities. (11:FA 127)?

Yes No

120. Are chemicals used in lawn care treatments limited to those listed as nonrestricted use?

Yes No

121. Are all chemicals used inside or outside stored in their original containers in a safe and secure manner, accessible only to authorized staff? They shall be used only according to manufacturers' instructions, and in a manner that will not contaminate play surfaces or articles. (11:FA 128)

Yes No

122. Are all arts and crafts materials used in the facility nontoxic?

Yes No

123. Is there no eating or drinking by children or staff during use of such arts and crafts materials?

Yes No

124. Is the use of old or donated arts and crafts materials with potentially harmful ingredients prohibited? (11:FA 129)

Yes

No

125. Are poisonous or potentially harmful plants on the premises inaccessible to children? All plants accessible to children shall be identified and checked by name with the local poison control center to determine safe use. (11:FA 130)

Yes

No

126. Is the use of incense, moth crystals or moth balls, and chemical air fresheners that contain ingredients on the Environmental Protection Agency's toxic chemicals lists and those not approved as safe by the state or local regulatory agency prohibited? Contact the EPA Regional offices listed in the federal agency section of the telephone directory for assistance, or contact any nationally certified regional poison control center. (11:FA 131)

Yes

No

127. Are carpets made of nylon, orlon, wool and/or silk, and other materials that emit highly toxic fumes when they burn not used. (11:FA 132)

Yes

No

128. Are areas that have been recently carpeted or paneled using an adhesive that may contain toxic materials well ventilated and not used by a facility for at least 7 days after such installation, or until there is no perceptible odor? Ambient testing in compliance with testing requirements of the Environmental Protection Agency shall be conducted if recommended by the local health department or building inspector before occupancy to ascertain that no unsafe levels of toxic substances (e.g., formaldehyde) resulting from the materials or their installation exist. (11:FA 133)

Yes

No

129. Is insulation or other materials that contain elements that may emit toxic substances (e.g., formaldehyde) over recommended levels in the child care environment not used in facilities? If existing structures contain such materials, the facility shall be monitored regularly to ensure a safe environment as specified by the regulatory agency. (11:FA 134)

Yes No

130. Are any surfaces painted before 1978 tested for excessive lead levels (11:FA 135)?

A. In all centers, both exterior and interior surfaces covered by paint with lead levels of 0.06 percent and above and accessible to children shall be removed by a safe chemical or physical means or made inaccessible to children, regardless of the condition of the surface.

Yes No

B. Where lead paint is removed, the surface shall be refinished with lead-free paint or nontoxic material. Sanding, scraping, or burning of high-lead surfaces shall be prohibited.

Yes No

131. No paint containing lead in excess of 0.06 percent is used when surfaces are repaired or when any new surfaces accessible to children are painted. (11:FA 136)

Yes No

132. Is construction, remodeling, or alterations of structures during child care operations done in such a manner as to prevent hazards or unsafe conditions (e.g., fumes, dust, safety hazards) (11:FA 137)?

Yes No

References

- Fiene (2007). Child Development Program Evaluation & Caregiver Observation Scale, in T Halle (Ed.), *Early Care and Education Quality Measures Compendium*, Washington, D.C.: Child Trends.
- Fiene (2003). Licensing related indicators of quality child care, *Child Care Bulletin*, Winter 2002-2003, pps 12-13.
- Fiene (2002). *Thirteen indicators of quality child care: Research update*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services.
- Fiene, & Kroh (2000). Measurement tools and systems, in *Licensing Curriculum*, National Association for Regulatory Administration, Minneapolis, Minnesota.
- Fiene (1997). Potential solution to the child day care trilemma related to quality, accessibility and affordability. *Child Care Information Exchange*, September, 57-60.
- Fiene (1996). Using a statistical-indicator methodology for accreditation, in *NAEYC Accreditation: A Decade of Learning and the Years Ahead*, S. Bredekamp & B. Willer, editors, Washington, D.C.: National Association for the Education of Young Children.
- Kuhns & Fiene (1995). Promoting health and safety in child care programs, *Child Care Bulletin*, January-February (1), 3.
- Fiene (1995). *National early childhood program accreditation standards*. Atlanta, Georgia: National Early Childhood Program Accreditation Commission.
- Griffin & Fiene (1995). *A systematic approach to policy planning and quality improvement for child care: A technical manual for state administrators*. Washington, D.C.: National Center for Clinical Infant Programs-Zero to Three.
- Fiene (1994). The case for national early care and education standards: Key indicator/predictor state child care regulations, *National Association of Regulatory Administration*, summer 1994, 6-8.
- Fiene (1988). Human services instrument based program monitoring and indicator systems, in *Information Technology and the Human Services*, B. Glastonburg, W. LaMendola, & S. Toole, editors, Chichester, England: John Wiley and Sons.
- Fiene & McDonald (1987). *Instrument based program monitoring for child welfare*, Portland, Maine: University of Southern Maine.

Fiene (1987). Using licensing data in human service programs, in *Licensing*, H. Hornby, editor, Portland, Maine: University of Southern Maine.

Fiene (1987). The indicator system, in *Evaluation and outcome monitoring*, H. Hornby, editor, Portland, Maine: University of Southern Maine.

Kontos & Fiene (1987). Child care quality, compliance with regulations, and children's development: The Pennsylvania Study, in *Quality in Child Care: What Does Research Tell Us?*, Phillips, editor, Washington, D.C.: National Association for the Education of Young Children.

Fiene (1987). Indicator checklist system, in *Maximizing the Use of Existing Data Systems*, Portland, Maine: University of Southern Maine.

Fiene (1986). State child care regulatory, monitoring and evaluation systems as a means for ensuring quality child development programs, in *Licensing of Children's Services Programs*, Richmond, Virginia: Virginia Commonwealth University School of Social Work. (ERIC/ECE ED322997)

Morgan, Stevenson, Fiene, & Stephens (1986). Gaps and excesses in the regulation of child day care, *Reviews of Infectious Diseases--Infectious Diseases in Child Day Care: Management and Prevention*, 8(4), 634-643.

Kontos & Fiene (1986). Predictors of quality and children's development in day care, in *Licensing of Children's Services Programs*, Richmond, Virginia: Virginia Commonwealth University School of Social Work.

Fiene & Nixon (1985). Instrument based program monitoring and the indicator checklist for child care, *Child Care Quarterly*, 14(3), 198-214.

Fiene (1985). Measuring the effectiveness of regulations, *New England Journal of Human Services*, 5(2), 38-39.

Fiene & Nixon (1983). *Indicator checklist system for day care monitoring*, Washington, D.C.: National Children's Services Monitoring Consortium.

Fiene & Nixon (1981). *An instrument based program monitoring information system: A new tool for day care monitoring*, Washington, D.C.: National Children's Services Monitoring Consortium.

Fiene (1981). A new tool for day care monitoring introduced by children's consortium, *Evaluation Practice*, 1(2), 10-11.

Fiene (1978). Theoretical model for computing adult child ratios, *Association of Regulatory Administration*, summer, 12-13.

Fiene, Cardiff, & Littles (1975). Ecological monitoring information system, *In the Best Interests of Children*, July-September, 1975.

Appendix

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2010

For those who fall behind or start late, see the catch-up schedule

This schedule includes recommendations in effect as of December 15, 2009. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, **800-822-7967**.

1. Hepatitis B vaccine (HepB). (Minimum age: birth)

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1 or 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks. The final dose should be administered no earlier than age 24 weeks.
- Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
- Administration of 4 doses of HepB to infants is permissible when a combination vaccine containing HepB is administered after the birth dose. The fourth dose should be administered no earlier than age 24 weeks.

2. Rotavirus vaccine (RV). (Minimum age: 6 weeks)

- Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
- The maximum age for the final dose in the series is 8 months 0 days
- If Rotarix is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).

(Minimum age: 6 weeks)

- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4 through 6 years.

4. Haemophilus influenzae type b conjugate vaccine (Hib).

(Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- TriHiBit (DTaP/Hib) and Hiberix (PRP-T) should not be used for doses at ages 2, 4, or 6 months for the primary series but can be used as the final dose in children aged 12 months through 4 years.

5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])

- PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
- Administer PPSV 2 or more months after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. See *MMWR* 1997;46(No. RR-8).

6. Inactivated poliovirus vaccine (IPV) (Minimum age: 6 weeks)

- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
- If 4 doses are administered prior to age 4 years a fifth dose should be administered at age 4 through 6 years. See *MMWR* 2009;58(30):829-30.

7. Influenza vaccine (seasonal). (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- Administer annually to children aged 6 months through 18 years.
- For healthy children aged 2 through 6 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used, except LAIV should not be given to children aged 2 through 4 years who have had wheezing in the past 12 months.
- Children receiving TIV should receive 0.25 mL if aged 6 through 35 months or 0.5 mL if aged 3 years or older.
- Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
- For recommendations for use of influenza A (H1N1) 2009 monovalent vaccine see *MMWR* 2009;58(No. RR-10).

8. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- Administer the second dose routinely at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 28 days have elapsed since the first dose.

9. Varicella vaccine. (Minimum age: 12 months)

- Administer the second dose routinely at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 3 months have elapsed since the first dose.

- For children aged 12 months through 12 years the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.

10. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- Administer to all children aged 1 year (i.e., aged 12 through 23 months). Administer 2 doses at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits
- HepA also is recommended for older children who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

11. Meningococcal vaccine. (Minimum age: 2 years for meningococcal conjugate vaccine [MCV4] and for meningococcal polysaccharide vaccine [MPSV4])

- Administer MCV4 to children aged 2 through 10 years with persistent complement component deficiency, anatomic or functional asplenia, and certain other conditions placing them at high risk.
- Administer MCV4 to children previously vaccinated with MCV4 or MPSV4 after 3 years if first dose administered at age 2 through 6 years. See *MMWR* 2009; 58:1042-3.

Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2010

For those who fall behind or start late, see the schedule below and the catch-up schedule

This schedule includes recommendations in effect as of December 15, 2009. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, **800-822-7967**.

- 1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
 - Administer at age 11 or 12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoid (Td) booster dose.
 - Persons aged 13 through 18 years who have not received Tdap should receive a dose.
 - A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose; however, a shorter interval may be used if pertussis immunity is needed.
- 2. Human papillomavirus vaccine (HPV).** (Minimum age: 9 years)
 - Two HPV vaccines are licensed: a quadrivalent vaccine (HPV4) for the prevention of cervical, vaginal and vulvar cancers (in females) and genital warts (in females and males), and a bivalent vaccine (HPV2) for the prevention of cervical cancers in females.
 - HPV vaccines are most effective for both males and females when given before exposure to HPV through sexual contact.
 - HPV4 or HPV2 is recommended for the prevention of cervical precancers and cancers in females.
 - HPV4 is recommended for the prevention of cervical, vaginal and vulvar precancers and cancers and genital warts in females.
 - Administer the first dose to females at age 11 or 12 years.
 - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
 - Administer the series to females at age 13 through 18 years if not previously vaccinated.
 - HPV4 may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of acquiring genital warts.
- 3. Meningococcal conjugate vaccine (MCV4).**
 - Administer at age 11 or 12 years, or at age 13 through 18 years if not previously vaccinated.
 - Administer to previously unvaccinated college freshmen living in a dormitory.
 - Administer MCV4 to children aged 2 through 10 years with persistent complement component deficiency, anatomic or functional asplenia, or certain other conditions placing them at high risk.
 - Administer to children previously vaccinated with MCV4 or MPSV4 who remain at increased risk after 3 years (if first dose administered at age 2 through 6 years) or after 5 years (if first dose administered at age 7 years or older). Persons whose only risk factor is living in on-campus housing are not recommended to receive an additional dose. See *MMWR* 2009;58:1042–3.
- 4. Influenza vaccine (seasonal).**
 - Administer annually to children aged 6 months through 18 years.
 - For healthy nonpregnant persons aged 7 through 18 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used.
 - Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
 - For recommendations for use of influenza A (H1N1) 2009 monovalent vaccine. See *MMWR* 2009;58(No. RR-10).
- 5. Pneumococcal polysaccharide vaccine (PPSV).**
 - Administer to children with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition. See *MMWR* 1997;46(No. RR-8).
- 6. Hepatitis A vaccine (HepA).**
 - Administer 2 doses at least 6 months apart.
 - HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
- 7. Hepatitis B vaccine (HepB).**
 - Administer the 3-dose series to those not previously vaccinated.
 - A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.
- 8. Inactivated poliovirus vaccine (IPV).**
 - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
 - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
- 9. Measles, mumps, and rubella vaccine (MMR).**
 - If not previously vaccinated, administer 2 doses or the second dose for those who have received only 1 dose, with at least 28 days between doses.
- 10. Varicella vaccine.**
 - For persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
 - For persons aged 7 through 12 years, the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
 - For persons aged 13 years and older, the minimum interval between doses is 28 days.