Chapter 3: Health Promotion and Protection

3.6 Management of Illness

3.6.1 Inclusion/Exclusion Due to Illness

3.6.1.1: Inclusion/Exclusion/Dismissal of Children


Preparing for managing illness:

Caregivers/teachers should:

a. With a child care health consultant, develop protocols and procedures for handling children’s illnesses, including care plans and an inclusion/exclusion policy.

b. Review with all families the inclusion/exclusion criteria. Clarify that the program staff (not the families) will make the final decision about whether children who are ill may attend. The decision will be based on the program’s inclusion/exclusion criteria and their ability to care for the child who is ill without compromising the care of other children in the program.

c. Encourage all families to have a backup plan for child care in the event of short- or long-term exclusion.

d. Consider the family’s description of the child’s behavior to determine whether the child is well enough to return, unless the child’s status is unclear from the family’s report.

e. A primary health care provider’s note may be required to readmit a child to determine whether the child is a health risk to others, or if guidance is needed about any special care the child requires.

Daily health checks as described in Standard 3.1.1.1 should be performed upon arrival of each child each day. Staff should objectively determine if the child is ill or well. Staff should determine which children with mild illnesses can remain in care and which need to be excluded.

Staff should notify the parent/guardian when a child develops 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 the child from the child care setting as soon as possible.

For children whose symptoms do not require exclusion, verbal or written notification of 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 reentering care.

Conditions/symptoms that do not require exclusion:

a. Common colds, runny noses (regardless of color or consistency of nasal discharge)

b. A cough not associated with fever, rapid or difficult breathing, wheezing or cyanosis (blueness of skin or mucous membranes)

c. Pinkeye (bacterial conjunctivitis) indicated by pink or red conjunctiva with white or yellow eye mucous drainage and matted eyelids after sleep. This may be thought of as a cold in the eye. Exclusion is no longer required for this condition. Health professionals may vary on whether or not to treat pinkeye with antibiotic drops. The role of antibiotics in treatment and preventing spread of conjunctivitis is unclear. Most children with pinkeye get better after 5 or 6 days without antibiotics. Parents/guardians should discuss care of this condition with their child’s primary care provider, and follow the primary care provider’s advice. Some primary care providers do not think it is necessary to examine the child if the discussion with the parents/guardians suggests that the condition is likely to be self-limited. If no treatment is provided, the child should be allowed to remain in care. If the child’s eye is painful, a health care [provider should examine the child. If 2 or more children in a group develop pinkeye in the same period, the program should seek advice from the program’s health consultant or a public health agency.

d. Watery, yellow or white discharge or crusting eye discharge without fever, eye pain, or eyelid redness

e. Yellow or white eye drainage that is not associated with pink or red conjunctiva (i.e., the whites of the eyes)

f. Fever without any signs or symptoms of illness in children who are older than four months regardless of whether
Acetaminophen or ibuprofen was given. For this purpose, fever is defined as temperature above 101 degrees F (38.3 degrees C) by any method. These temperature readings do not require adjustment for the location where they are made. They are simply reported with the temperature and the location, as in “101 degrees in the armpit/axilla”;

Fever is an indication of the body’s response to something, but is neither a disease nor a serious problem by itself. Body temperature can be elevated by overheating caused by overdressing or a hot environment, reactions to medications, and response to infection. If the child is behaving normally but has a fever, the child should be monitored, but does not need to be excluded for fever alone. For example, an infant with a fever after an immunization who is behaving normally does not require exclusion.

a. Rash without fever and behavioral changes. Exception: call EMS (911) for rapidly spreading bruising or small blood spots under the skin.
b. Impetigo lesions should be covered, but treatment may be delayed until the end of the day. As long as treatment is started before returning the next day, no exclusion is needed;
c. Lice or nits treatment may be delayed until the end of the day. As long as treatment is started before returning the next day, no exclusion is needed;
d. Ringworm treatment may be delayed until the end of the day. As long as treatment is started before returning the next day, no exclusion is needed;
e. Scabies treatment may be delayed until the end of the day. As long as treatment is started before returning the next day, no exclusion is needed;
f. Molluscum contagiosum (does not require covering of lesions);
g. Thrush (i.e., white spots or patches in the mouth or on the cheeks or gums);
h. Fifth disease (slapped cheek disease, parvovirus B19) once the rash has appeared;
i. Methicillin-resistant Staphylococcus aureus, or MRSA, without an infection or illness that would otherwise require exclusion. Known MRSA carriers or colonized individuals should not be excluded;
j. Cytomegalovirus infection;
k. Chronic hepatitis B infection;
l. Human immunodeficiency virus (HIV) infection;
m. Asymptomatic children who have been previously evaluated and found to be shedding potentially infectious organisms in the stool. Children who are continent of stool or who are diapered with formed stools that can be contained in the diaper may return to care. For some infectious organisms, exclusion is required until certain guidelines have been met. Note: These agents are not common and caregivers/teachers will usually not know the cause of most cases of diarrhea;
n. Children with chronic infectious conditions that can be accommodated in the program according to the legal requirement of federal law in the Americans with Disabilities Act. The act requires that child care programs make reasonable accommodations for children with disabilities and/or chronic illnesses, considering each child individually.

Key criteria for exclusion of children who are ill:
When a child becomes ill but does not require immediate medical help, a determination must be made regarding whether the child should be sent home (i.e., should be temporarily “excluded” from child care). Most illnesses do not require exclusion. 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.

If any of the above criteria are met, the child should be excluded, regardless of the type of illness. Decisions about caring for the child while awaiting parent/guardian pick-up should be made on a case-by-case basis providing care that is comfortable for the child considering factors such as the child’s age, the surroundings, potential risk to others and the type and severity of symptoms the child is exhibiting. The child should be supervised by someone who knows the child well and who will continue to observe the child for new or worsening symptoms. If symptoms allow the child to remain in their usual care setting while awaiting pick-up, the child should be separated from other children by at least 3 feet until the child leaves to help minimize exposure of staff and children not previously in close contact with the child. All who have been in contact with the ill child must wash their hands. Toys, equipment, and surfaces used by the ill child should be cleaned and disinfected after the child leaves.
Temporary exclusion is recommended when the child has any of the following conditions:

a. The illness prevents the child from participating comfortably in activities;
b. The illness results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;
c. A severely ill appearance - this could include lethargy/lack of responsiveness, irritability, persistent crying, difficult breathing, or having a quickly spreading rash;

d. Fever (temperature above 101°F [38.3°C] by any method) with a behavior change in infants older than 2 months of age. For infants younger than 2 months of age, a fever (above 100.4°F [38°C] by any method) with or without a behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea) requires exclusion and immediate medical attention;

e. Diarrhea is defined by stools that are more frequent or less formed than usual for that child and not associated with changes in diet. Exclusion is required for all diapered children whose stool is not contained in the diaper and toilet-trained children if the diarrhea is causing “accidents”. In addition, diapered children with diarrhea should be excluded if the stool frequency exceeds two stools above normal for that child during the time in the program day, because this may cause too much work for the caregivers/teachers, or those whose stool contains blood or mucus. Readmission after diarrhea can occur when diapered children have their stool contained by the diaper (even if the stools remain loose) and when toilet-trained children are not having “accidents” and when stool frequency is no more than 2 stools above normal for that child during the time in the program day;

Special circumstances that require specific exclusion criteria include the following (2):
A health care provider must clear the child or staff member for readmission for all cases of diarrhea with blood or mucus. Readmission can occur following the requirements of the local health department authorities, which may include testing for a diarrhea outbreak in which the stool culture result is positive for Shigella, Salmonella serotype Typhi and Paratyphi, or Shiga toxin-producing E. coli. Children and staff members with Shigella should be excluded until diarrhea resolves and test results from at least 1 stool culture are negative (rules vary by state). Children and staff members with Shiga toxin-producing E. coli (STEC) should be excluded until test results from 2 stool cultures are negative at least 48 hours after antibiotic treatment is complete (if prescribed). Children and staff members with Salmonella serotype Typhi and Paratyphi are excluded until test results from 3 stool cultures are negative. Stool should be collected at least 48 hours after antibiotics have stopped. State laws may govern exclusion for these conditions and should be followed by the health care provider who is clearing the child or staff member for readmission.

a. Vomiting more than two times in the previous twenty-four hours, unless the vomiting is determined to be caused by a non-infectious condition and the child remains adequately hydrated;

b. Abdominal pain that continues for more than two hours or intermittent pain associated with fever or other signs or symptoms of illness;

c. Mouth sores with drooling that the child cannot control unless the child’s primary care provider or local health department authority states that the child is noninfectious;

d. Rash with fever or behavioral changes, until the primary care provider has determined that the illness is not an infectious disease;

e. Active tuberculosis, until the child’s primary care provider or local health department states child is on appropriate treatment and can return;

f. Impetigo, only if child has not been treated after notifying family at the end of the prior program day. Exclusion is not necessary before the end of the day as long as the lesions can be covered;

g. Streptococcal pharyngitis (i.e., strep throat or other streptococcal infection), until the child has two doses of antibiotic (one may be taken the day of exclusion and the second just before returning the next day);

h. Head lice, only if the child has not been treated after notifying family at the end of the prior program day. (note: exclusion is not necessary before the end of the program day);

i. Scabies, only if the child has not been treated after notifying the family at the end of the prior program day. (note: exclusion is not necessary before the end of the program day);

j. Chickenpox (varicella), until all lesions have dried or crusted (usually six days after onset of rash and no new lesions have appeared for at least 24 hours);

k. Rubella, until seven days after the rash appears;

l. Pertussis, until five days of appropriate antibiotic treatment;

m. Mumps, until five days after onset of parotid gland swelling;

n. Measles, until four days after onset of rash;

o. Hepatitis A virus infection, until one week after onset of illness or jaundice if the child’s symptoms are mild or as directed by the health department. (Note: Protection of the others in the group should be checked to be sure everyone who was exposed has received the vaccine or receives the vaccine immediately.);

p. Any child determined by the local health department to be contributing to the transmission of illness during an outbreak.

**Procedures for a child who requires exclusion:**
The caregiver/teacher will:

a. Make decisions about caring for the child while awaiting parent/guardian pick-up on a case-by-case basis providing care
that is comfortable for the child considering factors such as the child’s age, the surroundings, potential risk to others and the type and severity of symptoms the child is exhibiting. The child should be supervised by someone who knows the child well and who will continue to observe the child for new or worsening symptoms. If symptoms allow the child to remain in their usual care setting while awaiting pick-up, the child should be separated from other children by at least 3 feet until the child leaves to help minimize exposure of staff and children not previously in close contact with the child. All who have been in contact with the ill child must wash their hands. Toys, equipment, and surfaces used by the ill child should be cleaned and disinfected after the child leaves;

b. Discuss the signs and symptoms of illness with the parent/guardian who is assuming care. Review guidelines for return to child care. If necessary, provide the family with a written communication that may be given to the primary care provider. The communication should include onset time of symptoms, observations about the child, vital signs and times (e.g., temperature 101.5°F at 10:30 AM) and any actions taken and the time actions were taken (e.g., one children’s acetaminophen given at 11:00 AM). The nature and severity of symptoms and or requirements of the local or state health department will determine the necessity of medical consultation. Telephone advice, electronic transmissions of instructions are acceptable without an office visit;

c. If the child has been seen by their primary health provider, follow the advice of the provider for return to child care;

d. If the child seems well to the family and no longer meets criteria for exclusion, there is no need to ask for further information from the health professional when the child returns to care. Children who had been excluded from care do not necessarily need to have an in-person visit with a health care provider;

e. Contact the local health department if there is a question of a reportable (harmful) infectious disease in a child or staff member in the facility. If there are conflicting opinions from different primary care providers about the management of a child with a reportable infectious disease, the health department has the legal authority to make a final determination;

f. Document actions in the child’s file with date, time, symptoms, and actions taken (and by whom); sign and date the document;

g. In collaboration with the local health department, notify the parents/guardians of contacts to the child or staff member with presumed or confirmed reportable infectious infection.

The caregiver/teacher should make the decision about whether a child meets or does not meet the exclusion criteria for participation and the child’s need for care relative to the staff’s ability to provide care. If parents/guardians and the child care staff disagree, and the reason for exclusion relates to the child’s ability to participate or the caregiver’s/teacher’s ability to provide care for the other children, the caregiver/teacher should not be required to accept responsibility for the care of the child.

**Reportable conditions:**

The current list of infectious diseases designated as notifiable in the United States at the national level by the Centers for Disease Control and Prevention (CDC) are listed at https://wwwn.cdc.gov/nndss/conditions/notifiable/2016/infectious-diseases/. The caregiver/teacher should contact the local health department:

a. When a child or staff member who is in contact with others has a reportable disease;

b. If a reportable illness occurs among the staff, children, or families involved with the program;

c. For assistance in managing a suspected outbreak. Generally, an outbreak can be considered to be two or more unrelated (e.g., not siblings) children with the same diagnosis or symptoms in the same group within one week. Clusters of mild respiratory illness, ear infections, and certain dermatological conditions are common and generally do not need to be reported.

Caregivers/teachers should work with their child care health consultants to develop policies and procedures for alerting staff and families about their responsibility to report illnesses to the program and for the program to report diseases to the local health authorities.

**RATIONALE**

Most infections are spread by children who do not have symptoms. Excluding children with mild illnesses is unlikely to reduce the spread of most infectious agents (germs) caused by bacteria, viruses, parasites and fungi. Exposure to frequent mild infections helps the child’s immune system develop in a healthy way. As a child gets older s/he develops immunity to common infectious agents and will become ill less often. Since exclusion is unlikely to reduce the spread of disease, the most important reason for exclusion is the ability of the child to participate in activities and the staff to care for the child.

The terms contagious, infectious and communicable have similar meanings. A fully immunized child with a contagious, infectious or communicable condition will likely not have an illness that is harmful to the child or others. Children attending child care frequently carry contagious organisms that do not limit their activity nor pose a threat to their contacts. Hand and personal hygiene is paramount in preventing transmission of these organisms. Written notes should not be required for return to child care for common respiratory illnesses that are not specifically listed in the excludable condition list above.

For specific conditions, *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*, 4th Edition has
educational handouts that can be copied and distributed to parents/guardians, health professionals, and caregivers/teachers. This publication is available from the American Academy of Pediatrics (AAP) at http://www.aap.org. For more detailed rationale regarding inclusion/exclusion, return to care, when a health visit is necessary, and health department reporting for children with specific symptoms, please see Appendix A: Signs and Symptoms Chart. State licensing law or code defines the conditions or symptoms for which exclusion is necessary. States are increasingly using the criteria defined in Caring for Our Children and the Managing Infectious Diseases in Child Care and Schools publications. Usually, the criteria in these two sources are more detailed than the state regulations so can be incorporated into the local written policies without conflicting with state law.

COMMENTS
When taking a child’s temperature, remember that:
- The amount of temperature elevation varies at different body sites;
- The height of fever does not indicate a more or less severe illness. The child’s activity level and sense of well-being are far more important that the temperature reading;
- If a child has been in a very hot environment and heatstroke is suspected, a higher temperature is more serious;
- The method chosen to take a child’s temperature depends on the need for accuracy, available equipment, the skill of the person taking the temperature, and the ability of the child to assist in the procedure;
- Oral temperatures are difficult to take for children younger than four years of age;
- Rectal temperatures should be taken only by persons with specific health training in performing this procedure and permission given by parents/guardians, however this method is not generally practiced due to concerns about proper procedure and risk of accusations of sexual abuse;
- Axillary (armpit) temperatures are accurate only when the thermometer remains within the closed armpit for the time period recommended by the device;
- Any device used improperly may give inaccurate results; and
- Only digital thermometers, not mercury thermometers, should be used.

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARDS
3.1.1.1 Conduct of Daily Health Check
3.6.1.2 Staff Exclusion for Illness
3.6.1.3 Thermometers for Taking Human Temperatures
3.6.1.4 Infectious Disease Outbreak Control
Appendix A: Signs and Symptoms Chart
Appendix J: Selecting an Appropriate Sanitizer or Disinfectant
Appendix K: Routine Schedule for Cleaning, Sanitizing, and Disinfecting

REFERENCES

NOTES
Content in the STANDARD was modified on 04/16/2015, on 8/2015, and on 4/4/2017.

3.6.1.2: Staff Exclusion for Illness
Please note that if a staff member has no contact with the children, or with anything with which the children has come into contact, this standard does not apply to that staff member.

A facility should not deny admission to or send home a staff member or substitute with illness unless one or more of the following conditions exists:
- Influenza, until fever free for 24 hours. (Health care providers can use a test to determine whether an ill person has
Most infections are spread by children who do not have symptoms. However, it is not practical to test all ill staff members to determine whether they have common cold viruses or influenza infection. Therefore, exclusion decisions are based on the symptoms of the staff member;

b. Chickenpox, until all lesions have dried and crusted, which usually occurs by six days;

c. Shingles, only if the lesions cannot be covered by clothing or a dressing until the lesions have crusted;

d. Rash with fever or joint pain, until diagnosed not to be measles or rubella;

e. Measles, until four days after onset of the rash (if the staff member or substitute has the capacity to develop an immune response following exposure);

f. Rubella, until six days after onset of rash;

g. Diarrheal illness, stool frequency exceeds two or more stools above normal for that individual or blood in stools, until diarrhea resolves, or until a primary care provider determines that the diarrhea is not caused by a germ that can be spread to others in the facility; For all cases of bloody diarrhea and diarrhea caused by Shiga toxin-producing Escherichia coli (STEC), Shigella, or Salmonella serotype Typhi, exclusion must continue until the person is cleared to return by the primary health care provider. Exclusion is warranted for STEC, until results of 2 stool cultures are negative (at least 48 hours after antibiotic treatment is complete (if prescribed)); for Shigella species, until at least 1 stool culture is negative (varies by state); and for Salmonella serotype Typhi, until 3 stool cultures are negative. Stool samples need to be collected at least 48 hours after antibiotic treatment is complete. Other types of Salmonella do not require negative test results from stool cultures. Vomiting illness, two or more episodes of vomiting during the previous twenty-four hours, until vomiting resolves or is determined to result from non-infectious conditions;

h. Hepatitis A virus, until one week after symptom onset or as directed by the health department;

i. Pertussis, until after five days of appropriate antibiotic therapy or until 21 days after the onset of cough if the person is not treated with antibiotics;

j. Skin infection (such as impetigo), until treatment has been initiated; exclusion should continue if lesion is draining AND cannot be covered;

k. Tuberculosis, until noninfectious and cleared by a health department official or a primary care provider;

l. Strep throat or other streptococcal infection, until twenty-four hours after initial antibiotic treatment and end of fever;

m. Head lice, from the end of the day of discovery until after the first treatment;

n. Scabies, until after treatment has been completed;

o. Haemophilus influenzae type b (Hib), prophylaxis, until cleared by the primary health care provider;

p. Meningococcal infection, until cleared by the primary health care provider;

q. Other respiratory illness, if the illness limits the staff member’s ability to provide an acceptable level of child care and compromises the health and safety of the children. This includes a respiratory illness in which the staff member is unable to consistently manage respiratory secretions using proper cough and sneeze etiquette.

Caregivers/teachers who have herpes cold sores should not be excluded from the child care facility, but should:

1. Cover and not touch their lesions;

2. Carefully observe hand hygiene policies; and


RATIONALE

Most infections are spread by children who do not have symptoms. The terms contagious, infectious and communicable have similar meanings. A fully immunized child with a contagious, infectious or communicable condition will likely not have an illness that is harmful to the child or others. Children attending child care frequently carry contagious organisms that do not limit their activity nor pose a threat to their contacts. Adults are as capable of spreading infectious disease as children (1,2). Hand and personal hygiene is paramount in preventing transmission of these organisms.

TYPE OF FACILITY

Center, Large Family Child Care Home

RELATED STANDARDS

3.2.2.1 Situations that Require Hand Hygiene

3.2.2.2 Handwashing Procedure

3.2.3.2 Cough and Sneeze Etiquette

3.6.1.1 Inclusion/Exclusion/Dismissal of Children

3.6.1.4 Infectious Disease Outbreak Control

REFERENCES

NOTES
Content in the STANDARD was modified on 4/5/2017.

3.6.1.3: Thermometers for Taking Human Temperatures

Digital thermometers should be used with infants and young children when there is a concern for fever. Tympanic (ear) thermometers may be used with children four months and older. However, while a tympanic thermometer gives quick results, it needs to be placed correctly in the child’s ear to be accurate.

Glass or mercury thermometers should not be used. Mercury containing thermometers and any waste created from the cleanup of a broken thermometer should be disposed of at a household hazardous waste collection facility.

Rectal temperatures should be taken only by persons with specific health training in performing this procedure. Oral (under the tongue) temperatures can be used for children over age four. Individual plastic covers should be used on oral or rectal thermometers with each use or thermometers should be cleaned and sanitized after each use according to the manufacturer’s instructions. Axillary (under the arm) temperatures are less accurate, but are a good option for infants and young children when the caregiver/teacher has not been trained to take a rectal temperature.

RATIONALE
When using tympanic thermometers, too much earwax can cause the reading to be incorrect. Tympanic thermometers may fail to detect a fever that is actually present (1). Therefore, tympanic thermometers should not be used in children under four months of age, where fever detection is most important.

Mercury thermometers can break and result in mercury toxicity that can lead to neurologic injury. To prevent mercury toxicity, the American Academy of Pediatrics (AAP) encourages the removal of mercury thermometers from homes. This includes all child care settings as well (1).

Although not a hazard, temporal thermometers are not as accurate as digital thermometers (2).

COMMENTS
The site where a child’s temperature is taken (rectal, oral, axillary, or tympanic) should be documented along with the temperature reading and the time the temperature was taken, because different sites give different results and affect interpretation of temperature.

More information about taking temperatures can be found on the AAP Website http://www.healthychildren.org/English/health-issues/conditions/fever/pages/How-to-Take-a-Childs-Temperature.aspx.

Safety and child abuse concerns may arise when using rectal thermometers. Caregivers/teachers should be aware of these concerns. If rectal temperatures are taken, steps must be taken to ensure that all caregivers/teachers are trained properly in this procedure and the opportunity for abuse is negligible (for example, ensure that more than one adult present during procedure). Rectal temperatures should be taken only by persons with specific health training in performing this procedure and permission given by parents/guardians.

Many state or local agencies operate facilities that collect used mercury thermometers. Typically, the service is free. For more information on household hazardous waste collections in your area, call your State environmental protection agency or your local health department.

TYPE OF FACILITY
Center, Large Family Child Care Home

REFERENCES
3.6.1.4: Infectious Disease Outbreak Control

During the course of an identified outbreak of any reportable illness at the facility, a child or staff member should be excluded if the health department official or primary care provider suspects that the child or staff member is contributing to transmission of the illness at the facility, 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 care provider who made the initial determination decides that the risk of transmission is no longer present.

RATIONALE

Secondary spread of infectious disease has been proven to occur in child care. Control of outbreaks of infectious diseases in child care may include age-appropriate immunization, antibiotic prophylaxis, observing well children for signs and symptoms of disease and for decreasing opportunities for transmission of that may sustain an outbreak. Removal of children known or suspected of contributing to an outbreak may help to limit transmission of the disease by preventing the development of new cases of the disease (1).

TYPE OF FACILITY

Center, Large Family Child Care Home

RELATED STANDARDS

3.6.1.1 Inclusion/Exclusion/Dismissal of Children
3.6.1.2 Staff Exclusion for Illness
3.6.4.1 Procedure for Parent/Guardian Notification About Exposure of Children to Infectious Disease
3.6.4.2 Infectious Diseases That Require Parent/Guardian Notification
9.2.4.4 Written Plan for Seasonal and Pandemic Influenza

REFERENCES


3.6.1.5: Sharing of Personal Articles Prohibited

Combs, hairbrushes, toothbrushes, personal clothing, bedding, and towels should not be shared and should be labeled with the name of the child who uses these objects.

RATIONALE

Respiratory and gastrointestinal infections are common infectious diseases in child care. These diseases are transmitted by direct person-to-person contact or by sharing personal articles such as combs, brushes, towels, clothing, and bedding. Prohibiting the sharing of personal articles and providing space so that personal items may be stored separately helps prevent these diseases from spreading.

TYPE OF FACILITY

Center, Large Family Child Care Home

RELATED STANDARDS

5.5.0.1 Storage and Labeling of Personal Articles

3.6.2 Caring for Children Who Are Ill

3.6.2.1: Exclusion and Alternative Care for Children Who Are Ill

At the discretion of the person authorized by the child care provider to make such decisions, children who are ill should be excluded from the child care facility for the conditions defined in Standard 3.6.1.1. When children are not permitted to receive care in their usual child care setting and cannot receive care from a parent/guardian or relative, they should be permitted to receive care in one of the following arrangements, if the arrangement meets the applicable standards:

a. Care in the child’s usual facility in a special area for care of children who are ill;
Young children who are developing trust, autonomy, and initiative require the support of familiar caregivers and environments during times of illness to recover physically and avoid emotional distress (1). Young children enrolled in group care experience a higher incidence of mild illness (such as upper respiratory infections or otitis media) and other temporary disabilities (such as exacerbation of asthma) than those who have less interaction with other children. Sometimes, these illnesses preclude their participation in the usual child care activities. To accommodate situations where parents/guardians cannot provide care for their own children who are ill, several types of alternative care arrangements have been established. The majority of viruses are spread by children who are asymptomatic, therefore, exposure of children to others with active symptoms or who have recently recovered, does not significantly raise the risk of transmission over the baseline (2).

**RATIONALE**

Young children who are developing trust, autonomy, and initiative require the support of familiar caregivers and environments during times of illness to recover physically and avoid emotional distress (1). Young children enrolled in group care experience a higher incidence of mild illness (such as upper respiratory infections or otitis media) and other temporary disabilities (such as exacerbation of asthma) than those who have less interaction with other children. Sometimes, these illnesses preclude their participation in the usual child care activities. To accommodate situations where parents/guardians cannot provide care for their own children who are ill, several types of alternative care arrangements have been established. The majority of viruses are spread by children who are asymptomatic, therefore, exposure of children to others with active symptoms or who have recently recovered, does not significantly raise the risk of transmission over the baseline (2).

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARDS**

3.6.1.1 Inclusion/Exclusion/Dismissal of Children
3.6.2.2 Space Requirements for Care of Children Who Are Ill
3.6.2.3 Qualifications of Directors of Facilities That Care for Children Who Are Ill
3.6.2.4 Program Requirements for Facilities That Care for Children Who Are Ill
3.6.2.5 Caregiver/Teacher Qualifications for Facilities That Care for Children Who Are Ill
3.6.2.6 Child-Staff Ratios for Facilities That Care for Children Who Are Ill
3.6.2.7 Child Care Health Consultants for Facilities That Care for Children Who Are Ill
3.6.2.8 Licensing of Facilities That Care for Children Who Are Ill
3.6.2.9 Information Required for Children Who Are Ill
3.6.2.10 Inclusion and Exclusion of Children from Facilities That Serve Children Who Are Ill

**REFERENCES**


**3.6.2.2: Space Requirements for Care of Children Who Are Ill**

Environmental space utilized for the care of children who are ill with infectious diseases and cannot receive care in their usual child care group should meet all requirements for well children and include the following additional requirements:

a. Indoor space that the facility uses for children who are ill, including classrooms, hallways, bathrooms, and kitchens, should be separate from indoor space used with well children. This reduces the likelihood of mixing supplies, toys, and equipment. The facility may use a single kitchen for ill and well children if the kitchen is staffed by a cook who has no child care responsibilities other than food preparation and who does not handle soiled dishes and utensils until after food preparation and food service are completed for any meal;

b. If the program for children who are ill is in the same facility as the well-child program, well children should not use or share furniture, fixtures, equipment, or supplies designated for use with children who are ill unless they have been cleaned and sanitized before use by well children;

c. Children whose symptoms indicate infections of the gastrointestinal tract (often with diarrhea) should receive their care in a space separate from other children with other illnesses. Limiting child-to-child interaction, separating staff responsibilities, and not mixing supplies, toys, and equipment reduces the likelihood of disease being transmitted between children;

d. Children with chickenpox, pertussis, measles, mumps, rubella, or diphtheria, require a room with separate ventilation including fresh outdoor air (1);

e. Each room/home that is designated for the care of children who are ill should have a handwashing sink that can provide a steady stream of clean, running water that is at a comfortable temperature at least for twenty seconds (2). Soap and disposable paper towels should be available at the handwashing sink at all times. A hand sanitizing dispenser is an alternative to traditional handwashing (3,4);

f. Each room/home that is designated for the care of children who are ill and are wearing diapers should have its own diaper changing area adjacent to a handwashing sink and/or hand sanitizer dispenser.
Transmission of infectious diseases in early care and education settings are influenced by the environmental sanitation and physical space of the facilities (5).

Handwashing sinks should be stationed in each room that is designated for the care of ill children to promote hand hygiene and to give the caregivers/teachers an opportunity for continuous supervision of the other children in care when washing their hands. The sink must deliver a consistent flow of water for twenty seconds so that the user does not need to touch the faucet handles. Diaper changing areas should be adjacent to sinks to foster cleanliness and to enable caregivers/teachers to provide continuous supervision of other children in care.

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARDS
3.2.2.1 Situations that Require Hand Hygiene
3.2.2.2 Handwashing Procedure
3.2.2.5 Hand Sanitizers
3.6.1.1 Inclusion/Exclusion/Dismissal of Children
5.4.1.10 Handwashing Sinks

REFERENCES

NOTES
Content in the STANDARD was modified on 8/9/2017.

3.6.2.3: Qualifications of Directors of Facilities That Care for Children Who Are Ill

The director of a facility that cares for children who are ill should have the following minimum qualifications, in addition to the general qualifications described in Director’s Qualifications, Standards 1.3.1.1 and 1.3.1.2:

a. At least forty hours of training in prevention and control of infectious diseases and care of children who are ill, including subjects listed in Standard 3.6.2.5;
b. At least two prior years of satisfactory performance as a director of a regular facility;
c. At least twelve credit hours of college-level training in child development or early childhood education.

RATIONALE
The director should be college-prepared in early childhood education and have taken college-level courses in illness prevention and control, since the director is the person responsible for establishing the facility’s policies and procedures and for meeting the training needs of new staff members (1).

TYPE OF FACILITY
Center

RELATED STANDARDS
1.3.1.1 General Qualifications of Directors
1.3.1.2 Mixed Director/Teacher Role
3.6.2.5 Caregiver/Teacher Qualifications for Facilities That Care for Children Who Are Ill

REFERENCES

3.6.2.4: Program Requirements for Facilities That Care for Children Who Are Ill

Any facility that offers care for the child who is ill of any age should:

a. Provide a caregiver/teacher who is familiar to the child;
b. Provide care in a place with which the child is familiar and comfortable away from other children in care;
c. Involve a caregiver/teacher who has time to give individual care and emotional support, who knows of the child’s interests, and who knows of activities that appeal to the level of child development age group and to a sick child;
d. Offer a program with trained personnel planned in consultation with qualified health care personnel and with ongoing medical direction.

RATIONALE
When children are ill, they are stressed by the illness itself. Unfamiliar places and caregivers/teachers add to the stress of illness when a child is sick. Since illness tends to promote regression and dependency, children who are ill need a person who knows and can respond to the child’s cues appropriately.

COMMENTS
Because children are most comfortable in a familiar place with familiar people, the preferred arrangement for children who are ill will be the child’s home or the child’s regular child care arrangement, when the child care facility has the resources to adapt to the needs of such children.

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARDS
3.6.2.2 Space Requirements for Care of Children Who Are Ill
3.6.4.1 Procedure for Parent/Guardian Notification About Exposure of Children to Infectious Disease
3.6.4.2 Infectious Diseases That Require Parent/Guardian Notification
3.6.4.3 Notification of the Facility About Infectious Disease or Other Problems by Parents/Guardians
3.6.4.4 List of Excludable and Reportable Conditions for Parents/Guardians
3.6.4.5 Death
10.5.0.1 State and Local Health Department Role

3.6.2.5: Caregiver/Teacher Qualifications for Facilities That Care for Children Who Are Ill

Each caregiver/teacher in a facility that cares for children who are ill should have at least two years of successful work experience as a caregiver/teacher in a regular well-child facility prior to employment in the special facility. In addition, facilities should document, for each caregiver/teacher, twenty hours of pre-service orientation training on care of children who are ill beyond the orientation training specified in Standards 1.4.2.1 through Standard 1.4.2.3. This training should include the following subjects:

a. Pediatric first aid and CPR, and first aid for choking;
b. General infection-control procedures, including:
   1. Hand hygiene;
   2. Handling of contaminated items;
   3. Use of sanitizing chemicals;
   4. Food handling;
   5. Washing and sanitizing of toys;
c. Care of children with common mild childhood illnesses, including:
   1. Recognition and documentation of signs and symptoms of illness including body temperature;
   2. Administration and recording of medications;
   3. Nutrition of children who are ill;
Because meeting the physical and psychological needs of children who are ill requires a higher level of skill and understanding than caring for well children, a commitment to children and an understanding of their general needs is essential (1). Work experience in child care facilities will help the caregiver/teacher develop these skills. States that have developed rules regulating facilities have recognized the need for training in illness prevention and control and management of medical emergencies. Staff members caring for children who are ill in special facilities or in a get well room in a regular center should meet the staff qualifications that are applied to child care facilities generally.

This training should be documented in the staff personnel files, and compliance with the content of training routinely evaluated. Based on these evaluations, the training on care of children who are ill should be updated with a minimum of six hours of annual training for individuals who continue to provide care to children who are ill.

**RATIONALE**

Because meeting the physical and psychological needs of children who are ill requires a higher level of skill and understanding than caring for well children, a commitment to children and an understanding of their general needs is essential (1). Work experience in child care facilities will help the caregiver/teacher develop these skills. States that have developed rules regulating facilities have recognized the need for training in illness prevention and control and management of medical emergencies. Staff members caring for children who are ill in special facilities or in a get well room in a regular center should meet the staff qualifications that are applied to child care facilities generally. Caregivers/teachers have to be prepared for handling illness and must understand their scope of work. Special training is required of caregivers/teachers who work in special facilities for children who are ill because the director and the caregivers/teachers are dealing with infectious diseases and need to know how to prevent the spread of infection. Each caregiver/teacher should have training to decrease the risk of transmitting disease (1).

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARDS**

1.4.2.1 Initial Orientation of All Staff
1.4.2.2 Orientation for Care of Children with Special Health Care Needs
1.4.2.3 Orientation Topics
10.5.0.1 State and Local Health Department Role

**REFERENCES**


### 3.6.2.6: Child-Staff Ratios for Facilities That Care for Children Who Are Ill

Each facility for children who are ill should maintain a child-to-staff ratio no greater than the following:

<table>
<thead>
<tr>
<th>Age of Children</th>
<th>Child to Staff Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-35 months</td>
<td>3 children to 1 staff member</td>
</tr>
<tr>
<td>36-71 months</td>
<td>4 children to 1 staff member</td>
</tr>
<tr>
<td>72 months and older</td>
<td>6 children to 1 staff member</td>
</tr>
</tbody>
</table>

**RATIONALE**

Some states stipulate the ratios for caring for children who are ill in their regulations. The expert consensus is based on theories of child development including attachment theory and recognition of children’s temporary emotional regression during times of illness (1-3); the lowest ratios used per age group seem appropriate.

**COMMENTS**

These ratios do not include other personnel, such as bus drivers, necessary for specialized functions such as transportation.

**TYPE OF FACILITY**

Center, Large Family Child Care Home
REFERENCES


3.6.2.7: Child Care Health Consultants for Facilities That Care for Children Who Are Ill

Each special facility that provides care for children who are ill should use the services of a child care health consultant for ongoing consultation on overall operation and development of written policies relating to health care. The child care health consultant should have the knowledge, skills and preparation as stated in Standard 1.6.0.1.

The facility should involve the child care health consultant in development and/or implementation, review, and sign-off of the written policies and procedures for managing specific illnesses. The facility staff and the child care health consultant should review and update the written policies annually.

The facility should assign the child care health consultant the responsibility for reviewing written policies and procedures for the following:

a. Admission and readmission after illness, including inclusion/exclusion criteria;
b. Health evaluation procedures on intake, including physical assessment of the child and other criteria used to determine the appropriateness of a child’s attendance;
c. Plans for health care and for managing children with infectious diseases;
d. Plans for surveillance of illnesses that are admissible and problems that arise in the care of children with illness;
e. Plans for staff training and communication with parents/guardians and primary care providers;
f. Plans for injury prevention;
g. Situations that require medical care within an hour.

RATIONALE:

Appropriate involvement of child care health consultants is especially important for facilities that care for children who are ill. Facilities should use the expertise of primary care providers to design and provide a child care environment with sufficient staff and facilities to meet the needs of children who are ill (2,3). The best interests of the child and family must be given primary consideration in the care of children who are ill. Consultation by primary care providers, especially those whose specialty is pediatrics, is critical in planning facilities for the care of children who are ill (1).

COMMENTS

Caregivers/teachers should seek the services of a child care health consultant through state and local professional organizations, such as:

a. Local chapters of the American Academy of Pediatrics (AAP);
b. Local Children’s hospital;
c. American Nurses Association (ANA);
d. Visiting Nurse Association (VNA);
e. American Academy of Family Physicians (AAFP);
f. National Association of Pediatric Nurse Practitioners (NAPNAP);
g. National Association for the Education of Young Children (NAEYC);
h. National Association for Family Child Care (NAFCC);
i. National Association of School Nurses (NASN);
j. Emergency Medical Services for Children (EMSC) National Resource Center;
k. State or local health department (especially public health nursing, infectious disease, and epidemiology departments).

TYPE OF FACILITY

Center, Large Family Child Care Home
3.6.2.8: Licensing of Facilities That Care for Children Who Are Ill

A facility may care for children with symptoms requiring exclusion provided that the licensing authority has given approval of the facility, written plans describing symptoms and conditions that are admissible, and procedures for daily care. In jurisdictions that lack regulations and licensing capacity for facilities that care for children who are ill, the child care health consultant with the local health authority should review these plans and procedures annually in an advisory capacity.

RATIONALE

Facilities for children who are ill generally are required to meet the licensing requirements that apply to all facilities of a specific type, for example, small or large family child care homes or centers. Additional requirements should apply when children who are ill will be in care.

This standard ensures that child care facilities are continually reviewed by an appropriate state authority and that facilities maintain appropriate standards in caring for children who are ill.

COMMENTS

If a child care health consultant is not available, than the local health authority should review plans and procedures annually.

TYPE OF FACILITY

Center, Large Family Child Care Home

RELATED STANDARDS

3.6.2.10 Inclusion and Exclusion of Children from Facilities That Serve Children Who Are Ill
10.2.0.1 Regulation of All Out-of-Home Child Care
10.3.1.1 Operation Permits

3.6.2.9: Information Required for Children Who Are Ill

For each day of care in a special facility that provides care for children who are ill, the caregiver/teacher should have the following information on each child:

a. The child’s specific diagnosis and the individual providing the diagnosis (primary care provider, parent/guardian);
b. Current status of the illness, including potential for contagion, diet, activity level, and duration of illness;
c. Health care, diet, allergies (particularly to foods or medication), and medication and treatment plan, including appropriate release forms to obtain emergency health care and administer medication;
d. Communication with the parent/guardian on the child’s progress;
e. Name, address, and telephone number of the child’s source of primary health care;
f. Communication with the child’s primary care provider.

Communication between parents/guardians, the child care program and the primary care provider (medical home) requires the free exchange of protected medical information (2). Confidentiality should be maintained at each step in compliance with any laws or regulations that are pertinent to all parties such as the Family Educational Rights and Privacy Act (commonly known as FERPA) and/or the Health Insurance Portability and Accountability Act (commonly known as HIPAA) (2).

RATIONALE

The caregiver/teacher must have child-specific information to provide optimum care for each child who is ill and to make appropriate decisions regarding whether to include or exclude a given child. The caregiver/teacher must have contact information for the child’s source of primary health care or specialty health care (in the case of a child with asthma, diabetes, etc.) to assist with the management of any situation that arises.

COMMENTS
For school-age children, documentation of the care of the child during the illness should be provided to the parent to deliver to the school health program upon the child’s return to school. Coordination with the child’s source of health care and school health program facilitates the overall care of the child (1).

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**REFERENCES**

http://www.nncc.org/1o/emp.sick.child.care.html.


**3.6.2.10: Inclusion and Exclusion of Children from Facilities That Serve Children Who Are Ill**

Facilities that care for children who are ill who have conditions that require additional attention from the caregiver/teacher, should arrange for a clinical health evaluation prior to admission, by a licensed primary care provider, for each child who is admitted to the facility. A child care health consultant can assist in arranging the evaluation. Facilities who serve children who are ill should include children with conditions listed in Standard 3.6.1.1: Inclusion/Exclusion/Dismissal of Children if their policies and plans address the management of these conditions, except for the following conditions which require exclusion from all types of child care facilities:

a. A severely ill appearance. This could include lethargy or lack of responsiveness, irritability, persistent crying, difficulty breathing, or having a quickly spreading rash;

b. Fever (temperature for an infant or child older than 2 months that is above 101° F [38.3° C] or, in infants younger than 2 months, a temperature above 100.4° F [38.0° C] by any method) and behavior change or other signs and symptoms;

c. Diarrhea (Defined by stool that is occurring with more frequency or is less formed in consistency than usual in the child and not associated with changes in diet.) Exclusion is required for all diapered children whose stool is not contained in the diaper. For toilet-trained children, exclusion is required when diarrhea is causing “accidents”. Exclude children whose stool frequency exceeds 2 stools above normal frequency) and one or more of the following:
   1. Signs of dehydration, such as dry mouth, no tears, lethargy, sunken fontanelle (soft spot on the head);
   2. Blood or mucus in the stool until it is evaluated for organisms that can cause dysentery;
   3. Diarrhea caused by Salmonella, Campylobacter, Giardia, Shigella or E.coli 0157:H7 until specific criteria for treatment and return to care are met.

d. Vomiting 2 or more times in the previous 24 hours, unless vomiting is determined to be caused by a non-communicable or noninfectious condition and the child is not in danger of dehydration;

e. Contagious stages of pertussis, measles, mumps, chickenpox, rubella, or diphtheria, unless the child is appropriately isolated from children with other illnesses and cared for only with children having the same illness;

f. Untreated infestation of scabies or head lice; exclusion not necessary before the end of the program day;

h. Undiagnosed rash WITH fever or behavior change;

i. Abdominal pain that is intermittent or persistent and is accompanied by fever, diarrhea, vomiting, or other signs and symptoms;

j. An acute change in behavior;

k. Undiagnosed jaundice (yellow skin and whites of eyes);

l. Upper or lower respiratory infection in which signs or symptoms require a higher level of care than can be appropriately provided; and

m. Severely immunocompromised children and other conditions as may be determined by the primary health care provider and/or child care health consultant (1,2).

**RATIONALE**

These signs and symptoms may indicate a significant systemic infection that requires professional medical management and parental care (1,2). Diarrheal illnesses that require an intensity of care that cannot be provided appropriately by a caregiver/teacher could result in temporary exclusion (1,2).

**TYPE OF FACILITY**

Center, Large Family Child Care Home
Center, Large Family Child Care Home

RELATED STANDARDS

1.6.0.1 Child Care Health Consultants
3.6.1.1 Inclusion/Exclusion/Dismissal of Children
3.6.1.4 Infectious Disease Outbreak Control

REFERENCES


NOTES

Content in the STANDARD was modified on 8/9/2017.

3.6.3 Medications

3.6.3.1: Medication Administration

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

a. Prescription or non-prescription medication (over-the-counter [OTC]) ordered by the prescribing health professional for a specific child with written permission of the parent/guardian. Written orders from the prescribing health professional should specify medical need, medication, dosage, and length of time to give medication;

b. Labeled medications brought to the child care facility by the parent/guardian in the original container (with a label that includes the child’s name, date filled, prescribing clinician’s name, pharmacy name and phone number, dosage/instructions, and relevant warnings).

Facilities should not administer folk or homemade remedy medications or treatment. Facilities should not administer a medication that is prescribed for one child in the family to another child in the family.

No prescription or non-prescription medication (OTC) should be given to any child without written orders from a prescribing health professional and written permission from a parent/guardian. Exception: Non-prescription sunscreen and insect repellent always require parental consent but do not require instructions from each child’s prescribing health professional.

Documentation that the medicine/agent is administered to the child as prescribed is required.

“Standing orders” guidance should include directions for facilities to be equipped, staffed, and monitored by the primary care provider capable of having the special health care plan modified as needed. Standing orders for medication should only be allowed for individual children with a documented medical need if a special care plan is provided by the child’s primary care provider in conjunction with the standing order or for OTC medications for which a primary care provider has provided specific instructions that define the children, conditions and methods for administration of the medication. Signatures from the primary care provider and one of the child’s parents/guardians must be obtained on the special care plan. Care plans should be updated as needed, but at least yearly.

RATIONALE

All medicines require clear, accurate instruction and medical confirmation of the need for the medication to be given while the child is in the facility. Prescription medications can often be timed to be given at home and this should be encouraged. Because of the potential for errors in medication administration in child care facilities, it may be safer for a parent/guardian to administer their child’s medicine at home.

Over the counter medications, such as acetaminophen and ibuprofen, can be just as dangerous as prescription medications and can result in illness or even death when these products are misused or unintentional poisoning occurs. Many children’s over the counter medications contain a combination of ingredients. It is important to make sure the child isn’t receiving the same medications in two different products which may result in an overdose. Facilities should not stock OTC medications (1).
Cough and cold medications are widely used for children to treat upper respiratory infections and allergy symptoms. Recently, concern has been raised that there is no proven benefit and some of these products may be dangerous (2,3,5). Leading organizations such as the Consumer Healthcare Products Association (CHPA) and the American Academy of Pediatrics (AAP) have recommended restrictions on these products for children under age six (4-7).

If a medication mistake or unintentional poisoning does occur, call your local poison center immediately at 1-800-222-1222. Parents/guardians should always be notified in every instance when medication is used. Telephone instructions from a primary care provider are acceptable if the caregiver/teacher fully documents them and if the parent/guardian initiates the request for primary care provider or child care health consultant instruction. In the event medication for a child becomes necessary during the day or in the event of an emergency, administration instructions from a parent/guardian and the child’s prescribing health professional are required before a caregiver/teacher may administer medication.

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARDS
3.4.5.1 Sun Safety Including Sunscreen
3.4.5.2 Insect Repellent and Protection from Vector-Borne Diseases
3.6.2.9 Information Required for Children Who Are Ill
3.6.3.2 Labeling, Storage, and Disposal of Medications

REFERENCES

3.6.3.2: Labeling, Storage, and Disposal of Medications

Any prescription medication should be dated and kept in the original container. The container should be labeled by a pharmacist with:

- The child’s first and last names;
- The date the prescription was filled;
- The name of the prescribing health professional who wrote the prescription, the medication’s expiration date;
- The manufacturer’s instructions or prescription label with specific, legible instructions for administration, storage, and disposal;
- The name and strength of the medication.

Over-the-counter medications should be kept in the original container as sold by the manufacturer, labeled by the parent/guardian, with the child’s name and specific instructions given by the child’s prescribing health professional for administration.

All medications, refrigerated or unrefrigerated, should:

- Have child-resistant caps;
- Be kept in an organized fashion;
- Be stored away from food;
Child-resistant safety packaging has been shown to significantly decrease poison exposure incidents in young children (1).

Center, Large Family Child Care Home

Medication Administration

- Be stored at the proper temperature;
- Be completely inaccessible to children.

Medication should not be used beyond the date of expiration. Unused medications should be returned to the parent/guardian for disposal. In the event medication cannot be returned to the parent or guardian, it should be disposed of according to the recommendations of the US Food and Drug Administration (FDA) (1). Documentation should be kept with the child care facility of all disposed medications. The current guidelines are as follows:

- If a medication lists any specific instructions on how to dispose of it, follow those directions.
- If there are community drug take back programs, participate in those.
- Remove medications from their original containers and put them in a sealable bag. Mix medications with an undesirable substance such as used coffee grounds or kitty litter. Throw the mixture into the regular trash. Make sure children do not have access to the trash (1).

RATIONALE

Child-resistant safety packaging has been shown to significantly decrease poison exposure incidents in young children (1). Proper disposal of medications is important to help ensure a healthy environment for children in our communities. There is growing evidence that throwing out or flushing medications into our sewer systems may have harmful effects on the environment (1-3).

TYPE OF FACILITY

Center, Large Family Child Care Home

RELATED STANDARDS

3.6.3.1 Medication Administration
3.6.3.3 Training of Caregivers/Teachers to Administer Medication

REFERENCES


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 trainer in medication administration should be a licensed health professional. The course should be repeated according to state and/or local regulation. At a minimum, skill and competency should be monitored annually or whenever medication administration error occurs. In facilities with large numbers of children with special health care needs involving daily medication, best practice would indicate strong consideration to the hiring of a licensed health care professional. Lacking that, caregivers/teachers should be trained to:

- Check that the name of the child on the medication and the child receiving the medication are the same;
- Check that the name of the medication is the same as the name of the medication on the instructions to give the medication if the instructions are not on the medication container that is labeled with the child’s name;
- Read and understand the label/prescription directions or the separate written instructions in relation to the measured dose, frequency, route of administration (ex. by mouth, ear canal, eye, etc.) and other special instructions relative to the medication;
- Observe and report any side effects from medications;
- Document the administration of each dose by the time and the amount given;
- Document the person giving the administration and any side effects noted;
- Handle and store all medications according to label instructions and regulations.
The trainer in medication administration should be a licensed health professional: Registered Nurse, Advanced Practice Registered Nurse (APRN), MD, Physician’s Assistant, or Pharmacist.

RATIONALE
Administration of medicines is unavoidable as increasing numbers of children entering child care take medications. National data indicate that at any one time, a significant portion of the pediatric population is taking medication, mostly vitamins, but between 16% and 40% are taking antipyretics/analgesics (5). Safe medication administration in child care is extremely important and training of caregivers/teachers is essential (1).

Caregivers/teachers need to know what medication the child is receiving, who prescribed the medicine and when, for what purpose the medicine has been prescribed and what the known reactions or side effects may be if a child has a negative reaction to the medicine (2,3). A child’s reaction to medication can be occasionally extreme enough to initiate the protocol developed for emergencies. The medication record is especially important if medications are frequently prescribed or if long-term medications are being used (4).

COMMENTS
Caregivers/teachers need to know the state laws and regulations on training requirements for the administration of medications in out-of-home child care settings. These laws may include requirements for delegation of medication administration from a primary care provider. Training on medication administration for caregivers/teachers is available in several states. Model Child Care Health Policies, 2nd Ed. from Healthy Child Care Pennsylvania is available at http://www.ecels-healthychildcarepa.org/publications/manuals-pamphlets-policies/item/248-model-child-care-health-policies and contains sample polices and forms related to medication administration.

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARDS
3.6.3.1 Medication Administration
3.6.3.2 Labeling, Storage, and Disposal of Medications
9.2.3.9 Written Policy on Use of Medications
Appendix O: Care Plan for Children with Special Health Care Needs
Appendix AA: Medication Administration Packet

REFERENCES

3.6.4 Reporting Illness and Death

3.6.4.1: Procedure for Parent/Guardian Notification About Exposure of Children to Infectious Disease
Caregivers/teachers should work collaboratively with local and state health authorities to notify parents/guardians about potential or confirmed exposures of their child to a infectious disease. Notification should include the following information:

a. The names, both the common and the medical name, of the diagnosed disease to which the child was exposed, whether there is one case or an outbreak, and the nature of the exposure (such as a child or staff member in a shared room or facility);
b. Signs and symptoms of the disease for which the parent/guardian should observe;
c. Mode of transmission of the disease;
d. Period of communicability and how long to watch for signs and symptoms of the disease;
Effective control and prevention of infectious diseases in child care depends on affirmative relationships between parents/guardians, caregivers/teachers, public health authorities, and primary care providers.

The child care health consultant can locate appropriate photographs of conditions for parent/guardian information use. Resources for fact sheets and photographs include the current edition of *Managing Infectious Diseases in Child Care and Schools* (1) and the Centers for Disease Control and Prevention Website on conditions and diseases. For a sample letter to parents notifying them of illness of their child or other enrolled children, see Healthy Young Children, available from the National Association for the Education of Young Children (NAEYC) at http://www.naeyc.org.

**TYPE OF FACILITY**
Center, Large Family Child Care Home

**RELATED STANDARDS**

3.6.1.4 Infectious Disease Outbreak Control

**REFERENCES**


3.6.4.2: Infectious Diseases That Require Parent/Guardian Notification

In cooperation with the child care regulatory authority and health department, the facility or the health department should inform parents/guardians if their child may have been exposed to the following diseases or conditions while attending the child care program, while retaining the confidentiality of the child who has the infectious disease:

- Neisseria meningitidis (meningitis);
- Pertussis;
- Invasive infections;
- Varicella-zoster (Chickenpox) virus;
- Skin infections or infestations (head lice, scabies, and ringworm);
- Infections of the gastrointestinal tract (often with diarrhea) and hepatitis A virus (HAV);
- Haemophilus influenzae type B (Hib);
- Parvovirus B19 (fifth disease);
- Measles;
- Tuberculosis;
- Two or more affected unrelated persons affiliated with the facility with a vaccine-preventable or infectious disease.

**RATIONALE**

Early identification and treatment of infectious diseases are important in minimizing associated morbidity and mortality as well as further reducing transmission (1). Notification of parents/guardians will permit them to discuss with their child’s primary care provider the implications of the exposure and to closely observe their child for early signs and symptoms of illness.

**TYPE OF FACILITY**
Center, Large Family Child Care Home

**RELATED STANDARDS**

3.6.1.4 Infectious Disease Outbreak Control

**REFERENCES**

3.6.4.3: Notification of the Facility About Infectious Disease or Other Problems by Parents/Guardians

Upon registration of each child, the facility should inform parents/guardians that they must notify the facility within twenty-four hours after their child or any member of the immediate household has developed a known or suspected infectious or vaccine-preventable disease (1). When a child has a disease that may require exclusion, the parents/guardians should inform the facility of the diagnosis.

The facility should encourage parents/guardians to inform the caregivers/teachers of any other problems which may affect the child’s behavior.

RATIONALE

This requirement will facilitate prompt reporting of disease and enable the caregiver/teacher to provide better care. Disease surveillance and reporting to local health authorities is crucial to preventing and controlling diseases in the child care setting (2,3). The major purpose of surveillance is to allow early detection of disease and prompt implementation of control measures. If it is known that the child attends another center or facility, all facilities should be informed (for example, if the child attends a Head Start program and a child care program that are separate—then both need to be notified and the notification of local health authority should name both facilities).

Ascertaining whether a child who is ill is attending a facility is important when evaluating childhood illnesses (2,3). Ascertaining whether an adult with illness is working in a facility or is a parent/guardian of a child attending a facility is important when considering infectious diseases that are more commonly manifest in adults. Cases of illness in family member such as infections of the gastrointestinal tract (with diarrhea), or infections of the liver may necessitate questioning about possible illness in the child attending child care. Information concerning infectious disease in a child care attendee, staff member, or household contact should be communicated to public health authorities, to the child care director, and to the child’s parents/guardians.

TYPE OF FACILITY

Center, Large Family Child Care Home

RELATED STANDARDS

3.6.1.1

REFERENCES


3.6.4.4: List of Excludable and Reportable Conditions for Parents/Guardians

The facility should give to each parent/guardian a written list of conditions for which exclusion and dismissal may be indicated (1).

For the following symptoms, the caregiver/teacher should ask parents/guardians to have the child evaluated by a primary care provider. The advice of the primary care provider should be documented for the caregiver/teacher in the following situations:

- The child has any of the following conditions: fever, lethargy, irritability, persistent crying, difficult breathing, or other manifestations of possible severe illness;
- The child has a rash with fever and behavioral change;
- The child has tuberculosis that has not been evaluated;
- The child has scabies;
- The child has a persistent cough with inability to practice respiratory etiquette.

The facility should have a list of reportable diseases provided by the health department and should provide a copy to each parent/guardian.

RATIONALE

Vomiting with symptoms such as lethargy and/or dry skin or mucous membranes or reduced urine output may indicate dehydration, and the child should be medically evaluated. Diarrhea with fever or other symptoms usually indicates infection. Blood and/or mucus may indicate shigellosis or infection with E. coli 0157:H7, which should be evaluated. Effective control and
prevention of infectious diseases in child care depend on affirmative relationships between parents/guardians, caregivers, health
departments, and primary care providers (2).

COMMENTS
If there is more than one case of vomiting in the facility, it may indicate either contagious illness or food poisoning.
If a child with abdominal pain is drowsy, irritable, and unhappy, has no appetite, and is unwilling to participate in usual activities,
the child should be seen by that child’s primary care provider. Abdominal pain may be associated with viral, bacterial, or parasitic
gastrointestinal tract illness, which is contagious, or with food poisoning. It also may be a manifestation of another disease or
illness such as kidney disease. If the pain is severe or persistent, the child should be referred for medical consultation (by
telephone, if necessary).
If the caregiver/teacher is unable to contact the parent/guardian, medical advice should be sought until the parents can be
located.
The facility should post the health department’s list of infectious diseases as a reference. The facility should inform
parents/guardians that the program is required to report infectious diseases to the health department.

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARDS
3.6.1.1 Inclusion/Exclusion/Dismissal of Children
Appendix P: Situations that Require Medical Attention Right Away

REFERENCES

3.6.4.5: Death
Each facility should have a plan in place for responding to any death relevant to children enrolled in the facility and their families.
The plan should describe protocols the program will follow and resources available for children, families, and staff.
If a facility experiences the death of a child or adult, the following should be done:

a. If a child or adult dies while at the facility:
   1. The caregiver/teacher(s) responsible for any children who observed or were in the same room where the death
      occurred, should take the children to a different room, while other staff tend to appropriate response/follow-up.
      Minimal explanations should be provided until direction is received from the proper authorities. Supportive and
      reassuring comments should be provided to children directly affected;
   2. Designated staff should:
   3. Immediately notify emergency medical personnel;
   4. Immediately notify the child’s parents/guardians or adult’s emergency contact;
   5. Notify the Licensing agency and law enforcement the same day the death occurs;
   6. Follow all law enforcement protocols regarding the scene of the death:
      1. Do not disturb the scene;
      2. Do not show the scene to others;
      3. Reserve conversation about the event until having completed all interviews with law enforcement.
   7. Provide age-appropriate information for children, parents/guardians and staff;
   8. Make resources for support available to staff, parents and children;

b. For a suspected Sudden Infant Death Syndrome (SIDS) death or other unexplained deaths:
   1. Seek support and information from local, state, or national SIDS resources;
   2. Provide SIDS information to the parents/guardians of the other children in the facility;
3. Provide age-appropriate information to the other children in the facility;
4. Provide appropriate information for staff at the facility;
c. If a child or adult known to the children enrolled in the facility dies while not at the facility:
   1. Provide age-appropriate information for children, parents/guardians and staff;
   2. Make resources for support available to staff, parents and children.

Facilities may release specific information about the circumstances of the child or adult’s death that the authorities and the deceased member’s family agrees the facility may share.

If the death is due to suspected child maltreatment, the caregiver/teacher is mandated to report this to child protective services.

Depending on the cause of death (SIDS, suffocation or other infant death, injury, maltreatment etc.), there may be a need for updated education on the subject for caregivers/teachers and/or children as well as implementation of improved health and safety practices.

RATIONAL
Following the steps described in this standard would constitute prudent action (1-3). Accurate information given to parents/guardians and children will help them understand the event and facilitate their support of the caregiver/teacher (4-7).

COMMENTS
It is important that caregivers/teachers are knowledgeable about SIDS and that they take proper steps so that they are not falsely accused of child abuse and neglect. The licensing agency and/or a SIDS agency support group (e.g., C) Foundation for SIDS at http://www.cjsids.org, the National Action Partnership to Promote Safe Sleep (NAPPSS) at http://nappss.org, and First Candle at http://www.firstcandle.org) can offer support and counseling to caregivers/teachers.

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARDS
3.1.4.1 Safe Sleep Practices and Sudden Unexpected Infant Death (SUID)/SIDS Risk Reduction
3.4.4.1 Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation
3.4.4.2 Immunity for Reporters of Child Abuse and Neglect
3.4.4.3 Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma
3.4.4.4 Care for Children Who Have Been Abused/Neglected
3.4.4.5 Facility Layout to Reduce Risk of Child Abuse and Neglect

REFERENCES