
Preventing and Managing Illness in ECE Programs



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This module is part of the California Training Institute's curriculum for Child Care Health Advocates.

LEARNING OBJECTIVES

To describe prevention measures to reduce the spread of infectious disease in early care and education (ECE) programs.

To develop skills in immunization assessment and monitoring.

To describe the standard precautions used to prevent the spread of bloodborne illness.

To identify prevention and management of illness resources to assist and support ECE providers and families.

RATIONALE

When young children are in ECE programs, they are exposed to many germs (e.g., viruses, bacteria). Thus, to prevent and manage illness effectively, ECE programs need clear health policies, up-to-date information and sensitive communication between ECE staff, families and children. When necessary, ECE staff may communicate with local health departments and primary care providers about specific diseases or health problems after they get written permission from a parent or guardian.

WHAT A CCHA NEEDS TO KNOW

Young children have frequent illnesses that are often caused by contagious viruses and bacteria. Illnesses are inevitable among young children, and children in ECE programs are more likely to get sick than children who stay at home (Holmes, Morrow & Pickering, 1996; Pickering & Morrow, 1996). Infants and young children in ECE programs have a higher rate of certain infectious diseases and a higher risk of getting organisms that are resistant to antibiotics (National Institute of Child Health and Human Development Early Child Care Research Network [NICHD], 2001, 2003). Children between the ages of 6 weeks and 17 months have a higher risk of respiratory (related to the lungs) illness if they are enrolled in an ECE program at least 10 hours per week (Hurwitz, Gunn, Pinsky & Schonberger, 1991). Children under 3 years of age attending ECE programs are 3.5 times more likely to have an acute gastrointestinal (related to the stomach and intestines) illness than children who stay at home. Children between the ages of 3 to 5 who are enrolled in ECE programs are twice as likely to have an acute gastrointestinal illness (Kotch & Bryant, 1990). Since young children have immune systems that are not fully developed, they are more vulnerable when they become ill.

An educational program for ECE staff to learn about how infections are transmitted and the importance of hand washing for both staff and children lowered the number of gastrointestinal illnesses for children over 2 years of age by 50% (Roberts, Jorm, Patel, Smith, Douglas & McGilchrist, 2000). Another educational program for ECE staff about how infections are transmitted, hand washing and an aseptic nose-wiping technique lowered the number of colds (respiratory illnesses) for children under 2 years of age by 17% (Roberts, Smith, Jorm, Patel, Douglas & McGilchrist, 2000).

The terms *infectious disease* and *communicable disease* are somewhat similar in meaning, but there is a difference. Infectious diseases are caused by germs, such as bacteria or viruses, no matter how the germs are picked up. Communicable diseases are a type of infectious disease. Communicable diseases are caused when germs are spread among people, either through contact

from person to person (such as the common cold or a viral illness) or through contact with a nonhuman host (such as West Nile virus, carried by mosquitoes that infect humans). See *Handout: Health and Safety Notes: Exposure to Communicable Disease*.

To help prevent and manage illness in ECE programs, it is important for the Child Care Health Advocate (CCHA) to understand the following:

- Why are children at risk?
- What types of diseases occur most often in ECE programs?
- How are diseases spread?
- What are the ECE provider's responsibilities for preventing and treating illness?

Why Are Children at Risk?

Children are at risk for getting communicable diseases in ECE programs for many reasons.

- Children have developing immune systems that are not as efficient at fighting off viruses as an adult's immune system. When people are exposed to an illness, the body responds by making antibodies (substances that help defend the body from the illness). The next time the immune system comes across that illness, the person either does not get the illness or gets a less severe case of it. Young children are more vulnerable to getting sick after they are exposed to a new germ in the environment. This "new" group of germs is often referred to as a *germ pool*. The germ pool in a private home might be very different from that found in an ECE program.
- Infants and young children explore their environment by using their hands and mouths. Children touch their noses, then touch toys, then touch other children and then put toys in their mouths to suck on. Through these hand-to-mouth activities, children are exposed to germs.
- Surfaces and objects, including toys, bottles, pacifiers, sandboxes, water tables and doorknobs, are often touched by children carrying germs.
- Because young children do not wash their hands on their own after toileting, eating or wiping their noses, they often spread germs.
- Young children are close to the ground and spend a lot of time on the floor.

- Staff members can also spread germs. ECE providers are very busy and may not always take time to wash their hands between activities (such as diapering, wiping noses and preparing food). In addition, if ECE providers come to work while sick, they may spread illness to children in their care.

What Types of Diseases Occur Most Often in ECE Programs?

Many infectious diseases are commonly seen in infants and young children in ECE programs (see Tables 1 and 2). Ear infections (otitis media), upper respiratory infections and gastrointestinal illnesses are more common in children enrolled in ECE programs than children raised at home (NICHD, 2001, 2003). Table 2 shows which diseases happen more often in ECE programs.

A list of communicable diseases that should be reported in California can also be found in the *Handout: Health and Safety Notes: Exposure to Communicable Disease*. Runny noses are often the sign of a respiratory illness caused by a virus, but can also come from crying, teething, being out in cold weather, or allergies (see *Handout: Health and Safety Notes: Runny Nose in the Child Care Setting*). Sometimes, a child will have been on nose drops for too long and will have what is called a “rebound” runny nose. Nose drops should never be used for longer than 5 days, especially if they contain a decongestant.

Infants often have rashes that are not contagious. Noncontagious rashes are sometimes seen in young children as well. Infants have two common rashes: heat rash and milia. Milia occurs on the face and consists of very small, white bumps over the forehead and cheeks. It is harmless and eventually goes away. Heat rash can be found mostly in the skin folds of a child and is a small, red rash that is most often the result of being too bundled up. It will disappear once the child is cooler. If it does not go away when the child is in a cooler place, the parents should be notified and asked to talk to a health care provider.

Nausea and vomiting are also commonly seen in ECE programs. There are many reasons for nausea and vomiting, including illness, so a vomiting infant should be separated from other children and monitored closely for signs of dehydration and illness.

How Are Diseases Spread in ECE Programs?

Understanding how infectious disease is spread is essential to preventing illness in ECE programs. Viruses, bacteria and germs can be spread from person to person in many different ways, including the following: respiratory, fecal-oral, skin-to-skin and through body fluids (such as blood, saliva and urine) (see Table 1).

Respiratory

The most common way diseases pass from one child to another is through direct contact with the mucous membranes of the nose, mouth or eyes. Children spread disease this way most often because of their inadequate hygiene (for example, infrequent or inadequate hand washing, or rubbing of eyes). For instance, if a child sneezes on a toy, and then another child puts that toy in his or her mouth, the germs have been passed on. This is known as respiratory transmission.

Illnesses caused by this method of transmission include the following:

- recurrent middle ear infection (otitis media)
- meningitis
- upper respiratory infections (colds, coughs, sinusitis)
- sore throat
- lower respiratory infections (pneumonia, respiratory syncytial virus [RSV])
- *Haemophilus influenzae* type B (Hib)
- whooping cough (pertussis)
- tuberculosis

Fecal-Oral

Viruses can be passed from one person to another through fecal-oral transmission. This means that through inadequate hand washing or hand-to-mouth behavior, fecal material is brought into a child’s mouth, causing illness. Children in diapers and children that put toys and other objects in their mouths are at risk for fecal-oral transmission of disease. In addition, an uncovered sandbox can contain cat or other animal feces that may cause disease in humans.

Illnesses caused by this method of transmission include diarrheal illnesses, pinworms, hand-foot-mouth disease (coxsackie), and hepatitis A.

TABLE 1
INFECTIOUS DISEASES DOCUMENTED IN ECE PROGRAMS

Route of Transmission	Bacteria	Virus	Parasite Protozoa
Respiratory	Streptococcus pneumoniae Neisseria meningitidis Bordetella catarrhalis Haemophilus influenzae type b Group A Streptococcus Mycobacterium tuberculosis Bordetella pertussis Corynebacterium diphtheriae	Influenza Respiratory syncytial virus (RSV) Parainfluenzae viruses Adenovirus Coronavirus Rhinovirus Measles Mumps Rubella Parvovirus B19 Varicella-Zoster (chicken pox) Cytomegalovirus (CMV)	
Gastrointestinal	Shigella Salmonella E coli 0157:H7 Clostridium difficile Campylobacter	Hepatitis A Rotavirus Astrovirus Enteric adenovirus Norwalk (calicivirus)	Giardia Cryptosporidium
Bloodborne		Hepatitis B HIV	
Skin-to-skin	Streptococcus pyogenes Staphylococcus aureus	Herpes simplex Molluscum contagiosum	Lice, scabies

Adapted from Osterholm, 1994

Skin-to-Skin

A number of viruses can be spread by skin-to-skin contact. Touching and sharing of personal belongings, dress-up clothes, stuffed toys and other items can contribute to the transmission of some infections.

Illnesses caused by this method of transmission include the following:

- chickenpox (varicella)
- impetigo (skin infection caused by bacteria)
- scabies (itchy skin caused by mites)
- head lice (pediculosis capitis)
- scalp ringworm (tinea capitis)
- body ringworm (tinea corporis)
- herpes simplex virus (cold sores)

Body Fluids: Blood, Urine, Saliva (Bloodborne Pathogens)

Germ live in body fluids such as blood, urine and saliva. When children put toys and fingers in their mouths, they can spread disease through their body fluids. Bacteria and viruses carried in the blood create a small but serious risk in ECE programs. However, the spread of illness through blood contact is rare in children.

Illnesses caused by this method of transmission include the following:

- cytomegalovirus (CMV) (viral infection that is usually harmless unless the immune system is weak)
- hepatitis B
- hepatitis C
- HIV/AIDS

TABLE 2
INFECTIOUS DISEASES ASSOCIATED WITH ECE PROGRAMS

Type of Disease or Infection	Examples	Higher Incidence
Enteric infection	Diarrhea Hepatitis A	yes yes
Respiratory tract infection	Otitis media Sinusitis Pharyngitis Pneumonia	yes probably probably probably
Invasive bacterial disease	Haemophilus influenzae type b Neisseria meningitidis Streptococcus pneumoniae	yes probably probably
Aseptic meningitis	Enteroviruses	probably
Herpes virus infections	Cytomegalovirus Varicella-zoster (chicken pox) Herpes simplex	yes yes yes
Bloodborne diseases	Hepatitis B Human immunodeficiency virus (HIV)	not established not established
Vaccine-preventable diseases	Measles, mumps, rubella, diphtheria, pertussis, tetanus H. influenzae type b	not established yes
Skin disease	Impetigo Scabies Pediculosis Ringworm	probably probably probably probably

Adapted from Pickering and Osterholm, 1997

Staff in ECE programs should receive training on preventing the spread of diseases through blood, often called the bloodborne pathogen training or the Occupational Safety and Health Administration (OSHA) Exposure Control Plan. Since ECE providers may handle blood if there is an injury or if blood is present in other body fluids such as vomit, they should be aware of standard precautions.

Standard precautions. The term *universal precautions* is used for the guidelines that were developed by the Centers for Disease Control and Prevention (CDC) in the 1980s to reduce the spread of infection through blood to health care providers and patients in health care settings. *Standard precautions* is the new term used for an expansion of universal precautions, recognizing that any body fluid may hold contagious germs. They are still mainly designed to prevent the spread of bloodborne disease (disease carried by blood or other body fluids), but are also excellent measures to prevent the spread of infectious disease in ECE programs (see *Handout: Health and Safety Notes: Standard and Universal Precautions in the Child Care Setting*).

ECE programs follow the same standard precautions as clinics and hospital settings with the following exceptions:

- Use of nonporous gloves is optional, except when blood or blood-containing body fluids may be involved.
- Gowns and masks are not required.
- Appropriate barriers include materials such as disposable diaper table paper, disposable towels and surfaces that can be cleaned in ECE programs.

Training on job-related risks related to handling body fluids. The director of an ECE program should make sure that all staff at risk of coming into contact with blood as part of their job has training in the following areas at the time of orientation and annually (American Academy of Pediatrics [AAP], American Public Health Association & National Resource Center for Health and Safety in Child Care, 2002):

- ways that bloodborne diseases can spread
- standard precautions
- program policies and procedures regarding exposure to blood and other body fluids

- reporting procedures under the exposure control plan to make sure that all first aid incidents involving blood exposure are reported to the employer before the end of the work shift during which the incident occurs

What Are the ECE Provider's Responsibilities Related to Prevention and Treatment of Illness?

Hand Washing

Regular hand washing is the most important method of infection control for preventing illness in children and ECE providers (Kotch, Weigle & Weber, 1994; Roberts, Smith, Jorm et al., 2000). Many studies have shown that unwashed or improperly washed hands are the main ways to spread infection. When providers, children and parents wash their hands at proper times and with the proper technique, the spread of illness can be drastically reduced.

Immunization

ECE providers often need help putting an immunization tracking program into place. Children must have current immunizations when they enter and during the time they are enrolled in an ECE program (State of California, 2002) (see *Handout: California Immunization Requirements for Child Care and Handout: School and Child Care Immunization Requirements for Schools and Child Care Programs, California Immunization Handbook, 7th Edition, July 2003*). These California child care requirements are different than the immunization schedule recommended by the U.S. Department of Health and Human Services, the CDC and the AAP (see *Handout: Recommended Childhood and Adolescent Immunization Schedule – United States, 2005*). CCHAs can explain the differences to ECE providers and emphasize that ECE programs need to follow the state child care requirements.

Reducing serious vaccine-preventable diseases in ECE programs is an important part of infection control. Making sure that children stay up-to-date on immunizations is an ongoing process and requires careful monitoring. Helping programs follow immunization recommendations also has a secondary gain in that it will connect families to a source of health care and health insurance. CCHAs can provide immunization training

and assessment, record review, immunization tracking systems, parent education and resources, and community resources. If there are children who have not received their immunizations, ECE providers need to be aware of the issues involved (see *Handout: Health and Safety Notes: Unimmunized Children in the Child Care Setting*).

WHAT A CCHA NEEDS TO DO

Prevent Illness

Prevention is the main way to reduce the frequency of communicable diseases in ECE programs. Prevention takes place through a variety of methods, such as immunization, hand washing, policy development and disease management.

The most important step a CCHA can take is to assure proper and frequent hand washing in the ECE program. It is especially important for the staff to model good hand washing, as the children will follow their examples.

Understanding the importance and impact of immunizations, educating staff and maintaining current immunization records on both children and staff is another effective way to prevent the occurrence of vaccine-preventable illnesses. See the following handouts: *California Immunization Requirements for Child Care*; *Recommended Childhood and Adolescent Immunization Schedule – United States*; and *Health and Safety Notes: Unimmunized Children in the Child Care Setting*.

Develop Policies

The CCHA needs to help develop and/or implement policies and practices that prevent the spread of illness. Each program needs to decide what policies are appropriate for its families. The following is a list of recommended policies that should be in place in an ECE program (AAP et al., 2002):

- hand washing
- diapering/toileting
- cleaning toys
- handling of body fluids, soiled clothing and bedding

- preparing, handling, labeling and storing breast milk and formula bottles
- preparing food
- understanding and putting into practice standard precautions
- understanding the immunization schedule and making sure that children and staff are up-to-date with their immunizations
- exclusion/inclusion
- knowing and understanding the reportable diseases in your area or state
- putting into practice competent and current sanitation practices
- communicating with parents about exclusion policies
- communicating with parents when children have been ill during care

Provide Guidance on Exclusion and Inclusion Policies

CCHAs can introduce ECE programs and families to up-to-date guidelines for exclusion from and inclusion into ECE programs. At first glance, one might think that exclusion and inclusion policies do not go together. Many ECE programs have exclusion policies, but do not address when children who have been excluded can come back to care (see *Handout: Health and Safety Notes: Excluding Children Due to Illness*). Recent guidelines tend to focus on a child's behavior, rather than on specific symptoms, which puts the focus on whether children are too sick to participate rather than on whether they have a frequent cough. There are times when a mildly ill child can be included, and these criteria need to be communicated clearly both verbally and in writing to families. Exclusion guidelines are clearly described in the National standards (AAP et al., 2002, Standard 3.065). It is important for an ECE program to have policies for staff sick days and staff exclusion and inclusion as well.

In general, a child with a runny nose does not need to be excluded, except in the following circumstances:

- The child is so uncomfortable that he or she cannot participate in activities.
- There is a smelly discharge on one side of the nostril, and it is a color other than white or yellow,

which may indicate that there is a foreign object in the nose such as a bean, pea or other small object.

- The nasal drainage is accompanied by a fever or other symptoms of a more serious condition (see *Handout: Fact Sheets for Families: Fever*).

CCHAs should be aware of and have a list of those diseases that are reportable to the health department and also have a list of criteria for when a child may return to care if he or she has certain diseases. This can be obtained through your Child Care Health Consultant (CCHC) or local health department.

The following sources may create challenges to putting exclusion and inclusion policies into practice: families, ECE providers, health care providers and CCHAs.

Families

Sometimes exclusion policies can cause conflict between families and ECE providers. Families whose children are ill have a dilemma. They are concerned about their child, yet also have to consider other family and work-related responsibilities. Parents of children attending ECE programs report that they miss from 1 to 4 weeks of work per year to care for their ill children (Davis, MacKenzie & Addis, 1994). It is important for ECE providers to be very clear that if children are ill, they must be excluded from care for the period of the illness. Parents may need assistance with developing backup plans if they are unable to pick up the child during the work day, or if they are unable to be absent from work to care for ill children.

ECE providers

ECE providers also face dilemmas. They must be alert to preventing the spread of communicable disease and be responsible for providing the best care possible to both sick and well children. Each ECE program has factors that may influence their exclusion and inclusion policies. Some of these may include the following:

- desire to reduce the spread of disease
- extra attention that a mildly ill child may require, and the capacity of the center or site to provide extra time
- qualifications of the staff to care for mildly ill children

- space to safely separate mildly ill children from the other children and time to supervise all children adequately
- needs of the other children
- needs of the parents
- amount of time involved in cleaning and strict hygiene practices

Health care providers

Health care providers face concerns when a child enrolled in an ECE program is ill. Their first consideration is for the child, but they may also feel pressure to permit the child to return to care as early as possible to allow the family to go back to work or to their usual routine. It is important to communicate clearly with families and health care providers when there is a health concern. Using standardized forms such as the *Handout: Information Exchange on Children with Health Concerns Form* is a good way to make sure that the proper information is communicated. ECE providers can document their concerns and observations on this form, and health care providers can communicate their diagnosis and recommended treatment to the ECE provider. Parents need to give their consent for this information to be released to the ECE provider.

CCHAs

The CCHA's role is to identify the needs of the ECE program and the needs of the children and families and adopt or revise a policy that best meets the needs of those affected by the policy. The CCHA encourages good choices that promote children's normal growth and development, as well as good disease prevention practices, by helping to develop and implement strong policies.

Conduct Daily Morning Health Checks

Daily morning health checks help ECE providers judge what is normal for each child and identify problems early. Discovering recent illness in children and their families reduces the spread of communicable diseases. CCHAs can help ECE providers establish a Daily Morning Health Check procedure and train staff in conducting checks (see *Handout: Morning Health Check*).

The National standards (AAP et al., 2002, Standard 3.001) state the following: everyday, a trained staff member shall conduct a health check of each child. This health check shall be conducted as soon as possible after the child enters the child care facility and whenever a change occurs while that child is in care. The health check shall address the following:

- changes in behavior (such as lethargy or drowsiness) or appearance from the behaviors and appearance observed during the previous day's attendance
- skin rashes, itchy skin, itchy scalp or (during a lice outbreak) nits
- high body temperature (determined by taking the child's temperature)
- complaints of pain or of not feeling well
- other signs or symptoms of illness (such as drainage from eyes, vomiting, diarrhea and so on)
- reported illness or injury in child or family members since last date of attendance

Practice Sanitation and Safety

To keep germs from spreading, surfaces and toys should be cleaned and sanitized on a regular basis (see *Handout: Health and Safety Notes: Recommendations for Cleaning, Sanitizing and Disinfecting*). Sanitation practices by the staff and children should be based on current research on the best and proper way to clean a variety of surfaces and objects. Use the information from labels, health departments and the CCHC to assist in developing good cleaning and janitorial practices. Toys that cannot be properly and safely sanitized should be eliminated if possible from the ECE program (AAP et al., 2002, Standard 3.036). Toys that children have placed in their mouths or that are otherwise contaminated by body secretion or excretion shall be set aside where children cannot reach them (AAP et al., 2002, Standard 3.036).

Environmental issues, such as open sandboxes and other outdoor and indoor safety and sanitation concerns, need to be followed up. Checking the outdoor play areas for used needles, used condoms, other evidence of body fluids, standing water and unusual debris or water on the grounds on a daily basis early in the morning is an essential part of protecting the children and staff from contact with unsafe materials.

One staff person should be assigned this duty at each ECE program.

Provide Links to Community Resources

The CCHA should be aware of local, convenient facilities that are licensed to care for mildly ill children and be prepared to provide this information to parents as needed. CCHAs can also make sure that ECE programs are connected to the local communicable disease branch of their health department. CCHAs should encourage key relationships with health department staff and the immunization coordinator.

Provide Educational Materials

Posters for hand washing and diapering procedures should be put up in many easy-to-see places in the ECE program. Handouts for parents are helpful in promoting illness prevention. There are many children's books about being sick and going to the doctor, dentist and other health care providers. These are a positive addition to reading centers in the ECE program. Regular communication with families and staff about prevention techniques, hand washing, coughing in your elbow and not in your hand, immunizations, or well family classes or books is positive and helps to model the message that preventive health is important. It is also important to have a system of communication with families when any unusual symptom is noticed in a child in care. For instance, a rash, a runny nose, upset stomach and other symptoms should be communicated to the family even if the symptom has gone away by the time the child is picked up for the day.

There are also books written by professionals who have experience with ECE programs that offer resources for developing policies and practices that help programs decrease the spread of communicable disease.

Train ECE Staff in Medication Administration

Because young children in ECE programs have frequent, common illnesses, or noncontagious illnesses, and because some children have chronic health con-

ditions, ECE providers will need to give medication in some circumstances (see *Handout: Health and Safety Notes: Medication Administration in Child Care Programs*). CCHAs can help programs develop clear policies and practices regarding medication administration, as well as train staff in proper medication administration. Precautions should always include checking that the name of the child on the medication and the child receiving the medication are the same; reading and understanding the label/prescription; administering medication according to the prescribed method and dose; observing and reporting any side effects from medications; and documenting the administration of each dose by the time and amount given (AAP et al., 2002, Standard 3.083).

Cultural Implications

Cultural traditions or personal beliefs may conflict with recommendations for the prevention of the spread of disease. For example, some cultures may discourage or forbid the use of immunizations for disease prevention, or it may be the custom to eat with hands until a certain age. Some cultures use folk medicine and elders who have experience with “healing” and may prefer to use the advice and treatments they recommend instead of interventions that are more familiar to ECE staff.

Implications for Children and Families

CCHAs can help children learn good hygiene practices that are appropriate to their age. Parents will potentially miss less work if good preventive measures are in place in the ECE program and the policies for ill children are brief and easy to understand.

Implications for ECE Providers

If prevention efforts are successful, children will have fewer illnesses requiring absence from ECE, and ECE staff will be healthier as well. The ECE program will be cleaner and the staff will understand the reasons for sanitizing and cleaning toys and other materials. Staff will know the signs and symptoms of communicable diseases and how the diseases are transmitted, and will be able to step in more quickly, thereby decreasing the opportunity for a disease to spread rapidly.

ACTIVITY 1: I'VE GOT A SECRET

The trainer will pass around a sheet marked “I’ve got a secret” and ask participants to write about a medication error they have made while working in an ECE program. This information will be confidential and anonymous. Complete the sheet anonymously and give it to the trainer.

Discuss the kinds of medications you expect to see in ECE programs. Discuss common ways medications are given in ECE programs. What are common errors made? How can these errors be avoided in the future?

ACTIVITY 2: IMMUNIZATION ASSESSMENT ACTIVITY

Using the California Immunization Handbook as a guide, perform an immunization assessment on a sample immunization card handed out by the trainer. Transfer all of the information from the child’s record to the blue card. Determine which immunizations are due by using two methods: the immunization schedule and the “pink windows.” Complete a *Notice of Immunizations Needed* form to give to the parent. Find out when immunizations will be due again. Discuss immunization tracking systems for ECE programs.

NATIONAL STANDARDS

From *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, Second Edition*

1.009, 1.023, 1.025, 1.031, 1.033, 3.001, 3.002, 3.003, 3.005, 3.007, 3.014, 3.019, 3.020, 3.030, 3.035, 3.036, 3.037, 3.060, 3.062, 3.064, 3.065, 3.066, 3.067, 3.068, 3.069, 3.070-3.077, 3.078, 3.081, 3.082, 3.083, 4.010, 4.052, 6.001, 6.002, 6.003, 6.004, 6.005, 6.006, 6.007, 6.008, 6.008-6.039, 6.009, 6.010, 6.011, 6.012, 6.013, 6.014, 6.015, 6.016, 6.017, 6.018, 6.019, 6.020, 6.021, 6.022, 6.023, 6.024, 6.025, 6.026, 6.027, 6.028, 6.029, 6.030, 6.031, 6.032, 6.033, 6.034, 6.035, 6.036, 6.037, 6.038, 6.039, 6.100, 8.011, 8.012, 8.014, 8.021, 8.051, 8.061, 8.063, 9.025, Appendices W and X.

CALIFORNIA REGULATIONS

From *Manual of Policies and Procedures for Community Care Licensing Division*

Title 22, Division 12, Chapters 1, Article 6, Section 101226, 101226.1, 101226.2, 101226.3, 101212, 101426.2.

RESOURCES

Organizations and Resources

Organization and Contact Information	Description of Resources
<p>American Academy of Pediatrics 141 Northwest Point Blvd. Elk Grove Village, IL, 60007 (847) 434-4000 www.aap.org</p>	<p>The American Academy of Pediatrics Web site has information on children's health and immunizations as well as the following relevant publications: <i>Managing Infectious Disease in Child Care and Schools</i> <i>Health in Child Care Manual, 4th Ed.</i> Brochures: <i>Your Child and Antibiotics</i> <i>Common Childhood Infections</i> <i>Urinary Tract Infections in Young Children</i> <i>A Guide to Children's Medication</i> <i>Croup and our Young Child</i> <i>Bronchiolitis and Your Young Child</i> <i>Tonsils and Adenoids</i> <i>Anemia and Your Young Child</i></p>
<p>A Place of Our Own (Los Ninos En Su Casa in Spanish) www.aplaceofourown.org</p>	<p>Public television series which addresses the important role of home-based child care providers as children's first teachers. The series provides education and resources for child caregivers on a variety of topics in early childhood development, including children's cognitive, social and emotional development, physical well being, nutrition, and health. Their Web site also has health topics listed.</p>
<p>California Child Care Health Program 1333 Broadway, Suite 1010 Oakland, CA 94612-1926 (800) 333-3212 Healthline www.ucsfchildcarehealth.org</p>	<p>CCHP has developed health and safety notes and fact sheets for families on 35 illnesses common in ECE programs, many handouts, 11 posters related to illness in ECE programs, and a Prevention of Infectious Disease curriculum. Most of this information can be downloaded from the Web site. In addition, Healthline is available for consultation on preventing and managing illness in ECE programs.</p>
<p>Cal/OSHA Statewide consultation number (800) 963-9424 www.dir.ca.gov/Dosh</p>	<p>The Cal/OSHA Program is responsible for enforcing California laws and regulations pertaining to workplace safety and health and for providing assistance to employers and workers about workplace safety and health issues.</p>
<p>Centers for Disease Control and Prevention Child Care Health and Safety Program, MS-A07 1600 Clifton Road, N.E. Atlanta, Georgia 30333 (404) 639-3534 www.cdc.gov/ncidod/publications/daycare/execsum.htm</p>	<p>The Child Care Health and Safety Program, in collaboration with representatives of programs throughout CDC involved in child care health and safety, representatives of other federal agencies engaged in child care issues, and a diversity of experts from the child care, child health, public health, and child advocacy communities, including national organizations, academic institutions, state and local government, and the business community, has developed a CDC Action Plan for Child Care Health and Safety. The CDC publishes a <i>Parents' Guide to Childhood Immunizations</i>. This 94-page booklet introduces parents to 12 childhood diseases and the vaccines that can protect children from them. Available in English and Spanish.</p>

Organization and Contact Information	Description of Resources
Centros para el Control y la Prevención de Enfermedad www.cdc.gov/spanish	Información sobre alergias, cigarrillo/tabaco, drogadicción, enfermedades, inmunización, prevención, salud ambiental, dental y mental.
Doctor Para la Familia www.familydoctor.org/spanish.xml	Temas variadas sobre la salud.
Early Childhood Linkages System (ECELS) Pennsylvania Chapter, American Academy of Pediatrics Rose Tree Corporate Center II 1400 North Providence Road #3007 Media, PA 19063 (484) 446-3003 www.ecels-healthychildcarepa.org	Since December 1989, the PA Chapter of the American Academy of Pediatrics (PA AAP) has operated the Early Childhood Education Linkage System (ECELS). Now operating Healthy Child Care Pennsylvania, ECELS provides health professional consultation, training, and technical assistance to improve early childhood education programs in the Commonwealth. To carry out this work, the PA AAP links the resources of government, early childhood educators, and health professionals. The following publications are also available: <i>Hand Hygiene Update</i> <i>The Role of the Child Care Health Consultant: Food Safety and Facility Sanitation</i> <i>Preparing for Illness, 4th Ed.</i> <i>Model Child Care Health Policies</i> <i>Situations that Require Immediate Medical Attention</i> <i>Keeping Safe When Touching Blood and Other Body Fluids</i>
Family Doctor www.familydoctor.org	Health information for the whole family from the American Academy of Family Physicians.
Immunization Action Coalition www.immunize.org	A source of childhood, adolescent, and adult immunization information, and Hepatitis B educational materials. All materials on this site are camera ready and copyright free.
Immunization Branch California Department of Health Services 2151 Berkeley Way Berkeley, CA 94704 (510) 540-2065 www.dhs.ca.gov/ps/dcdc/izgroup	The Immunization Branch of the California Department of Health Services provides leadership and support to public and private sector efforts to protect the population against vaccine-preventable diseases.
KidsHealth http://kidshealth.org	KidsHealth provides doctor-approved health information about children from before birth through adolescence. Created by The Nemours Foundation's Center for Children's Health Media, KidsHealth provides families with accurate, and up-to-date health information.
Maternal and Child Health Bureau Health Resources and Services Administration 5600 Fishers Lane, Rm. A-39 Rockville, MD 20857 (301) 443-6600 www.mchb.hrsa.gov	The MCHB mission is to provide national leadership and to work in partnership with states, communities, public-private partners, and families to strengthen the maternal and child health (MCH) infrastructure, assure the availability and use of medical homes, and build knowledge and human resources in order to assure continued improvement in the health, safety, and well-being of the maternal and child health population.

Organization and Contact Information	Description of Resources
<p>National Association for the Education of Young Children 1509 16th Street, NW Washington, DC 20036 (800) 424-2460 www.naeyc.org</p>	<p>The National Association for the Education of Young Children (NAEYC) is dedicated to improving the well-being of all young children, with particular focus on the quality of educational and developmental services for all children from birth through age 8. The Web site lists many relevant resources including the following publications: <i>Healthy Young children: A Manual for Programs, 4th edition</i> <i>Keeping Health: Parents, Teachers, and Children. 2003</i> (brochure)</p>
<p>National Association of Child Care Resource and Referral Networks 1319 F Street, NW, Suite 500 Washington, DC 20004 (202) 393-5501 www.naccrra.org</p>	<p>NACCRRRA is the national network of more than 850 child care resource and referral centers (CCR&Rs) located in every state and most communities across the US. CCR&R centers help families, child care providers, and communities find, provide, and plan for affordable, quality child care.</p>
<p>National Institute of Child Health and Human Development 9000 Rockville Pike Bethesda, MD 20892 www.nichd.nih.gov</p>	<p>The mission of the NICHD is to ensure that every person is born healthy and wanted, that women suffer no harmful effects from reproductive processes, and that all children have the chance to achieve their full potential for healthy and productive lives, free from disease or disability, and to ensure the health, productivity, independence, and well-being of all people through optimal rehabilitation.</p>
<p>National Resource Center for Health and Safety in Child Care UCHSC at Fitzsimons 1784 Racine Drive Bldg. 401, Room 106 Aurora, CO 80045-0508 (800) 598-KIDS http://nrc.uchsc.edu/contacts.htm</p>	<p>The National Resource Center is located at the University of Colorado Health Sciences Center in Denver, Colorado, and is funded by the Maternal and Child Health Bureau, U.S. Department of Health & Human Services, HRSA. The NRC's primary mission is to promote health and safety in out-of-home child care settings throughout the nation.</p>
<p>Nemours Foundation 4600 Touchton Road East Building 200, Suite 500 Jacksonville, FL 32246 (904) 232-4100 phone (904) 232-4125 fax www.nemours.org</p>	<p>Nemours, established in 1936 by philanthropist Alfred I. duPont, is dedicated to improving the health and spirit of children. Nemours supports the operation of a number of children's health facilities throughout the nation, including the Alfred I. duPont Hospital for Children in Wilmington, Delaware, and the Nemours Children's Clinics throughout Florida. Nemours also supports clinical research aimed at translating advances in science into practical ways of improving health care for infants, children, and teens.</p>
<p>Public Health Foundation 1220 L Street, NW, Suite 350 Washington, DC 20005 (202) 898-5600 info@phf.org www.phf.org</p>	<p>The Public Health Foundation (PHF) is dedicated to achieving healthy communities through research, training, and technical assistance. For more than 30 years, this national, nonprofit organization has been creating new information and helping health agencies and other community health organizations connect to and more effectively use information to manage and improve performance, understand and use data, and strengthen the workforce.</p>

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Audio/Visual

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HANDOUTS FOR THE PREVENTING AND MANAGING ILLNESS IN EARLY CARE AND EDUCATION PROGRAMS MODULE

Handouts from California Childcare Health Program (CCHP), Oakland, CA

Page	Handout Title
21	<i>Fact Sheets for Families: Fever</i>
23	<i>Health and Safety Notes: Excluding Children Due to Illness</i>
25	<i>Health and Safety Notes: Exposure to Communicable Disease</i>
29	<i>Health and Safety Notes: Medication Administration in Child Care Programs</i>
33	<i>Health and Safety Notes: Recommendations for Cleaning, Sanitizing and Disinfecting</i>
35	<i>Health and Safety Notes: Runny Nose in the Child Care Setting</i>
37	<i>Health and Safety Notes: Standard and Universal Precautions in the Child Care Setting</i>
39	<i>Health and Safety Notes: Unimmunized Children in the Child Care Setting</i>
41	<i>Information Exchange on Children with Health Concerns Form</i>
43	<i>Morning Health Check</i>

Handouts from Other Sources

Page	Handout Title
44	<i>California Immunization Requirements for Child Care</i>
45	<i>Recommended Childhood and Adolescent Immunization Schedule – United States, 2005</i> <i>School and Child Care Immunization Requirements for Schools and Child Care Programs, California Immunization Handbook, 7th Edition, July 2003 (handed out as a booklet separate from this module)</i>

Fever

What is fever?

Fever is a rise in body temperature above normal. Although the range of normal temperature varies depending on the method used, it is generally accepted that a temperature of more than 100° F (38° C) measured by any method is a fever.

Fever is not an illness. In fact, a fever is one way the body fights infections caused by either viruses or bacteria. It usually will not hurt your child.

How do you measure a fever?

By feeling your child's forehead, face or chest you may know if he or she has a fever, but taking his or her temperature is the only way to know for sure. Although temperature measurement in children seems simple, the choice of method is complicated. It depends on your child's age, simplicity of use, cost, accuracy and choice of technology.



Ways to measure a fever

- **By mouth** (oral method)—recommended for children older than 4 years.
- **In the armpit** (axillary method)—recommended for infants and toddlers, but also reliable for older children.
- **Rectally**—not recommended for safety reasons.
- **In the ear** (tympanic method)—requires special thermometers and training.

When should you get medical help?

Despite our concerns, fever is a common symptom for young children that is rarely harmful and usually does not require treatment. Mild or short-term higher temperature is common with minor infections and many other things including exercise, time of the day and environment (such as a hot room or hot day). High fevers (temperatures of 103° F and up) or those rising rapidly can signal a potentially dangerous infection.

In seeking medical help, the child's age and appearance are two major factors. While fever in newborns is rare and often indicates a serious problem, for older infants and children it depends on how the child looks and behaves.

Call the health care provider immediately if:

- The infant is 4 months of age or younger and has fever.
- A child between 4 months and one year of age has a fever lasting more than 24 hours.
- The child's fever is 104° F or more.
 - The child looks very sick, is not eating or playing, is unresponsive, or is having difficulty breathing unrelated to a stuffy nose.
- The child has other signs of illness such as stiff neck, rash or a sore throat that has lasted for 2 to 3 days.
- The fever remains above 103° F after an hour or two of home treatment.
- The fever lasts more than two days.

How do you manage a fever at home?

Without medicine: Fever doesn't always need to be treated. If active, playful and showing no other symptoms, the child may not need medication. Dress in light clothing to allow heat loss through skin, but use a light blanket if the child feels cold. Give extra fluids to prevent dehydration or extra loss of water.

With medicine: Medication is only needed to make a child more comfortable or when the child has seizures with fever. If you wish to treat a fever, acetaminophen (Tylenol) can be used to lower a fever. The child's health care provider can suggest the recommended pediatric dose. If the health care provider recommends ibuprofen (Motrin / Advil), it can be used every 6 to 8 hours. *Always avoid aspirin because of its association with the sometimes deadly Reye's syndrome.*

Temperature tips

- Take young children's temperature in the armpit.
- Don't use temperature strips or pacifiers; they are not accurate.
- Do not use glass thermometers with mercury; they are dangerous.
- Wash the thermometer after use with warm (not hot) soapy water or swab with rubbing alcohol.

by A. Rahman Zamani, MD, MPH



Provided by California Childcare Health Program
For more information, please contact:
Healthline 1-800-333-3212

Distributed by:



Excluding Children Due to Illness

Four steps to a healthier program

1. Start the day with a health check. Perform a brief and casual assessment of each child every day upon arrival and before the parent leaves. You are familiar with what is typical for each child and can identify “red flags.”

- *Listen* to what the child and parent tell you about how the child is feeling. Is the child hoarse, having trouble breathing, or coughing? Did he or she eat breakfast?
- *Look* at children from their level. Observe for signs of crankiness, pain, discomfort or fatigue. Does the child look pale, have a rash, sores or runny nose or eyes?
- *Feel* the child’s cheek and neck with the back of your hand for warmth, clamminess or bumps.
- *Smell* for unusual odors in their breath or diaper.

2. Distribute and explain your exclusion policies to parents and staff. Have a clear, up-to-date exclusion policy for illness and provide parents with a copy. Ask your health consultant or a health professional to review it periodically. Writing a sound policy and enforcing it consistently will help reduce conflicts. Make sure all staff understand the policies and how to enforce them.

3. Understand the reasons for exclusion.

- The child doesn’t feel well enough to participate comfortably in routine activities.
- The ill child requires more care than staff are able to provide without compromising the health and safety of the other children.
- The illness is any of the specific list of diagnosed symptoms or conditions for which exclusion is recommended.

4. Notify parents. Inform parents of observed signs or symptoms, and promptly notify all families when a diagnosed communicable condition arises. Post a notice that includes the signs and symptoms to watch for, what to do, and when children with the condition can return.

Conditions for which exclusion is not recommended:

Certain conditions, by themselves, do not require exclusion unless recommended by the child’s health care provider or the public health department. However, the reasons listed in step 3 still apply.

1. Fever in the absence of any other signs or symptoms of illness.
2. Presence of germs in urine or stool in the absence of symptoms of illness. Exceptions include potentially serious organisms such as E. coli 0157:H7, shigella or salmonella.
3. Nonpurulent conjunctivitis, defined as a pink eye with a clear, watery discharge and without fever, eye pain, or eyelid redness.
4. Rash without fever and without behavior changes.
5. Diagnosed CMV infection.
6. Carrier of hepatitis B virus, if they have no behavioral or medical risk factors such as unusually aggressive behavior (biting), oozing rashes or bleeding.
7. HIV infection, provided the child’s health, immune status and behavior are appropriate as determined by that child’s medical provider.

Symptoms or conditions for which exclusion *is* recommended:

For some conditions, exclusion can significantly reduce the spread of infection or allow children time to recover to the point where you can safely care for them:

1. **Fever along with behavior change or other signs of illness** such as sore throat, rash, vomiting, diarrhea, earache, etc. Fever is defined as having a temperature of 100° F or higher taken under the arm. Oral temperatures should not be taken on children younger than four years of age. Rectal temperatures are no longer recommended in the child care setting, and mercury-containing thermometers should be avoided. *A temperature over 99° F (under the arm) in an infant under 4 months of age should be evaluated by a medical professional.*

2. Symptoms and signs of possible severe illness such as unusual tiredness, uncontrolled coughing or wheezing, continuous crying, or difficulty breathing.
3. **Diarrhea** - runny, watery or bloody stools.
4. **Vomiting** - more than once in a 24-hour period.
5. **Body rash with fever.**
6. **Sore throat with fever and swollen glands or mouth sores with drooling.**
7. **Eye discharge** - thick mucus or pus draining from the eye. (Viral conjunctivitis usually has a clear, watery discharge and may not require medication or exclusion.)
8. **Head lice or nits (eggs)**
9. **Severe coughing** - child gets red or blue in the face, or makes high-pitched whooping sound after coughing.
10. **Child is irritable, continuously crying,** or requires more attention and care than you can provide without compromising the health and safety of the other children in your care.

What to do when a child becomes ill in your program

- Attempt to keep the child from intimate contact with other children and staff. Remove and sanitize toys and other items they may have put into their mouth. **WASH HANDS!**
- Contact the parents to have the child picked up as soon as possible. Make the child as comfortable as possible. Do not isolate them in such a way that you cannot provide supervision at all times.
- Continue to observe the child for new or worsening symptoms.
- If the child does not respond to you, is having trouble breathing, or is having a seizure, call 9-1-1.
- Document your actions in the child's file with date, time, symptoms, actions taken, by whom, and be sure to add your signature.

When to get immediate help

Some conditions require immediate medical help. If the parent can be reached, tell them to come right away and to notify their medical provider. If the parent or the child's medical provider is not immediately available, call 9-1-1 (EMS) for immediate help.

Tell the parent to come right away, and get medical help immediately, when any of the following things happen:

- An infant under four months of age has an axillary ("armpit") temperature of 100° F or higher.
- A child over four months of age has an axillary temperature of 105° F or higher.
- An infant under four months of age has two or more forceful vomiting episodes (not the simple return of swallowed milk or spit-up) after eating.
- A child looks or acts very ill, or seems to be getting worse quickly.
- A child has neck pain when the head is moved or touched.
- A child has a stiff neck or severe headache.
- A child has a seizure for the first time.
- A child acts unusually confused.
- A child has uneven, different-sized pupils (black center spots of the eyes).
- A child has a blood-red or purple rash made up of pinhead-sized spots or bruises that are not associated with injury.
- A child has a rash of hives or welts that appears quickly.
- A child breathes so fast or hard that he or she cannot play, talk, cry or drink.
- A child has a severe stomach ache that causes the child to double up and scream.
- A child has a stomach ache without vomiting or diarrhea after a recent injury, blow to the abdomen or hard fall.
- A child has stools that are black or have blood mixed through them.
- A child has not urinated in more than eight hours, and the mouth and tongue look dry.
- A child has continuous, clear drainage from the nose after a hard blow to the head.

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Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs. Washington, D.C.: American Public Health Association and American Academy of Pediatrics (1992).

Keeping Kids Healthy: Preventing and Managing Communicable Disease in Child Care. CA Department of Education (1994).

By Lyn Dailey, PHN; Rev. 03/03

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Exposure to Communicable Disease

As a child care provider, you join hands with parents in your efforts to create a healthy environment for children in your care. You and the parents will benefit from the communication of your health and safety policies, health and safety messages and new knowledge gained on health and safety issues. You are also required to inform parents when children in your care are exposed to a communicable disease.

This health and safety note will help you prepare a written notice to parents about exposure of their children to a communicable disease. The notice will alert them to watch for signs of that illness and seek medical advice when necessary.

Confidentiality

Please keep in mind that when notifying parents about exposure, the confidentiality of the ill person should be maintained. You should not report the name of the child, other family member, or staff member who is ill to other parents. Let the parents of an ill child know ahead of time that you will be sending exposure notices to other parents but will not mention any names.

Reporting Communicable Diseases to Outside Agencies

All licensed child care programs are required to report outbreaks of some communicable diseases to both Community Care Licensing and the local public health department. A list of those diseases which are reportable in California is included on the final page of this note. An outbreak is defined as two or more known or suspected cases of a disease. However, the American Academy of Pediatrics strongly recommends that child care providers report even if there is only a single case, to ensure that the local Public Health Department is aware that this serious illness is present in a child care setting.

When you report to licensing and your local health department, the parents of the children must be informed that you are required to report the disease. The children's health care providers are also required to report communicable disease to the health department. We encourage you to work closely with the local health department to reassure and inform parents and staff.

The requirement to report communicable diseases to the local health department applies to any licensed facility, whether it is a center or family child care home. However, we strongly encourage unlicensed providers to report communicable diseases as well and work closely with their local health department.

Parental Responsibilities

Just as child care providers have an obligation to report when children in care are exposed to a communicable disease, parents have the same obligation to report diseases to the child care program within 24 hours of a diagnosis, *even if they keep their child at home*. That way, the child care provider can alert other parents to watch for signs of that illness in their children and seek medical advice when necessary.

Exclusion Policies

Distribute and explain your exclusion policies to parents and staff before illness arises. Have a clear, up-to-date exclusion policy for illness and provide parents with a copy when they enroll their child in your program. Ask your health consultant or a health professional to review it periodically. Writing a sound policy and enforcing it consistently will help reduce conflicts. Make sure all staff understand the policies and how to enforce them.

Please call the Healthline at (800) 333-3212 for more information.

Rev. 02/05

Notice of Exposure to Communicable Disease

NAME OF CHILD CARE PROGRAM _____

ADDRESS OF CHILD CARE PROGRAM _____

TELEPHONE NUMBER OF CHILD CARE PROGRAM _____

DATE _____

Dear Parent or Legal Guardian:

A child in our program has or is suspected of having: _____

INFORMATION ABOUT THIS DISEASE

The disease is spread by: _____

The symptoms are: _____

The disease can be prevented by: _____

What the program is doing to reduce the spread: _____

What you can do at home to reduce the spread: _____

If your child has any symptoms of this disease, call your health care provider to find out what to do and be sure to tell them about this notice. If you do not have a regular health care provider to care for your child, contact your health department for instructions on how to find one, or ask staff here for a referral. If you have any questions, please contact:

_____ at _____

(CAREGIVER'S NAME)

(TELEPHONE NUMBER)

Suspected Illness or Communicable Disease Exclusion Form

NAME OF CHILD _____

FACILITY _____ DATE _____

Dear Parent or Legal Guardian:

Today at our child care facility, your child was observed to have one or more of the following signs or symptoms:

- | | |
|--|--|
| <input type="checkbox"/> Diarrhea (more than one abnormally loose stool) | <input type="checkbox"/> Child gets red or blue in the face |
| <input type="checkbox"/> Difficult or rapid breathing | <input type="checkbox"/> Child makes a high-pitched croupy or whooping sound after s/he coughs |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Severe itching of body/scalp |
| <input type="checkbox"/> Fever (101° F or above orally) | <input type="checkbox"/> Sore throat or trouble swallowing |
| <input type="checkbox"/> Gray or white stool | <input type="checkbox"/> Unusual behavior |
| <input type="checkbox"/> Headache and stiff neck | <input type="checkbox"/> Child cries more than usual |
| <input type="checkbox"/> Infected skin patches | <input type="checkbox"/> Child feels general discomfort |
| <input type="checkbox"/> Crusty, bright yellow, dry or gummy areas of skin | <input type="checkbox"/> Cranky or less active |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Just seems unwell |
| <input type="checkbox"/> Pink eye | <input type="checkbox"/> Unusual spots or rashes |
| <input type="checkbox"/> Tears, redness of eyelid lining | <input type="checkbox"/> Unusually dark, tea-colored urine |
| <input type="checkbox"/> Irritation | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Swelling and/or discharge of pus | <input type="checkbox"/> Yellow skin or eyes |
| <input type="checkbox"/> Severe coughing | <input type="checkbox"/> Head lice or nits |

Contact your health care provider if there is:

- | | |
|--|--|
| <input type="checkbox"/> Persistent fever (over 100° F) without other symptoms | <input type="checkbox"/> Yellow skin and/or eyes |
| <input type="checkbox"/> Breathing so hard he cannot play, talk, cry or drink | <input type="checkbox"/> Unusual confusion |
| <input type="checkbox"/> Severe coughing | <input type="checkbox"/> Rash, hives or welts that appear quickly |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Severe stomach ache that causes the child to double up and scream |
| <input type="checkbox"/> Sore throat with fever | <input type="checkbox"/> No urination over an 8 hour period; the mouth and tongue look dry |
| <input type="checkbox"/> Thick nasal drainage | <input type="checkbox"/> Black stool or blood mixed with the stool |
| <input type="checkbox"/> Rash accompanied by fever | <input type="checkbox"/> Any child who looks or acts very ill or seems to be getting worse quickly |
| <input type="checkbox"/> Persistent diarrhea | |
| <input type="checkbox"/> Severe headache and stiff neck with fever | |

We are excluding your child from attendance at our program until (possible options):

- The signs or symptoms are gone
- The child can comfortably participate in the program
- We can provide the level of care your child needs
- Other: _____

Communicable Diseases Reportable in California

Licensed child care providers are required to report outbreaks of any disease, including diseases not on the list.

Acquired Immune Deficiency Syndrome (AIDS)	Malaria ①☒
Amebiasis ①☒	Measles (Rubeola) ①☒
Anisakiasis ①☒	Meningitis—viral, bacterial, fungal or parasitic (specify etiology) ①☒
Anthrax ☎	Meningococcal infections ☎
Babesiosis ①☒	Mumps
Botulism (<i>infant, foodborne or wound</i>)	Non-Gonococcal Infections (<i>Excluding laboratory confirmed Chlamydial Infections</i>)
Brucellosis	Occurrence of any unusual disease
Campylobacteriosis ①☒	Outbreaks of any disease (<i>including diseases not listed here</i>) ☎
Chancroid	Paralytic shellfish poisoning ☎
Chlamydial Infections	Pelvic Inflammatory Disease (PID)
Cholera ☎	Pertussis (whooping cough) ①☒
Ciguatera Fish Poisoning ☎	Plague ☎
Coccidioidomycosis	Poliomyelitis, paralytic ①☒
Colorado Tick Fever ①☒	Psittacosis ①☒
Conjunctivitis, acute infectious of the newborn (specify etiology) ①☒	Q fever ①☒
Cryptosporidiosis ①☒	Rabies (<i>human or animal</i>) ☎
Cysticercosis	Relapsing Fever ①☒
Dengue ☎	Reye's Syndrome
Diarrhea of the newborn (<i>outbreaks</i>) ☎	Rheumatic Fever, acute
Diphtheria ☎	Rocky Mountain Spotted Fever
Domoic Acid Poisoning (Amnestic Shellfish Poisoning) ☎	Rubella (German measles)
Echinococcosis (Hydatid Disease)	Rubella Syndrome Congenital
Ehrlichiosis	Salmonellosis (<i>Other than typhoid Fever</i>) ①☒
Encephalitis—viral, bacterial, fungal or parasitic (specify etiology) ①☒	Scombroid fish poisoning ☎
<i>Escherichia coli</i> 0157:H7 infection ☎	Shigellosis ①☒
Foodborne illness (<i>food poisoning</i>) †①☒	Streptococcal infections (<i>outbreaks and cases in food handlers & dairy workers only</i>) ①☒
Giardiasis	Swimmer's Itch (Schistosomal Dermatitis) ①☒
Gonococcal infections	Syphilis ①☒
<i>Haemophilus influenzae</i> (invasive disease) ①☒	Tetanus
Hantavirus infections ☎	Toxic Shock Syndrome
Hemolytic Uremic Syndrome ☎	Toxoplasmosis
Hepatitis A ①☒	Trichinosis ①☒
Hepatitis B (<i>specify acute case or chronic</i>)	Tuberculosis ①☒
Hepatitis C (<i>specify acute case or chronic</i>)	Tularemia
Hepatitis D (Delta)	Typhoid Fever (<i>specify whether case/carrier</i>) ①☒
Hepatitis, other, acute	Typhus Fever
Kawasaki Syndrome	<i>Vibrio</i> infections ①☒
Legionellosis	Viral hemorrhagic Fever (e.g. Crimean-Congo, Ebola, Lassa and Marburg Viruses) ☎
Leprosy (Hansen's disease)	Water-associated disease ①☒
Leptospirosis	Yellow Fever ☎
Listeriosis ①☒	Yersiniosis ①☒
Lyme disease	
Lymphocytic Choriomeningitis	

Urgency Reporting Requirements

- ☎ = Report immediately by telephone (designated by a ♦ in regulations*).
- † = Report immediately by telephone when two (2) or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a • in regulations).
- ①☒ = Report by Fax, telephone, or mail within one (1) working day of identification (designated by a + in regulations).

All other diseases/ conditions should be reported by FAX, telephone, or mail within seven (7) calendar days of identification.

There are no standard reporting forms for child care providers to use. Please call your local health department immediately to report any outbreak or suspected outbreak of a communicable disease at a child care center.

*Community Care Licensing Title 22 Regulations.



Medication Administration in Child Care Programs

If you care for children, especially infants and toddlers, it's more than likely that you will care for a child with an acute or chronic health condition that requires giving medication. If a child has a mild illness or a non-contagious illness that requires medication there is no reason to exclude that child from your program. However, it is important to develop plans to assure that medications are given safely and stored correctly, and to seek advice when needed. All staff who work with children should have training on these practices (American Academy of Pediatrics and the American Public Health Association, 2002).

- Check that the name of the child listed on the medication and the child receiving the medication are the same.
- Read and understand the label/prescription instructions related to measured dose, frequency, and other circumstances related to administration (such as in relation to meals).
- Administer the medication according to the prescribed methods and prescribed dose.
- Observe and report any side effects from medications.
- Document the administration of each dose by recording time and amount given.

Medication should be given at home whenever possible, but there will be times when it must be given while the child is in child care. States have different regulations; be sure you understand the regulations for your state. California Community Care Licensing (CCL) regulations permit child care providers to administer medications under the following conditions:

- All prescription and nonprescription medications must bear the child's name and date.
- All medications must be administered according to the label direction. Permission and instruc-

tions must be provided by the parent for each medication. The instructions should not conflict with the label directions and should be filed in the child's record.

- Nonprescription medications do not require approval of the child's health care provider if administered according to the product label and if parental approval and instructions are provided in writing from the parent. The instructions from the parent cannot conflict with the product label and must be filed with the child's records. (Please note that *Caring for Our Children* recommends that obtaining a written approval or instruction from the child's health care provider is a safe practice.)
- The child care provider has a plan to record administration of medication and to inform the parent of daily medication administration.
- When no longer needed all medications are returned to the parent.

Most Frequently Given Medications in Child Care Programs

Antibiotics (given by mouth) – used to treat bacterial infections of the ear, respiratory tract, urinary tract or skin.

Acetaminophen (e.g. Children's Tylenol or Panadol) – used to treat fever and pain.

Antihistamines (e.g. Benadryl) – used to treat allergic reactions such as runny nose or hives.

Bronchodilators – used to prevent or treat asthma attacks. Special equipment such as inhalers or nebulizers is also needed to give bronchodilators. When a nebulizer is needed, a special form from CCL must be completed by the parent and child care provider.

Decongestants (e.g. Dimetapp) – used to reduce stuffiness in ears, nose, chest.

Eye medication (liquid or ointment administered directly into the eye) – used to treat bacterial eye infections or “pink eye.”

Iron (by mouth) – used to treat anemia.

Cough medicine – suppressant for dry cough or expectorant for wet cough.

Topical medications – used to treat skin conditions such as diaper rash, infections.

Medications for chronic conditions – used to treat seizure disorders, cystic fibrosis, and other chronic illnesses.

Common Routes (Ways) Medication Is Given

Oral medication can be solid such as tablets or capsules or can be liquid such as elixirs or suspensions. All oral medications should be followed by two to four ounces of water unless otherwise indicated.

Eye drops require some preparation. First gather supplies (medications, tissue, gloves) and wash hands. Clean eyelids, if necessary, wearing gloves. Position child on back or if seated, with head tilted back. Gently but firmly pull down lower lid and insert medication drops into pocket formed by lower lid. Be careful not to touch the eye or eyelid with container. Wipe closed eye with tissue. Praise the child for helping and wash your hands after removing the gloves. To apply eye ointment, follow the same procedure but drop a line of ointment along the lower lid, again without touching the container to the eye.

Topical medications are applied to skin. First, clean the skin where you will be applying the medication. Wear gloves if directed. Apply medication using applicator, gauze or gloves. Cover area if directed.

Inhaled medication is delivered by a spray bottle, inhaler or nebulizer. The medication forms a fine mist to be inhaled. A nasal spray is fairly easy to administer in older children who can cooperate. Ask them to hold one nostril closed while you squirt and they inhale the medication into the open nostril. Medication delivered by an inhaler or nebulizer

requires special training from the parent or health care provider and specific written instruction and warnings. The nebulizer is a machine that requires special cleaning after each use and instructions on its use must be provided by the parent and health care provider. There is a form available from CCL that discusses the appropriate training.

Injected medication is delivered through a syringe/needle. At this time, child care providers cannot inject medications such as insulin, with the exception of using an Epi-Pen® after receiving training. However, CCL regulations allow child care providers to do a blood test for children with diabetes that involves a finger prick, although very strict training and guidelines from CCL must be followed.

Tips for Administering Medication by Age

For Infants

Assemble all supplies within reach—medication, tissues, measuring devices—and wash your hands. Measure the correct amount of medication. If you are not able to hold the infant and give the medication at the same time, ask for help. Talk to the infant and gently touch his or her mouth with the dropper or medication syringe. If his or her mouth doesn't open, gently pull down the chin. Make smacking sounds with your mouth to model what you want. When the infant's mouth is open, place the dropper or syringe on the middle of the tongue and slowly drop the medication a little at a time. If the infant does not cooperate, gently slide the dropper or syringe between the inside of cheek and gums and slowly drop in medication. Or, try dropping pre-measured amount of medication into a bottle nipple and let the infant suck it up.

For Toddlers and Preschoolers

Follow the same preparation as for infants, but try to prepare toddlers by letting them know you are going to be giving medication and you will need their help. Pre-measured medication may be placed in a spoon or in a small cup. If they are cooperative they may not need your help and will do it themselves; if not, you may have to firmly hold them while you use a dropper or medication syringe to place medication in the mouth between cheek and gums. Allow time for the medication to be slowly swallowed. Always praise children for their cooperation.

Medication Storage

Medications should always be stored in their original container in a secure place out of the reach of children. Refrigerated medication should be stored in a plastic or zip-lock bag in the food section of the fridge. Storing medication in clear plastic containers where it can be seen will help providers remember to give it. Do not freeze medication. If the medication is left unrefrigerated for a long period of time, check with a pharmacist to see if it is still effective.

Reactions

Children may react to the medications you administer. Typical reactions include rashes, tiredness and irritability. It's also very common for children to have diarrhea during antibiotic treatment, although as long as it can be contained in the pants or diaper there is no reason to exclude a child for this kind of diarrhea. If you have any concerns about a reaction, notify the parent and seek advice from the health care provider or pharmacist.

Special Situations

A number of situations may arise related to administering medication in child care:

- Parents may ask you to give their child herbal remedies. Because many remedies are not standardized, it's best not to give them unless they are properly labeled and prescribed by a licensed health care provider. Suggest that parents administer these at home instead.
- Parents may not want to reveal what condition their child has. You must respect their desire for confidentiality, but you still need to know if there are any medication reactions to watch for. Remember that a child's medication or health condition cannot be discussed with anyone without the parent's permission.
- You may unexpectedly need to give children a fever-reducing medication or something for pain if they become sick during the day. In these cases, it's acceptable to get telephone permission from a parent to follow the manufacturers' instructions for over-the-counter medication. You must then get written permission when the parent picks up the child.

Antibiotic Resistance

The overuse of antibiotics for the treatment of child-

hood illnesses has created a serious public health problem. Some antibiotics no longer work with certain illnesses because the bacteria are now resistant to the effects of the drug. You can help address this problem by educating parents on proper antibiotic use.

- Two main types of germs—bacteria and viruses—cause illness. Most illnesses in child care are caused by viruses. Antibiotics are not useful for illnesses caused by viruses such as colds, coughs or the flu. (FDA, 2002). Encourage parents not to demand antibiotics when their health care provider determines it isn't necessary. Suggest that they ask about ways to help relieve symptoms instead.
- Administer medication exactly as prescribed. This means taking it for as long as it's prescribed until it is gone, even if the child feels better.
- Don't take leftover antibiotics, expired antibiotics, or antibiotics prescribed for someone else.
- Parents may forget to give prescribed medications to their child. This is especially common for children with ear infections who must take antibiotics for 10 days even though they may feel and act healthy sooner. When you administer medication to the child each day, you may notice from the level of medication in the bottle that it's not being given at home. You can stress the importance of the 10-day period needed for the antibiotic to completely eliminate the bacteria which have caused the infection. Remind parents that giving an incomplete cycle of antibiotics can make the germs resistant to antibiotics in the future.

Working with a Pharmacist or Health Care Provider

Patient information sheets on medications provide a wealth of information. They may be obtained free from pharmacies with each prescription and for non-prescription drugs upon request, or downloaded from www.nlm.nih.gov/medlineplus/druginformation.html. The sheets describe how the drug works, what to do if a dose is forgotten, and which side effects might occur. Request that parents bring the information sheet with the medication so the child care staff will be more informed, but don't hesitate to ask questions of the prescribing health care provider or pharmacist if you need more information.

Safeguards To Prevent Errors

- Assign a staff member to administer medications at the right time.
- Consult with the parent, pharmacist or health care provider if uncertain about the next dose.
- If a medication is crucial and has been left at home, ask the parent to return home and get medication before the child is admitted for the day. Establish a system for ensuring that medications are returned each day to the family for use at home.
- Develop systems to alert all staff members that a child has medication—something as simple as a red dot next to a child’s name on the sign-in sheet can be a good reminder.
- Set an alarm clock for the times of administration.
- Use measuring devices such as medicine caps or oral syringes for liquid medications, rather than household utensils, which are not accurate. Read the measured amount at eye level.
- Do not accept medication without written, understandable instructions. Check with a pharmacist or the child’s health care provider if the instructions conflict with the label.
- Require that prescribed medication must have the child’s name and current date.

- Make certain that medication is always administered by trained staff who know the children.
- Always provide written notification of medication administered so that the parent or other caregivers will know when to give the next dose.
- If a medication error is made, notify the parent immediately and consider seeking advice from the child’s pharmacist or health care provider.

References

American Academy of Pediatrics and the American Public Health Association. (2002). *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*. Second Edition.

U.S. Food and Drug Administration, *Battle of the Bugs: Fighting Antibiotic Resistance*. Retrieved September 9, 2004, www.fda.gov/fdac/features/2002/402_bugs.html.

Resources

California Childcare Health Program. *Medication Administration Form*. Available at www.ucsfchildcarehealth.org or from the Healthline 1-800-333-3212.

California Childcare Health Program. *Medication Administration Poster*. Available at www.ucsfchildcarehealth.org or from the Healthline 1-800-333-3212.

By Judith Calder, RN, MS (10/04).

Medication Safeguards

Remember the Five R’s

Right Medication is given to the **Right Child** using the **Right Amount** at the **Right Time** given by the **Right Route**

Always check

Parental Permission – must be in writing and filed in the child’s record

Medication Label - the child’s name, dosing instructions, special instructions

Parent Notification – use standard form to notify parents of medication given

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

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Recommendations for Cleaning, Sanitizing and Disinfecting

Illnesses may be spread in various ways, such as by coughing, sneezing, direct skin-to-skin contact, and by touching an object or surface with germs on it. Germs causing infection may be present in human waste (urine, stool) and body fluids (saliva, nasal discharge, drainage from lesions or injuries, eye discharge, vomit and blood).

Infected persons may carry communicable diseases without having symptoms, and they may be contagious before they experience symptoms. Child care staff need to protect themselves and the children by routinely cleaning and disinfecting exposed areas. Gloves should be worn when cleaning up blood, and hands should be washed any time body fluids are touched. Since children will touch any surface they can reach, all surfaces may be contaminated. Therefore, all surfaces must be properly cleaned and sanitized.

Cleaning

Prior to using a bleach solution to sanitize, remove dirt and debris such as blood, urine, vomit, stool, food, dust or fingerprints by scrubbing and washing with detergent and rinsing well with water.

Routine cleaning with an all-purpose liquid detergent or abrasive cleanser gets rid of the dirt you can see. Scrubbing physically reduces the number of germs on surfaces (as when we wash our hands). Use a disposable cloth or one that can be washed after each use, so that you don't

move germs from one place to another. Sponges are not recommended as they harbor bacteria and are difficult to clean. Some items and surfaces should receive an additional step, *disinfection*, to kill germs **after** cleaning with detergent and rinsing with clear water.

Carpeting should be vacuumed daily (when children are not present) and shampooed at least every three months. Carpets should be cleaned monthly in infant areas. Carpet cleaning must be done when children are not present to avoid fumes and allow the carpet to dry. Use a cleaning method approved by the local health authority.

Do not mix household bleach with other household chemicals such as toilet cleaners, rust removers, acids or products containing ammonia.

Mixing these chemicals with bleach will produce harmful gases.

Sanitizing or disinfecting

After cleaning, you can eliminate virtually all germs left on surfaces through the use of a chemical, such as a germicide or chlorine, or a physical agent such as heat.

In the child care setting, a solution of 1/4 cup household liquid chlorine bleach added to 1 gallon of cool tap water (or 1 tablespoon bleach to 1 quart of water) prepared fresh daily is an effective disinfectant. Disinfecting with bleach is NEVER effective unless the surface has been thoroughly cleaned first.

Apply disinfectant solution by spraying from a spray bottle, wiping with a cloth rinsed in disinfectant solution, or by dipping the object into

Area	Clean	Sanitize	Frequency
Countertops/tabletops, floors, doors and cabinet handles	X	X	Daily and when soiled
Food preparation and service surfaces	X	X	Before and after food activity; between prep of raw/cooked foods
Cribs and crib mattresses	X	X	Weekly, before use by a different child and when soiled or wet
Utensils, surfaces and toys that go into the mouth or have been in contact with saliva or other body fluids	X	X	After each child's use, or use disposable, one-time utensils or toys
Toilet bowls, seats and handles, door knobs, floors	X	X	Daily or immediately if soiled
Hand washing sinks, faucets, surrounding counters, soap dispensers, door knobs	X	X	Daily and when soiled
Changing tables, potty chairs (use of potty chairs in child care is discouraged because of high risk of contamination)	X	X	After each child's use

the solution. Allow object or surface to air dry for at least two minutes before wiping it and/or using it again.

Hand-washed dishes must **always** be cleaned and disinfected after each use using bleach water only. *Pacifiers and manipulatives* can go in the dishwasher in a mesh bag on the upper level and heat dried to be disinfected. Items that can go through the dishwasher or washing machine cycle are disinfected if the water is hot enough to kill the germs (160° F). *Washable cloth toys* and other items can be machine-washed and machine heat-dried.

Household bleach with water is recommended because it is effective, economical, convenient and readily available. However, to avoid fumes, corrosion and color loss on some surfaces, you may look for a commercial product which is a "quaternary ammonium" and dilute according to the label instructions. Some of the newer products have a detergent in them and can be used to clean and disinfect in one step **if** there is no gross contamination with food particles,

meat juices, blood or dirt. If these are present, cleaning first is still required.

Good ventilation is always important, especially in enclosed areas (such as bathrooms) and where chemicals are stored. Chemical air fresheners may cause nausea or allergic responses in some children and should never be used.

Note: We urge our readers to obtain more comprehensive information on cleaning and disinfection from "Caring for Our Children" and from the CCHP *Prevention of Infectious Disease Curriculum*.

References

American Public Health Association and American Academy of Pediatrics, *Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*, Washington, D.C., 2002.

by Gail D. Gonzalez, R.N., *Child Care Health Consultant, August, 1999 (Revised 02/05)*

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Runny Nose in the Child Care Setting

(The Snuffly Child or Green Gooky Nose)

What Is it?

The child with a runny nose and stuffiness is a familiar problem in the child care setting. The nose is lined or covered by a delicate tissue called “mucosa” which produces mucus (sticky, slippery secretions) to protect the nose. If this tissue is irritated, it swells up, causing blockage and a lot of mucus. Sometimes children get repeated runny noses or permanent sniffles and a green nasal discharge, which are uncomfortable conditions for the child as well as child care provider.

What causes the runny nose?

1. *The common cold* is the most typical cause of a runny nose and chronic runny nose. This is generally a mild illness, and the child feels and looks well otherwise. The child usually gets better on his own within a week. The runny nose is usually accompanied by a mild fever. There may also be other symptoms such as headache, sore throat, coughing, sneezing, watery eyes, and fatigue.

Children with the common cold usually get better on their own within a week.

2. *Allergies* can also cause a runny nose. They usually occur after two years of age and after the child has had plenty of exposure to allergens (the substances that can produce allergic reaction in the body). They might occur during a specific season or after a particular exposure—for example, after being around grass or animals. The child may also have watery and itchy eyes, sneezing, asthma, rubbing of the nose and a lot of clear mucus.

With allergies, the runny nose may last for weeks or months, but there is no fever or spread of disease to others.

3. *Bacterial infection (sinus infection)* may occasionally develop and contribute to the continuation of illness. This additional infection of the common cold tends to cause yellow-greenish mucus and sometimes pain that continues for more than 10 days.

Remember that yellow or green mucus does not always mean that a child has a bacterial infection. It is normal for the mucus to get thick and change color as common viral cold progresses.

Is green mucus more of a concern than clear mucus?

In most cases green nasal mucus (usually found toward the end of the cold) is not more contagious than clear mucus and may even be less contagious. The runny nose usually starts with clear mucus which then becomes whitish or greenish as the cold dries up and gets better. This happens because as the body mounts its defenses against the virus, the white blood cells enter the mucus and give it the green color. Usually the green mucus is in smaller amounts and thicker, a sign that the cold is “drying up” and ending.

Green runny nose that lasts for more than 10 to 14 days, and that may be accompanied by fever, headache, cough and foul-smelling breath, might be a sign of sinus infection. The child should have a medical evaluation and may need antibiotic treatment.

When are children contagious?

The amount of virus present is usually highest two to three days before a person develops symptoms of the illness and continues to be present for two to three days after symptoms begin. As a result, infected chil-

dren have already spread viruses before they begin to feel ill.

If a person is infected, how is the infection spread?

Germs may be spread to others by:

- wiping a nose and then touching other people and objects before washing hands;
- sharing of mouthed toys by infants and toddlers;
- coughing and sneezing into the air;
- kissing on the mouth; and
- poor ventilation.

How can we limit the spread of infection?

To prevent the spread of infection from respiratory illnesses and runny noses, follow routine healthy practices:

- Avoid contact with mucus as much as possible.
- Make sure that all children and staff use good handwashing practices, especially after wiping or blowing noses, after contact with any nose, throat or eye secretions, and before preparing or eating food.
- Do not allow food to be shared.
- Clean and disinfect all mouthed toys and frequently used surfaces on a daily basis.
- Wash eating utensils carefully in hot, soapy water, then disinfect and air dry. Use a dishwasher whenever possible. Use disposable cups whenever possible.
- Make sure that the facility is well ventilated and that children are not crowded together, especially during naps on floor mats or cots. Open the windows and play outside as much as possible, even in the winter.
- Teach children to cough and sneeze into their elbow, wipe noses using disposable tissues, throw the tissue into the wastebasket, and wash their hands.

When should a child stay home?

Exclusion policies should be based on your general illness policies, not merely the color of the mucus. For example, you might decide to exclude any child who is too sick to participate, no matter what the cause or color of the discharge.

Excluding children with runny noses and mild respiratory infections and colds is generally not recommended. As long as the child feels well, can participate comfortably and does not require a level of care that would jeopardize the health and safety of other children, he or she can be included.

Exclusion is of little benefit since viruses are likely to be spread even before symptoms have appeared.

When should a child be sent home or seen by a health provider?

- When the child looks sick, has a rash, has a fever over 102 degrees (oral), or has difficulty breathing or seems to be in pain.
- When a child complains of earache and/or is pulling at his or her ears, which might be accompanied by fever and fussiness (all possible signs of ear infection).
- When a child has redness, sores and crusting of the skin around the nose and mouth.
- When an infant, especially under 4 months of age, does not get better in a couple of days or gets worse.

References

Healthy Young Children, A Manual for Programs, 1995 Edition.

Keeping Kids Healthy, Preventing and Managing Communicable Diseases in Child Care, Preliminary Edition.

The ABCs of Safe and Healthy Child Care, A Handbook for Child Care Providers, published by CDC.

by A. Rahman Zamani, MD, MPH (Oct 2001)

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Standard and Universal Precautions in the Child Care Setting

What are standard and universal precautions?

Universal precautions is the term used for the guidelines that were developed by the Centers for Disease Control and Prevention in the 1980s to reduce the spread of infection to health care providers and patients in health care settings.

Standard precautions is the new term used for an expansion of universal precautions, recognizing that any body fluid may hold contagious germs. They are still primarily designed to prevent the spread of bloodborne disease (disease carried by blood or other body fluids), but are also excellent measures to prevent the spread of infectious disease in group care settings such as child care facilities.

Why are standard precautions needed?

Standard precautions are designed to reduce the risk of spreading infectious disease from both recognized and unrecognized sources of infections. Germs that are spread through blood and body fluids can come at any time from any person. You may not know if someone is infected with a virus such as hepatitis B or HIV, and the infected person may not even know. This is why you must behave as if every individual might be infected with any germ in all situations that place you in contact with blood or body fluids.

What do standard precautions consist of?

Standard precautions include the following:

Hand washing

- after diapering or toileting children
- after handling body fluids of any kind
- before and after giving first aid (such as clean-

ing cuts and scratches or bloody noses)

- after cleaning up spills or objects contaminated with body fluids
- after taking off your disposable gloves
- remember that wearing gloves does not mean that you don't have to wash your hands!

Latex gloves should be worn

- during contact with blood or body fluids which contain blood (such as vomit or feces which contain blood you can see)
- when individuals have cuts, scratches or rashes which cause breaks in the skin of their hands

Environmental sanitizing should be done regularly and as needed. In the child care setting this means cleaning toys, surfaces and diapering areas with a bleach solution (1 tablespoon of bleach per quart of water made fresh daily). Blood spills or objects with blood on them need a stronger solution of $\frac{1}{4}$ cup bleach to 2 $\frac{1}{2}$ cups water. (Donowitz, 1999). Wear gloves when handling blood.

Proper disposal of materials that are soaked in or caked with blood requires double bagging in plastic bags that are securely tied. Send these items home with the child, or if you wash them, wash them separately from other items. Items used for procedures on children with special needs (such as lancets for finger sticks, or syringes for injections given by parents) require a special container for safe disposal. Parents can provide what is called a "sharps container" which safely stores the lancets or needles until the parent can take them home for disposal.

Standard precautions in child care settings vs. hospitals and clinics

Child care facilities follow the standard precautions in clinic and hospital settings with the following exceptions:

- Use of nonporous gloves is optional except when blood or blood-containing body fluids may be involved.
- Gowns and masks are not required.
- Appropriate barriers include materials such as disposable diaper table paper, disposable towels and surfaces that can be sanitized in group care settings.

What else am I required to do?

The Occupational Safety and Health Administration (OSHA) also requires that all child care programs with staff (even family child care homes with assistants or volunteers) have an *Exposure Control Plan for Bloodborne Pathogens*. This plan must be in writing and include:

Exposure determination. This is a list of the job titles or duties which might put an individual in contact with blood or blood-containing fluids (such as first aid, nose blowing, diapering, etc.)

Methods of compliance. These are the ways you will assure your plan will work and which include written standard precautions and cleaning plans, training of staff in their use, and the availability of gloves.

Hepatitis B vaccination. This must be offered by the employer at no cost to staff. The vaccine series can begin either

- within 10 days of employment, or
- within 24 hours after a potential blood exposure (accidental contact with blood while administering first aid, diapering an infant with a bloody stool, etc.)

Note: Hepatitis B is a series of three shots which must be given on a specific schedule. Now that all children are required to have the series before entering care, child care providers should be at a reduced risk of getting hepatitis B in a child care setting.

Exposure reporting procedures. These are required and will tell staff what to do if something happens which puts an employee in contact with blood on their broken skin (cuts, scratches, open rashes or

chapped skin) or on their mucous membranes (in the eye, mouth or nose). There are also record-keeping requirements to document the exposure situation, whether or not the employee received a free medical exam and follow-up, and that the employee was offered the hepatitis B vaccination if she/he did not already have the series.

Training on OSHA regulations. This must be provided to all staff at the time that they start work and must include:

- an explanation of how HIV (which causes AIDS) and HBV (which causes hepatitis B) are transmitted
- an explanation of standard precautions and the exposure control plan for your program.

For more information on OSHA requirements, contact the Cal/OSHA Consultation Service office listed in your telephone directory, or call the Healthline at (800) 333-3212 for a referral to the office nearest you.

References

American Public Health Association and American Academy of Pediatrics. *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*. (2002). Second Edition.

Child Care Law Center. (1994). *CalOSHA Regulations on Bloodborne Pathogens*. San Francisco, CA.

Donowitz, L.G. (1999). *Infection control in the child care center and preschool*. Fourth edition. Pennsylvania: Lippincott, Williams & Wilkins.

by Lyn Dailey, PHN Revised Nov. 2004



Unimmunized Children in the Child Care Setting

Immunizations (vaccines) protect us, and those around us, from potentially dangerous infectious diseases. Vaccines are rigorously tested for safety before being used routinely. Because of vaccines, devastating diseases like *Haemophilus influenzae* type B meningitis, *pneumococcal meningitis*, *polio* and *pertussis* are now uncommon in young children who have been vaccinated. Outbreaks of vaccine-preventable diseases still occur in areas where groups of parents are choosing not to immunize their children, such as the pertussis outbreak that occurred in Davis, California, in 2002 and the measles outbreak that occurred in Seattle, Washington, in 2001. Some children are not immunized for medical reasons such as allergies, or because of the parents' religious or personal beliefs. Unimmunized children and staff run the risk of getting seriously ill or even dying from vaccine-preventable diseases.

Immunization Requirements for Child Care in California

Children are required by the California School Immunization Law to be appropriately immunized against diseases prior to attending licensed child care and school settings. Immunization requirements apply equally to both child care centers and licensed family child care programs. Parents must present their child's immunization record to the child care provider before enrollment. Providers are required to assess children's immunization status and transfer each child's immunization record to a California School Immunization Record or "blue card," which is available free of charge from the Immunization Coordinator at your local health department. Providers are also required to follow up with children who are incomplete until they have completed all required immunizations.

Can a Child be Exempted from Immunization Requirements?

There are two situations where California law allows a child to be exempted from the immunization requirements.

Medical Exemptions

A medical exemption is granted when a child should not get some or all shots for temporary or permanent medical reasons.

If a child has a temporary medical condition which rules out one or more immunizations, or their physician wishes to delay an immunization, a child can be temporarily exempted from the requirement. To receive a Temporary Medical Exemption, the parent must provide a statement from a physician (preferably on letterhead), stating which immunizations the child cannot have at this time, why, and when the immunization(s) will be given. The letter of exemption must be attached to the immunization "blue card" and the follow-up date should be noted. *It is the child care provider's responsibility to follow up before the exemption expires.* The child must either receive the immunization(s) needed or another Temporary Medical Exemption when the current one expires.

If a child has a medical condition that permanently rules out one or more immunizations, the child can be exempted from the immunization requirement. To grant a Permanent Medical Exemption, the parent must provide a statement from a physician stating that there is a medical condition which permanently rules out immunization(s), and which immunization(s) the child cannot receive. The letter of exemption must be attached to the immunization "blue card."

Religious and Personal Beliefs Exemptions

If immunization is against a family's religious or personal beliefs, they are asked to sign the Personal Beliefs Affidavit on the back of the "blue card." By signing the affidavit, parents acknowledge that if there is an outbreak of any disease their child is not protected against, the child may be temporarily excluded from attending child care. However, *the Personal Beliefs Exemption is to be granted to parents only for reasons of personal belief, and not as a matter of convenience because a parent can't find the immunization record, or does not "have time" to take the child to get immunized.*

NOTE: Under California law, child care providers cannot legally exclude those whom they know are unimmunized or under-immunized for *medical* or *religious/personal* reasons that are properly documented. If the parent provides documentation for medical exemption and/or signs the Personal Beliefs Affidavit on the back of the “blue card” then they are protected by law and may not be excluded from child care.

What is the Risk?

An outbreak of vaccine-preventable diseases can have serious consequences. Vaccine-preventable diseases remain a threat, can be difficult to treat, and sometimes can be deadly. Immunizations have proven very effective in *significantly* lowering the risk of getting sick or dying from a vaccine-preventable disease. A child who is not immunized is at greater risk of catching a vaccine-preventable disease AND infecting others. The greatest risk is to infants who have not yet received all of their immunizations, the elderly, persons who cannot be immunized for medical reasons or have immune system problems, and the small percentage of children whose immunizations failed to provide resistance.

What Can Child Care Providers Do?

Providers need to protect children, families, staff and themselves from serious illness, as well as protecting themselves from potential liability.

- Establish an immunization tracking system to remind parents to bring in their child’s immunization record, in order to update the “blue card.” It’s the child care providers’ responsibility to track immunization of the children in their care who are 2, 4, 6, 15, and 18 months and at age 4 years old until immunizations are finished. For a downloadable PDF version of *California Immunization Requirements for Child Care*, visit www.dhs.cahwnet.gov/ps/dcdc/izgroup/pdf/IMM230-0503.pdf. To help set up an immunization tracking system, acquire a copy of the *California Immunization Handbook for School and Child Care*, 7th Ed., by contacting your health department’s Immunization Program or online at: www.dhs.cahwnet.gov/ps/dcdc/izgroup/handbook.htm.
- Provide information for parents on the importance and benefits of immunization, available at www.cdc.gov/nip and www.aap.org.

- Include a policy in your Parent’s Handbook stating that there are or may be unimmunized and/or under-immunized children in the program. Explain what will be done in case of an outbreak of a vaccine-preventable disease in your program. The National Health and Safety Standards recommends that if a vaccine-preventable disease outbreak occurs “*unimmunized children shall be excluded for the duration of possible exposure or until the age-appropriate immunizations have been completed (whichever comes first)*”.¹ This is to ensure the “protection of unimmunized and under-immunized (e.g., infants) individuals in the child care setting.”
- Maintain a confidential list of children with medical exemptions or personal belief affidavits so that these children can be quickly identified and excluded if an outbreak occurs.
- Remember that all medical information, including a child’s immunization status, is personal and *confidential*.

The information given here is not to be taken as legal advice. It’s a good idea to consult with legal counsel before excluding a child based on immunization status. The Child Care Law Center (www.childcarelaw.org or 415-394-7144) is an excellent, free resource. For more information call the Healthline at (800) 333-3212.

Online Resources

California School Immunization Record (“blue card”): www.dhs.cahwnet.gov/publications/forms/pdf/pm286b.pdf.

“Notice of Immunizations Needed” sample form to show parents/guardians what immunizations are required for their children, available in English and Spanish at: www.immunization-sd.org/docs/iz10.pdf.

Immunization names/abbreviations: www.immunization-sd.org/docs/iz78.pdf.

Parents Guide to Childhood Immunization (English and Spanish). National Immunization Program at (800) 232-2522 or www.cdc.gov/nip/publications/Parents-Guide/default.htm#order.

Recommended Childhood Immunization Schedule. www.cdc.gov/nip/recs/child-schedule.pdf.

References

Legal Update. Unimmunized Children in Child Care Settings. (Summer 2003-Corrected December 2003). Child Care Law Center, 221 Pine St., 3rd Floor, San Francisco, CA 94104. Online at www.childcarelaw.org/Publications/Summer2003-corrected.pdf.

¹*Caring for Our Children: Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, 2nd Ed. (2002).*

05/04

California Childcare Health Program • 1333 Broadway, Suite 1010 • Oakland, CA 94612-1926

Telephone 510-839-1195 • Fax 510-839-0339 • Healthline 1-800-333-3212 • www.ucsfchildcarehealth.org

Information Exchange on Children with Health Concerns Form

Dear Health Care Provider:

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

To be filled out by Child Care Provider:

Facility Name: _____ Telephone: _____

Address: _____

We would like you to evaluate and give us information on the following signs and symptoms: _____

Questions we have regarding these signs and symptoms are: _____

Date ___ / ___ / ___ Child Care Provider Signature: _____

Child Care Provider Printed Name: _____

To be filled out by Health Care Provider:

Health Care Provider's Name: _____ Telephone: _____

Address: _____

Diagnosis for this child: _____

Recommended Treatment: _____

Major side effects of any medication prescribed that we should be aware of: _____

Should the child be temporarily excluded from care, and if so, for how long? _____

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

Please attach additional pages for any other information, if necessary.

Date ___ / ___ / ___ Health Care Provider Signature: _____

Health Care Provider Printed Name: _____

California Childcare Health Program www.ucsfchildcarehealth.org rev. 05/03

Consent for Release of Information Form

I, _____, give my permission for
(parent/guardian)
_____ to exchange health information with
(sending professional/agency)
_____.
(receiving professional/agency)

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

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

Name of Child: _____ Date of Birth: _____

Parent/Guardian Name: _____
(print full name)

Parent/Guardian Signature: _____

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

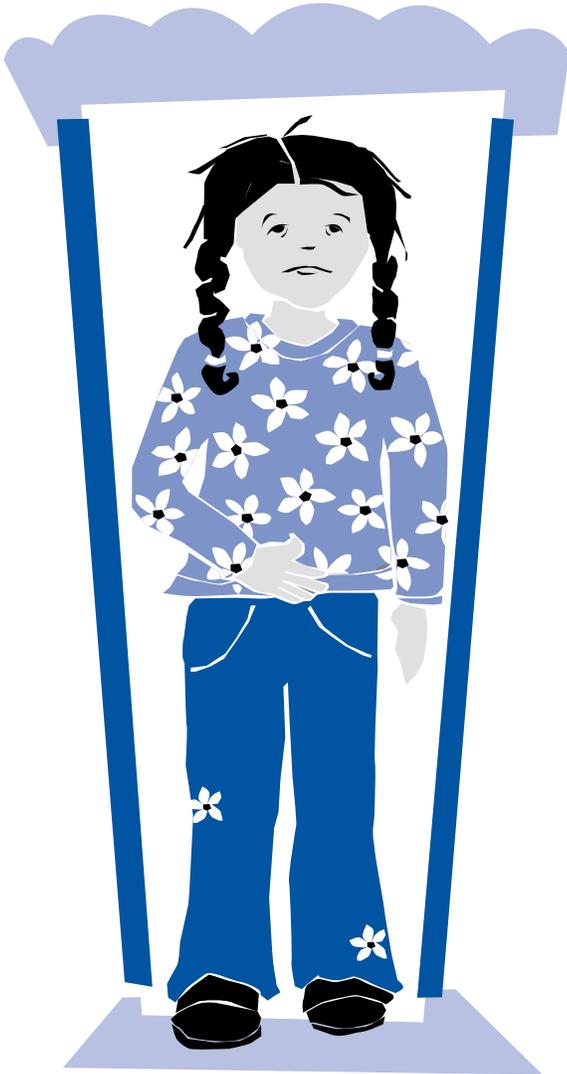
Note: In accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable California laws, all personal and health information is private and must be protected.

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

California Childcare Health Program www.ucsfchildcarehealth.org rev. 10/03

**STOP
DISEASE**

MORNING HEALTH CHECK



Signs to Observe:

- General mood and changes in behavior
- Fever or elevated body temperature
- Skin rashes, unusual spots, swelling or bruises
- Complaints of pain and not feeling well
- Signs/symptoms of disease (severe coughing, sneezing, breathing difficulties, discharge from nose, ears or eyes, diarrhea, vomiting etc.)
- Reported illness in child or family members

Use all of your senses . . .

- **LOOK** - for signs
- **LISTEN** - for complaints
- **FEEL** - for fever
- **SMELL** - for unusual odor

Child Care



REFERENCE Health and Safety Code, Division 105, Part 2, Chapter 1, Sections 120325-120380; California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 8, Sections 6000-6075

INSTRUCTIONS To attend child care, children must have immunizations outlined below by age. Parents must present their child's Immunization Record as proof of immunization. Copy the full date of each shot onto the blue California School Immunization Record card and then determine if the child is up-to-date. Blue cards are available free from the Immunization Coordinator at your local health department. As the child care provider, it is your responsibility to follow up regularly until all shots are finished.

IMMUNIZATIONS (SHOTS) REQUIRED TO ATTEND CHILD CARE, BY AGE	Age When Enrolling	Immunizations (Shots) Required	Vaccines
	2–3 months.....	1 each of Polio, DTaP, Hib, Hep B	DTaP: Diphtheria, tetanus, and pertussis combined vaccine. Record may show DT or DTP. Hib: <i>Haemophilus influenzae</i> type b vaccine; required only for children up to age 4 years, 6 months. MMR: Measles, mumps, and rubella combined vaccine. Hep B: Hepatitis B vaccine. Varicella: Chickenpox vaccine.
	4–5 months.....	2 each of Polio, DTaP, Hib, Hep B	
	6–14 months.....	3 DTaP 2 each of Polio, Hib, Hep B	
	15–17 months.....	3 each of Polio, DTaP 2 Hep B 1 MMR, on or after the first birthday ¹ 1 Hib on or after the first birthday ¹	
	18 months–5 years.....	3 Polio 4 DTaP 3 Hep B 1 MMR, on or after the first birthday ¹ 1 Hib on or after the first birthday ^{1,3} 1 Varicella (chickenpox) ²	

You may admit a child who is lacking one or more required vaccine doses if the dose(s) is not currently due **on the condition** that they receive the remaining dose(s) when due, according to the schedule above. You will need to review records to make sure this occurs. If the maximum time interval between doses has passed, the child cannot be admitted until the next immunization is obtained.

¹ Receipt of the dose up to (and including) 4 days before the birthday will satisfy the child care entry immunization requirement.

² If a child had chickenpox disease and this is indicated on the Immunization Record by the child's physician, they meet the requirement. Write "disease" in the chickenpox date box on the blue card.

³ Required only for children who have not reached the age of 4 years 6 months.

WHEN NEXT SHOTS ARE DUE	
Polio #2	6–10 weeks after 1st dose
Polio #3	6 weeks–12 months after 2nd dose
DTP or DTaP #2, #3	4–8 weeks after previous dose
Hib #2	2–3 months after 1st dose
DTP or DTaP #4	6–12 months after 3rd dose
Hep B #2	1–2 months after 1st dose
Hep B #3	Under age 18 months: 2–12 months after 2nd dose and at least 4 months after 1st dose Age 18 months and older: 2–6 months after 2nd dose and at least 4 months after 1st dose

EXEMPTIONS The law allows (a) parents/guardians to choose exemptions from immunization requirements based on their personal beliefs, and (b) physicians of children to choose medical exemptions from them. The law does not allow parents/guardians to choose an exemption simply because the "shot" record is lost or incomplete and it is too much trouble to get to a physician or clinic to correct the problem. The back of the blue California School Immunization Record has instructions and an affidavit to be signed by parents who want a personal beliefs exemption. An up-to-date list of children with exemptions should be maintained separately by the child care staff so that these children can be quickly identified and excluded from attendance if an outbreak occurs.

Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • 2005

Vaccine ▼	Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4-6 years	11-12 years	13-18 years
Hepatitis B ¹		HepB #1	HepB #2	HepB #2		HepB #3	HepB #3				HepB Series		
Diphtheria, Tetanus, Pertussis ²			DTaP	DTaP	DTaP	DTaP		DTaP	DTaP		DTaP	Td	Td
<i>Haemophilus influenzae</i> type b ³			Hib	Hib	Hib	Hib	Hib						
Inactivated Poliovirus			IPV	IPV	IPV	IPV	IPV	IPV			IPV		
Measles, Mumps, Rubella ⁴						MMR #1	MMR #1				MMR #2	MMR #2	MMR #2
Varicella ⁵							Varicella	Varicella			Varicella		
Pneumococcal ⁶			PCV	PCV	PCV	PCV	PCV	PCV		PCV	PPV		
Influenza ⁷						Influenza (Yearly)	Influenza (Yearly)	Influenza (Yearly)			Influenza (Yearly)		
Hepatitis A ⁸											Hepatitis A Series		

contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form can be found on the Internet: www.vaers.org or by calling 800-822-7967.

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2004, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible.

Indicates age groups that warrant special effort to administer those vaccines not previously given. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not

-  Range of recommended ages
-  Preadolescent assessment
-  Only if mother HBsAg(-)
-  Catch-up immunization

--- Vaccines below red line are for selected populations



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION



The Childhood and Adolescent Immunization Schedule is approved by:
Advisory Committee on Immunization Practices www.cdc.gov/nip/acip
American Academy of Pediatrics www.aap.org
American Academy of Family Physicians www.aafp.org

Recommended Childhood and Adolescent Immunization Schedule

UNITED STATES • 2005

1. Hepatitis B (HepB) vaccine. All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is hepatitis B surface antigen (HBsAg) negative. Only monovalent HepB can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be given at least 4 weeks after the first dose, except for combination vaccines which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 24 weeks.

Infants born to HBsAg-positive mothers should receive HepB and 0.5 mL of Hepatitis B Immune Globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1–2 months. The last dose in the immunization series should not be administered before age 24 weeks. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) at age 9–15 months.

Infants born to mothers whose HBsAg status is unknown should receive the first dose of the HepB series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1–2 months. The last dose in the immunization series should not be administered before age 24 weeks.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP)

vaccine. The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. The final dose in the series should be given at age ≥ 4 years. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11–12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

3. Haemophilus influenzae type b (Hib) conjugate vaccine. Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB or ComVax [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months but can be used as boosters following any Hib vaccine. The final dose in the series should be given at age ≥ 12 months.

4. Measles, mumps, and rubella vaccine (MMR). The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by the visit at age 11–12 years.

5. Varicella vaccine. Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons aged ≥ 13 years should receive 2 doses, given at least 4 weeks apart.

6. Pneumococcal vaccine. The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children aged 2–23 months. It is also recommended for certain children aged 24–59 months. The final dose in the series should be given at age ≥ 12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000;49(RR-9):1-35.

7. Influenza vaccine. Influenza vaccine is recommended annually for children aged ≥ 6 months with certain risk factors (including but not limited to asthma, cardiac disease, sickle cell disease, HIV, and diabetes), healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk (see *MMWR* 2004;53[RR-6]:1-40) and can be administered to all others wishing to obtain immunity. In addition, healthy children aged 6–23 months and close contacts of healthy children aged 0–23 months are recommended to receive influenza vaccine, because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5–49 years, the intranasally administered live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2004;53(RR-6):1-40. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if 6–35 months or 0.5 mL if ≥ 3 years). Children aged ≤ 8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).

8. Hepatitis A vaccine. Hepatitis A vaccine is recommended for children and adolescents in selected states and regions and for certain high-risk groups; consult your local public health authority. Children and adolescents in these states, regions, and high-risk groups who have not been immunized against hepatitis A can begin the hepatitis A immunization series during any visit. The 2 doses in the series should be administered at least 6 months apart. See *MMWR* 1999;48(RR-12):1-37.

Recommended Immunization Schedule for Children and Adolescents Who Start Late or Who Are More Than 1 Month Behind

UNITED STATES • 2005

The tables below give catch-up schedules and minimum intervals between doses for children who have delayed immunizations. There is no need to restart a vaccine series regardless of the time that has elapsed between doses. Use the chart appropriate for the child's age.

CATCH-UP SCHEDULE FOR CHILDREN AGED 4 MONTHS THROUGH 6 YEARS

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Diphtheria, Tetanus, Pertussis	6 wks	4 weeks	4 weeks	6 months	6 months¹
Inactivated Poliovirus	6 wks	4 weeks	4 weeks	4 weeks²	
Hepatitis B ³	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Measles, Mumps, Rubella	12 mo	4 weeks⁴			
Varicella	12 mo	4 weeks			
<i>Haemophilus influenzae</i> type b ⁵	6 wks	4 weeks if first dose given at age <12 months 8 weeks (as final dose) if first dose given at age 12-14 months No further doses needed if first dose given at age ≥15 months	4 weeks⁶ if current age <12 months 8 weeks (as final dose)⁶ if current age ≥12 months and second dose given at age <15 months No further doses needed if previous dose given at age ≥15 mo	8 weeks (as final dose) This dose only necessary for children aged 12 months-5 years who received 3 doses before age 12 months	
Pneumococcal ⁷	6 wks	4 weeks if first dose given at age <12 months and current age <24 months 8 weeks (as final dose) if first dose given at age ≥12 months or current age 24-59 months No further doses needed for healthy children if first dose given at age ≥24 months	4 weeks if current age <12 months 8 weeks (as final dose) if current age ≥12 months No further doses needed for healthy children if previous dose given at age ≥24 months	8 weeks (as final dose) This dose only necessary for children aged 12 months-5 years who received 3 doses before age 12 months	

CATCH-UP SCHEDULE FOR CHILDREN AGED 7 YEARS THROUGH 18 YEARS

Vaccine	Minimum Interval Between Doses		
	Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Booster Dose
Tetanus, Diphtheria	4 weeks	6 months	6 months ⁸ if first dose given at age <12 months and current age <11 years 5 years ⁸ if first dose given at age ≥12 months and third dose given at age <7 years and current age ≥11 years 10 years ⁸ if third dose given at age ≥7 years
Inactivated Poliovirus ⁹	4 weeks	4 weeks	4 weeks IPV ^{2,9}
Hepatitis B	4 weeks	8 weeks (and 16 weeks after first dose)	
Measles, Mumps, Rubella	4 weeks		
Varicella ¹⁰	4 weeks		

Footnotes

Children and Adolescents Catch-up Schedules UNITED STATES • 2005

- 1. DTaP.** The fifth dose is not necessary if the fourth dose was given after the fourth birthday.
- 2. IPV.** For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was given at age ≥4 years. If both OPV and IPV were given as part of a series, a total of 4 doses should be given, regardless of the child's current age.
- 3. HepB.** All children and adolescents who have not been immunized against hepatitis B should begin the HepB immunization series during any visit. Providers should make special efforts to immunize children who were born in, or whose parents were born in, areas of the world where hepatitis B virus infection is moderately or highly endemic.
- 4. MMR.** The second dose of MMR is recommended routinely at age 4–6 years but may be given earlier if desired.
- 5. Hib.** Vaccine is not generally recommended for children aged ≥5 years.
- 6. Hib.** If current age <12 months and the first 2 doses were PRP-OMP (PedvaxHIB or ComVax [Merck]), the third (and final) dose should be given at age 12–15 months and at least 8 weeks after the second dose.
- 7. PCV.** Vaccine is not generally recommended for children aged ≥5 years.
- 8. Td.** For children aged 7–10 years, the interval between the third and booster dose is determined by the age when the first dose was given. For adolescents aged 11–18 years, the interval is determined by the age when the third dose was given.
- 9. IPV.** Vaccine is not generally recommended for persons aged ≥18 years.
- 10. Varicella.** Give 2-dose series to all susceptible adolescents aged ≥13 years.

Report adverse reactions to vaccines through the federal Vaccine Adverse Event Reporting System. For information on reporting reactions following immunization, please visit www.vaers.org or call the 24-hour national toll-free information line **800-822-7967**. Report suspected cases of vaccine-preventable diseases to your state or local health department.

For additional information about vaccines, including precautions and contraindications for immunization and vaccine shortages, please visit the National Immunization Program Web site at www.cdc.gov/nip or call the National Immunization Information Hotline at **800-232-2522 (English) or **800-232-0233 (Spanish)**.**