Health Program Services

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Child Health and Developmental Services Advisory Committee

Regulation Reference:
(2016) 45 CFR; 1301.2(c); Section 642(c)(1)(E)(iv)(XI); 1302.40(b); 1302.42(b)(1-i),(4)

Policy:
As appropriate, an Advisory Committee will function to review and/or make recommendations to components. This Committee includes EHS-HS FCC parents; health, education, and mental health professionals; and other volunteers from the community. This Advisory Committee serves the following programmatic areas: Nutrition, Dental, Health, Mental Health, Disability, and Child Development.

The Advisory Committee meets at least twice a year; other meetings are scheduled as needed. Committee members are available for additional consultation if needed.

Procedure:
1. The Advisory Committee provides EHS-HS FCC with a broad range of professional expertise and linkages to community resources. The Advisory Committee partners with Program Specialists and Coordinators in planning efficient and comprehensive services for children, parents, and staff, as described in the Head Start Performance Standards.
2. This Advisory Committee serves the following programmatic areas: Nutrition, Dental, Health, Mental health, Disability, and Child Development. The Committee assists with the following:
   - Developing guidelines for child health, dental, nutrition, mental health, education, and services to children with disabilities.
   - Selection and use of program screening tools.
   - Identification of child and family medical, dental, nutrition, mental health, early childhood, and disabilities services.
   - Planning methods to enhance parent involvement in children's dental care, health care, nutrition, mental health, education, and disabilities services.
   - Developing health and dental emergency procedures.
   - Identifying conditions for short-term exclusion conditions.
   - Planning procedures for medication administration and parent authorization.
   - Identifying required contents of first aid kits.
   - Planning procedures for Standard Precautions.
   - Designating community child and family nutrition, dental, health, mental health, disabilities services, and early childhood education issues.
   - Developing training ideas for staff, Providers, and parents in health, dental, nutrition, mental health, education, and services to children with disabilities.
   - Finding services for low-income pregnant women.
   - Encouraging parent participation on this committee.

- Identification and development of community partners and collaborative agreements for health, dental, nutrition, mental health, education, and services to children with disabilities.
- Planning short-term and long-term program goals for health, dental, nutrition, mental health, education, and services to children with disabilities.
- Developing health guidelines for staff, Provider, and volunteer health.
- Annual review and development of Program Plans for health, dental, nutrition, mental health, education, and services to children with disabilities.
- Advocating for EHS-HS FCC families and children.
- Targeting specific community agencies and programs to recruit children with diagnosed or suspected disabilities.
- Choosing the children's educational curriculum for all program areas.
- Development of costs for program areas in health, dental, nutrition, mental health, education, and services to children with disabilities.
- Reviewing all collaborative agreements related to health, dental, nutrition, mental health, education, and services to children with disabilities.

3. Membership may include, but is not limited to, the following representatives:
   - Jefferson County Department of Health
   - Dentist
   - Pediatric nurse
   - School of Optometry
   - Speech and Language Professional
   - Mental Health Professional
   - Cerebral Palsy Center
   - Early Intervention services
   - LEA
   - UAB Department of Early Childhood Education
   - Public school teacher
   - DHR Family Child Care Licensing
   - JCCDC Child Care Nutrition Program
   - Three (3) EHS-HS FCC Providers
   - Three (3) EHS-HS FCC Parents
   - PFCE Staff
   - EHS-HS FCC Executive Director
4. The Program Service Coordinators select their committee membership list, and invitations along with meeting notices are mailed to the committee members prior to the scheduled meeting.
5. Providers are instructed to secure a DHR approved substitute to stay with EHS-HS FCC children while attending the meeting; substitute is paid by EHS-HS FCC.
6. Mileage reimbursement available to invited parents.
7. The Advisory Committee meets at least twice a year; other meetings are scheduled as needed.
8. A meeting agenda is submitted to the Executive Director prior to the meeting.

9. If food is to be served, the Health & Safety Coordinator requests this in writing to the Executive Director, prior to the meeting date.
10. All meeting participants sign in at each meeting. This sign-in sheet provides documentation for In-Kind services.

Home Safety

Regulation Reference:
(2016) 45CFR; 1302.21(d)(1); 1302.23(d); 1302.47

Policy:
All EHS-HS FCC facilities meet applicable State and local licensing and zoning requirements for fire, health, and laws regarding environmental hazards and safety regulations. In cases where licensing requirements are less comprehensive or stringent, the Head Start regulations are followed. The EHS-HS FCC Program requires all Provider Homes to comply with these standards.

Every potential Provider Home must have a current Alabama Family Child Care License in good standing before being considered for a Provider Agreement. Failure to follow these standards can result in termination of this Agreement.

Provider Homes are kept in a safe and orderly manner, free of potential hazards. Providers demonstrate safety practices and discuss safety issues with children and with parents.

Procedure:
1. The Health and Education staffs are responsible for the health and safety of children at the Provider homes. The Monitoring Tools are used during inspections.

2. The Health and Education staff documents any concerns on the Monitoring Tool. If a hazard is in violation of the Childcare License or Provider Agreement, the Head Start/Early Head Start Director is notified in writing. The Head Start/Early Head Start Director or Executive Director will report to DHR as required. If the violation is serious enough to have placed a child in danger, the Provider Agreement may be terminated.

3. The Health & Safety Coordinator conduct twice yearly safety and health inspections of each current or potential Provider Home using the Home Health & Safety Checklists. Inspections are conducted near the beginning and the middle of the program year. Homes found to require repair and service must complete the repair and service prior to being offered a Provider Agreement for the next year.

4. All Provider Homes are smoke-free and tobacco-free.

5. All outdoor play areas must meet DHR guidelines.

JCCDC EHS-HS FCC
Home Health & Safety Checklist

Health & Safety Criteria	Yes	No	Need to repair
Have you checked parts of your house to see if they are safe, clean, sturdy, and in good repair?			
Stairs (indoor, outdoor, fire escape) -- free from clutter and well lit			
Porches, decks, and balconies – free from splinters or loose nails			
Railing secure – on stairs, porches, decks, lofts			
Furniture placed so children **cannot** climb to reach windows or hazardous objects			
Electrical cords are in good condition and away from children's reach			
Electrical or extension cords **do not** run under rugs			
Paint in good condition – no peeling or chipped paint			
All household plants identified; no poisonous plants in children's reach			
No standing water - Empty water from pails immediately after use; toilet lids down; bathroom door closed			
Latches or plastic doorknob covers on all doors that children should **not** use.			
Outlet covers or plugs in every electrical outlet in rooms used by children			
Matches and lighters out of children's reach			
No tobacco products in the children's areas, either inside or outside.			
Secured basement or garage doors, including automatic garage doors, so they cannot be opened by young children			
Use secure gates to block access to stairs or other dangerous areas			
Removed and replaced any accordion-style gates			

Storage	**Yes**	**No**	**Need to repair**
Installed safety latches on all drawers and cabinets containing dangerous items			
Potentially toxic items out of children's reach including;			
* Medicines, vitamins, aspirin, etc.			
* cosmetics, shampoo, perfume, mouthwash, etc.			
* Cleaning supplies, bleach, polish, ammonia, drain cleaner, etc.			
* Alcoholic beverages			
* Pet supplies			
* Pesticides			
* Home repair supplies, paint, turpentine, solvents, etc.			
* Vehicle supplies, gasoline, antifreeze, windshield washer solvent, etc.			
* Flammable liquids, charcoal lighter fluid			
Keep all poisons, cleaning supplies, etc. in their original labeled container			
Store all poisons away from food products			
Poison Center number posted at all telephones			
Prevent Burns:			
Keep all hot items out of children's reach, including:			
* Pots on stoves placed on rear burner; turn handle toward back of stove			
* Crock pots, electric fry pan, coffee maker			
***** Hot beverages, coffee, tea			
Tap water is 120 degrees F or less			
Always test water with hand or bath thermometer before placing a child in tub or washing child's hands			
Prevent children's access to space heaters			

Objects out of Reach	**Yes**	**No**	**Need to repair**
Sharp objects out of reach - knives, scissors			
No latex balloons in Provider Home			
All plastic bags out of reach – trash bags, dry cleaner bags, grocery bags, Zipper-type bags, etc.			
Check toys regularly for breakage or potential hazards, such as:			
* Avoid marbles, small balls, items that fit within choking tube			
* Stuffed animals securely stitched; no small eyes to remove			
* Rattles with removable parts			
* Squeeze toys with removable “squeeze”			
* Toys with cords or strings – strings less than 9”			
In bathroom, remove all objects that could cause electrical shock, such as:			
* Hair dryer, electric curler, curling iron			
* Electric razor, radio, space heater			
Outdoor Play Area			
Play area free of hazards such as:			
* Machines, power mowers, tools			
* Unused refrigerators, chests, boxes			
* Tree roots and other tripping hazards			
* Glass, trash, debris			
Empty all water containers immediately after use			
Play area is fenced or barricaded, especially if near a busy street, water source, or trash dump			

Outdoor Play Area	**Yes**	**No**	**Need to repair**
Play equipment spaced at least six feet from other equipment, vehicles, buildings, fences, walkways, trees, large rocks.			
Have impact-absorbent surface under and at least 6 feet from all edges of play equipment (follow CPSC Standards).			
No protruding bolts or screws – covered with plastic safety cap or tape.			
No pinch points on play equipment, swings, gliders.			
If swings used, S hooks are completely closed.			
Swing chains are covered with plastic hose for at least lower 4 feet.			
Play equipment firmly anchored in the ground; no exposed concrete or anchors.			
Storage areas such as garages, barns, or sheds, are locked or barricaded.			
If you have an in-ground or above-ground pool, it inaccessible to children, locked with a self-latching device or enclosed with fence at least 48” high or protective barrier.			
Emergency Planning			
Have local community emergency numbers posted by your phone – police, fire, ambulance, hospital, poison center.			
Have two people for emergency back care who live within 10 minutes of your home.			
Have children’s emergency numbers available in writing when you leave the Provide Home site (field trips, walks).			
Have a fully stocked first aid kit – checked regularly.			
Have an evacuation plan for when children are awake?			
Have an evacuation plan for when children are asleep?			
Have a currently charged fire extinguisher located away from the stove and near an exit.			
Have at least 1 working smoke detector located on each level of your Home.			
Check smoke detectors monthly; change batteries every 6 months.			
Two (2) clear exits to the outside on each level of your Home used for childcare.			
You and staff trained in first aid and CPR.			

Daily Health Check

Regulation Reference:
(2016) 45 CFR 1302.47 (b-4, K)(b-5, i)

Policy:

Providers should do a quick health check not in a formal exam routine, but as a casual observation of the child in their initial contact as they welcome the child checking easily observable, simple signs of well-being. A health check is not a medical examination. It is not the way to enforce policies with a parent. It is not a way to find reasons to exclude children. Exclusion of a child may result from a quick check observation and your follow-up, but the goal is to know your children better and to provide good care.

Each Provider will conduct health checks on a daily basis as children arrive. Children who appear to be ill should not be allowed to stay in the EHS-HS FCC Home.

Procedure:

1. Each Provider and/or Assistant checks each child upon arrival. This routine is accomplished in a non-threatening manner (e.g., greeting games can be used). This check is done before the parent or guardian leaves the child in the room so a child who appears to be ill can be taken home or to the doctor/clinic as appropriate.
2. If any signs/symptoms are noted, the Provider writes specific details of the observation on the Daily Health Check form and the Body Chart form.
3. If any signs or symptoms are noted, both the Provider and the parent sign and date the Daily Health Check and the Body Chart form verifying that he/she has witnessed or has knowledge of illness or incident.
4. Children with signs or symptoms of illness, as described on the Exclusion Guidelines, are sent home with the adult who brought them to the Provider Home.
5. If appropriate, the Provider recommends that the child be seen by a Health Care provider.
6. The Provider completes the Daily Health Check and Body Chart Forms and immediately notifies the Central Office and/or Health and Safety Coordinator so that a follow-up can be conducted. The original forms are sent to the Health and Safety Coordinator and a copy should be maintained in the child’s Home File.
7. The Daily Health Check and Body Chart Forms are sent to Health and Safety Coordinator directly via email/mail or collected and given to Health and Safety Coordinator by other JCCDC staff visiting a site. All forms are due monthly unless there is an emergency then it is due immediately.

8. In addition to the daily health check requirement, each Provider shall complete the “monthly reconciliation of daily health check” form and submit it monthly along with the daily forms to the Health and Safety Coordinator.

Suspicious injury:

1. If a child arrives with suspicious injuries, the Provider notes these injuries on the Daily Health Check and Body Chart forms. The injuries are brought to the attention of the adult bringing the child to care; the adult signs Daily Health Check and Body Chart forms, acknowledging that these injuries have been noted.

2. If this adult is not the primary caregiver (parent or guardian), then the parent/guardian is immediately contacted and questioned about the injury.
3. If the Provider is still suspicious about the origin of the injury, the Provider allows the adult delivering the child to leave. The Provider then follows procedures for Reporting Suspected Child Abuse or Neglect, as required by State Law.

Jefferson County Child Development Council, Inc

Head Start/Early Head Start Program
DAILY HEALTH CHECK (OBSERVATIONS)

Child's Name:_____ Month of:_____

In the Health section indicate **OK** if there are no concerns:

Week of:_____	Health Check:	Parent/Guardian/Person dropping off Child: Signature below
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

If you observe any illnesses or concerns indicate below:

_____
_____
_____
_____
_____

Describe any suspected abuse:

_____
_____
_____
_____

Provider Signature:_____
Date:_____

If child becomes ill during childcare hours, provider is to contact parent for pick up. Provider is to complete the DHR-CDC 1950 injury/illness form and send to Health and Safety Coordinator. Approved by JCCDC Executive Board.

Signs to Observe When conducting a morning health check, you should watch for the following:

- General mood and changes in behavior (happy, sad, cranky, sluggish, sleepy, unusual behavior)
- Fever or elevated body temperature (if there is a change in child's behavior or appearance)
- Skin rashes, itchy skin, or itchy scalp, unusual spots, swelling or bruises
- Complaints of pain and not feeling well
- Other signs and symptoms of disease (such as severe coughing, sneezing, breathing difficulties, discharge from nose, ears or eyes, diarrhea, vomiting and so on)
- Reported illness in child or family members since last date of attendance.

Use all of your senses . . .

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

Daily Health Check
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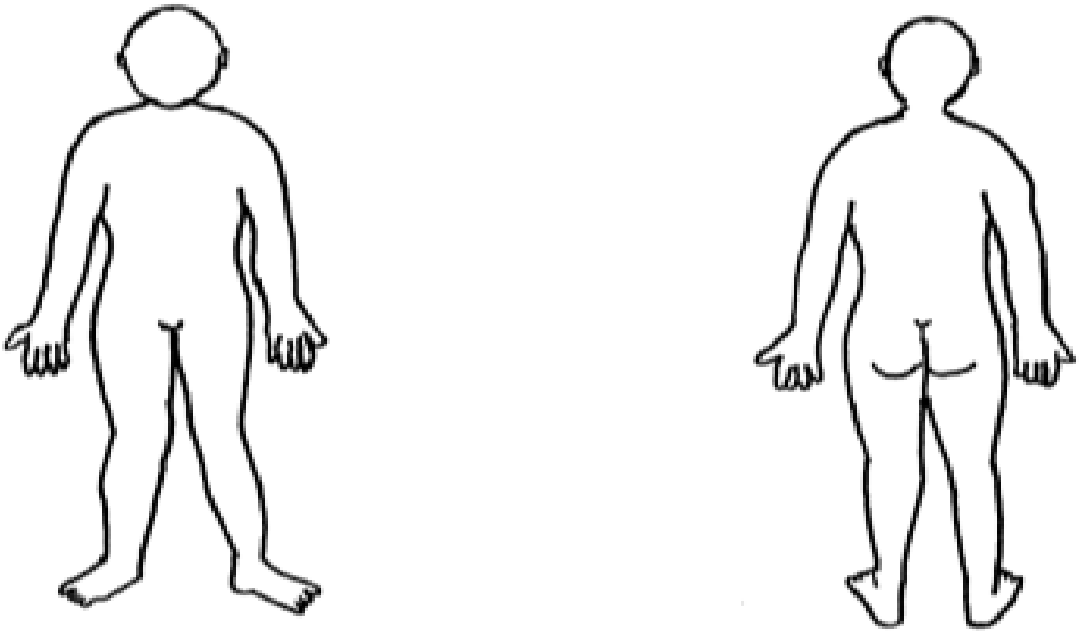
Front **Back**



Use this body chart to mark where noticeable sign of a physical bruise, rash, cut, sore, etc. appears on the child.

FCC Provider Monthly Reconciliation of Daily Health Checks

Provider: _____ Month and Year: _____

Key: Present = X Absent = |

Name of Child (Type or Print)	Monday	Tuesday	Wednesday	Thursday	Friday	Monday	Tuesday	Wednesday	Thursday	Friday	Monday	Tuesday	Wednesday	Thursday	Friday	Monday	Tuesday	Wednesday	Thursday	Friday	Monday	Tuesday	Wednesday	Thursday	Friday	Comments
Last, First Name: Date:																										
1.																										
2.																										
3.																										
4.																										
5.																										
6.																										
7.																										
8.																										
9.																										
10.																										
11.																										
12.																										
13.																										
14.																										
15.																										
Total Present: _____																										

This form corresponds with Health and Safety Policy #Daily Health Check #3

Exclusion Guidelines for Specific Conditions

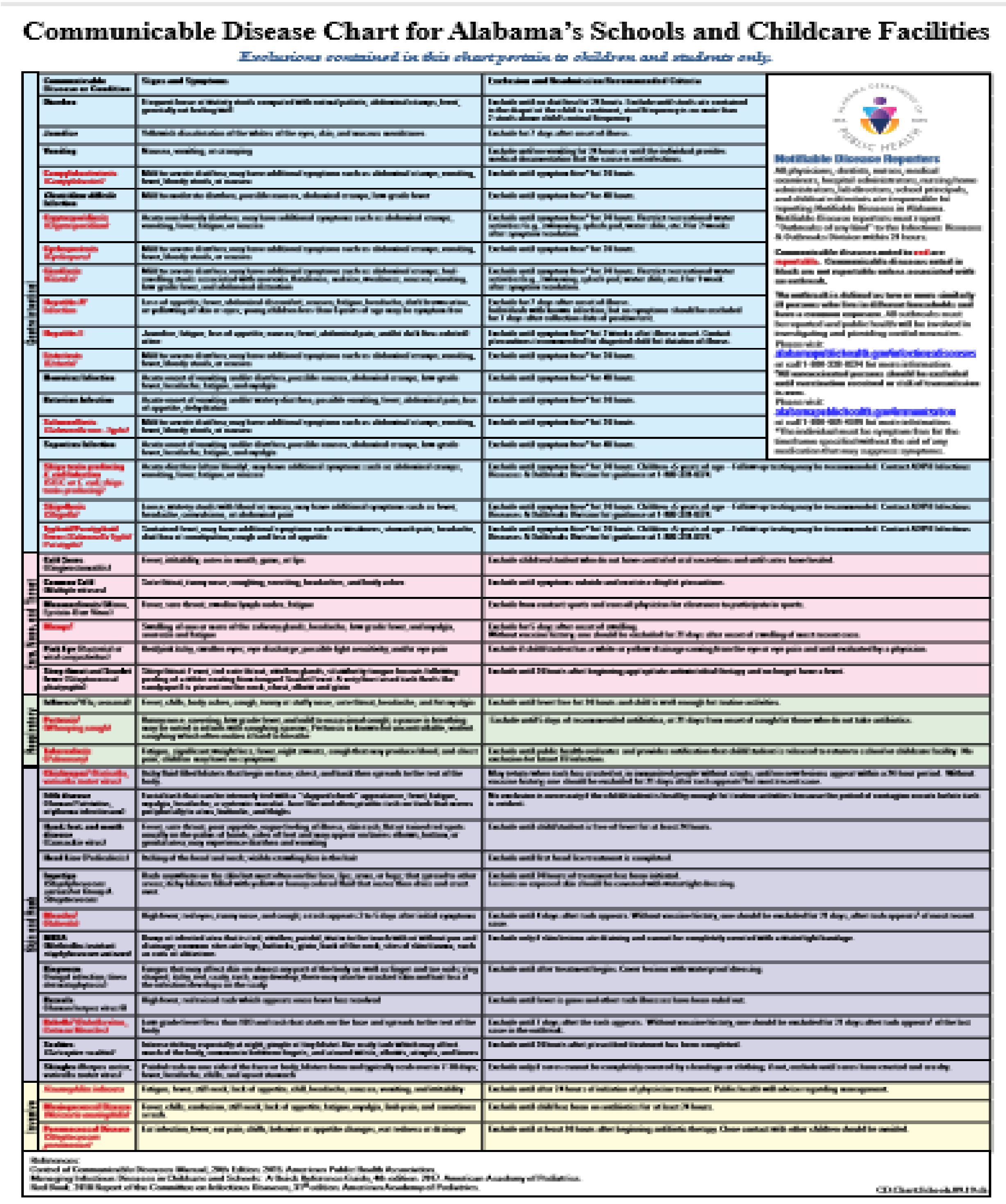
Illness or Condition	Recommended Response
Chicken Pox	Stay at home until all sores are crusted over. Health Care Provider must sign a Return to Care authorization.
Conjunctivitis (pink eye)	See a Health Care Provider to obtain medication. Health Care Provider must sign a Return to Care authorization.
Hepatitis A	Stay at home until all individual who should be protected have received gamma globulin injections. Health Care Provider must sign a Return to Care authorization.
Lice	Treatment can be purchased over-the-counter at pharmacy or other store. Health Care Provider or Public Health Nurse must sign a Return to Care authorization when treatment completed.
Ringworm	See a Health Care Provider to obtain medication; medication may be purchased over-the-counter. Health Care Provider must sign a Return to Care authorization.
Scabies	See a Health Care Provider to obtain medication; medication may be purchased over-the-counter. Health Care Provider must sign a Return to Care authorization.
Pinworms	See a Health Care Provider to obtain medication. Health Care Provider must sign a Return to Care authorization. Two treatments, one week apart, may be prescribed.
Strep Throat or Scarlet Fever	See a Health Care Provider to obtain medication. Health Care Provider must sign a Return to Care authorization after treatment is begun. Complete all treatment medication as prescribed.
Vaccine preventable diseases	See a Health Care Provider to obtain Return to Care authorization. Health Care Provider must report these diseases to the Health Department.
Severe Respiratory Problems	See a Health Care Provider for excessive coughing, sneezing, wheezing, labored or rapid breathing, or excessive runny nose (especially if drainage is thick, green, or yellow)
Open Sores on skin or in mouth	See a Health Care Provider for diagnosis and treatment. Health Care Provider must sign a Return to Care authorization.
Rash	See a Health Care Provider for diagnosis and treatment. Health Care Provider must sign a Return to Care authorization.
Drastic changes in behavior or signs of illness	See a Health Care Provider for diagnosis and treatment if the child is unusually irritable, without energy, excessively sleepy, overly active, withdrawn, loss of appetite, etc.
Diarrhea	Child has more than 2 loose stools. May return to care 24 hours after last loose stool without medication
Fever	Child has oral or under-the-arm temperature of 100 F or higher. Child may return when free of fever for 24 hours without medication.
Vomiting	Child may return to care 12 hours after last episode of vomiting.

Short Term Exclusion Guidelines

Regulation Reference:

(2016) 45 CFR 1302.47 (b-7, iii)

Parents or guardians of children with the following conditions should not bring a child to the childcare until after they receive a Return to Care Authorization from a Health Care Provider. Parent/guardians are urged to notify the EHS-HS FCC Provider when their child is known to have been exposed to a contagious disease outside of childcare. A chart will be made available to each FCC Provider.


Communicable Disease Chart for Alabama's Schools and Childcare Facilities

Exclusions contained in this chart pertain to children and students only.

Emergency Care

Regulation Reference:
(2016) 45 CFR 1302.47(b-7)(b-8); 1302.102 (d)(ii)
(2001) Alabama DHR Minimum Standards D.6.2.c; D.7.(a-b); H.2.c.(1-10); H.4.b.(1-2); H.4.b.4

Policy:
Immediate and appropriate procedures will be followed in case of illness (e.g., allergic reaction, asthma attack), injury, or incident. An "incident" will be defined as a situation that could cause injury; for example, a child may fall off the playground equipment and not appear to be injured. All incidents, regardless of whether injuries involved or not, are reported.

EHS-HS FCC maintains an updated Authorization form for every enrolled child. In case of an illness, injury, or incident, the staff will:

- Administer immediate first aid to, and obtain appropriate medical care for, children sustaining injuries while in our care.
- Notify parent immediately when a child is injured.
- Document all sudden serious illnesses/injuries/incidents.
- Notify DHR if the illness/injury/incident requires medical treatment.

Providers immediately report any illness/injury/incident to the Health and Safety Coordinator. Failure to report as specified will result in disciplinary action. Three incidents/injuries in any one Provider Home within one month's time will be reported to the Executive Director.

Procedure:

Planning for emergencies:

1. The Health staff, in collaboration with the Advisory Committee, annually evaluates guidelines for medical and dental emergencies.
2. Providers receive training and written information regarding these guidelines and procedures. Providers also receive bi-annual first aid and CPR certification training.
3. The Health and Education staff review each Provider's Emergency plan and posted first aid and emergency information. This is completed prior to offering an Agreement to potential Providers; and during the annual Health and Safety Inspection of current Providers.
4. The Health & Safety Coordinator works with Providers to create individual Emergency Information posters for each EHS-HS FCC Home.
    - On the first day of Pre-service, each Provider is given a blank Emergency Information Poster. Providers complete and return this information the following day.

The Emergency Information Posters and other emergency procedures are posted in a conspicuous place in each EHS-HS FCC (see sample). The following information must be included/posted:

- Poster indicating Provider name, address, and telephone number; emergency contact numbers; and location of telephone, emergency files, first aid kit, and fire extinguisher.
- Instructions for medical and dental emergencies (e.g., spiral-bound *Quick Guide to Medical Emergencies)*.
- Fire escape routes – two ways out.
- Tornado safety and response

5. Children with asthma, severe allergies, or other chronic health condition have an Asthma Health Care Plan or Health Care Plan in their file. A copy of that plan is kept in the child's office file as well.
6. All Area staff periodically monitors the Provider Home files to ensure accurate and up-to-date emergency contact information and authorization for each child.

In the event that a child sustains an injury, becomes suddenly ill, or is involved in an incident that may have caused an injury not immediately apparent, the following procedures must be followed to insure that the child receives necessary and appropriate first aid and medical attention:

1. The attending Provider or assistant gives immediate first aid to the child. In case of injury **do not move the child** unless the child is in immediate danger of further injury. Basic first aid procedures must be followed. Remember that moving a child with possible broken bones or head/spinal injury can result in more serious injury.
2. Never leave a child unattended following an illness/injury/incident.
3. **IMPORTANT!** When injury occurs, a decision must be made quickly about the severity of the injury and whether an Agency vehicle can transport the child, or if 911 should be called for ambulance transport. If a child must be transported to a medical facility, but does not require ambulance transport, an authorized staff driver may transport the child in an Agency vehicle. However, if an Agency vehicle is not immediately available, then 911 is called for ambulance transport.
4. If the child has asthma, severe allergy, or other chronic illness, the Provider follows the child's Health Care Plan.
5. If the injury/illness/incident could possibly be serious:
    - The Provider will call 911.
    - The Health & Safety Coordinator is immediately notified of the emergency. The Head Start/Early Head Start Director and/or Executive Director or other Administrative Office Staff is notified if the Health and Safety Coordinator cannot be reached.
    - Providers immediately remove the Authorization form, as well as any medical records or allergy reports, from the child's folder and take it with the child to the hospital.

- The child's parent(s) is contacted by the Provider or Health & Safety Coordinator as soon as possible to inform them of the emergency and where the child has been taken for emergency treatment. This is usually Children's Hospital, but other facilities can be used if the emergency warrants. The parent is expected to meet the staff member and child at the hospital. If the parent cannot be reached right away, staff members continue to try to reach the parent.
- A staff member **must** accompany the child to the hospital and remain there until the parent or guardian arrives. A staff member stays with the child/family until the child has been discharged and notification of the child's condition has been made to the Health & Safety Coordinator or Head Start/Early Head Start Director.

6. The Provider completes the necessary forms.
7. The Financial Officer or Human Resource staff completes any necessary insurance forms.

SAMPLE Emergency Poster

Childcare Program

PROVIDER:
ASSISTANT:
FAMILY WORKER:

ADDRESS:

EMERGENCY NUMBER: 911 (fire, police, emergency services)

POISON CONTROL: 800-222-1222

NEAREST HOSPITAL: Children's Hospital

UTILITY SERVICES: Gas Company _____
Power Company _____

NEAREST TELEPHONE: # ( )
Located: _____

CHILDREN'S EMERGENCY FILES:
Located: _____

FIRST AID KIT:
Located: _____

FIRE EXTINGUISHER:

_____

_____

First Aid Kits

Regulation Reference:
(2016) 45 CFR 1302.47(b-1)(vi)
(2001) Alabama DHR Minimum Standards D.7.b; E.1.f.(1-5)

Policy:
A first aid kit should be readily available wherever children are in care, including during field trips and outdoor play. First aid supplies must be stored in a clearly marked closed container. First aid kits must be accessible to child caregivers, but out of children's reach. Kits are restocked after each use, and checked monthly. Only approved items are included in the first aid kit. Do NOT include any medications.

Procedure:
1. The EHS-HS FCC program will give Providers a fully stocked First Aid Kit and Fanny Pack prior to serving children. (Refer to Checklist for items.) The Health and Safety Coordinator assures that each Provider has a fully stocked First Aid Kit and Fanny Pack.
2. First aid kits are stored in an easily accessible location, out of children's reach. The location is noted on the posted Emergency Poster. The Central Office First Aid Kit is located in the Health & Safety Coordinator's office.
3. Providers check the contents of kits each month to ensure supplies are in good condition, in sufficient supply, and not expired. Only approved supplies are included in the kit!
4. Each kit includes a Checklist form. The Provider initials this checklist each month when the kit is inspected. The kit will be reviewed at each Health & Safety Inspection.
5. All kits are restocked after use. Refer to procedures on Requesting Health Supplies.
6. If the Resusci Face Shield is used, the Provider notifies the Health and Safety Coordinator immediately and an Injury Report Form is completed.

Fanny Packs:
7. An abbreviated first aid kit containing essential items may be more practical for playground or outside activities taking place near the facility. Supplies may be carried in a clearly marked fanny pack worn by the staff member.
8. Providers follow procedures described above for checking and replenishing Fanny Packs.

First Aid Kit Checklist

Check contents of each first aid kit on the first Monday of each month and initial box.

Item	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
The following items are <u>not</u> considered consumables. Replacement of these items is the responsibility of the Provider												
First aid kit box												
Non-glass Thermometer												
Flashlight												
Measuring spoons												
Bandage scissors												
Current standard first aid chart												
The following items are consumables. Complete Health Supplies Request form when items need replenishing.												
Disposable gloves												
Liquid soap												
Adhesive strip bandages												
Sterile gauze pads												
Flexible roller gauze												
Bandage tape												
Safety pins												
Eye shield												
Resusci Face Shield												
Plastic zipper bags												
Plastic bags to dispose of contaminated supplies												
Pen/pencil and note pad												
Poison center and other emergency numbers.												
Emergency contact person												

First Aid Fanny Pack Checklist

Check contents of each Fanny Pack on the first Monday of each month and initial box.

Item	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
The following items are <u>not</u> considered consumables. Replacement of these items is the responsibility of the Provider												
Standard First Aid Chart												
Bandage Scissors												
Small Spray Bottle												
Front Pocket												
Pediatric First Aid Reference cards												
Resusci Face Shield												
Adhesive bandages												
Main Compartment												
Sterile gauze pads												
Eye shield												
Liquid soap												
Disposable gloves												
Bandage scissors												
Bandage tape												
Flexible roller gauze												
Tissues												
Zippered Rear Pocket												
Poison center and other emergency numbers.												
Emergency contact person												

- There is a place to store keys in the main compartment

Illness or Injury Occurring While in Child Care

Regulation Reference:
(2016) 45 CFR 1302.47(b-4)(i-A,D,G,J,K); 1302.47(b-5,i,iii)(7-iii)
(2001) Alabama DHR Minimum Standards 6.a.1; 6.a.2.(a-c); 6.a.3.(a-c); 7.b; H.2.d.1-4); H.4.b.2

Policy:
Providers will check each child's health status every day as he/she enters the Home. A child who appears ill will not be admitted (see Daily Health Check Procedure). Children who become ill while in attendance (e.g., suffering from sore throat, earache, vomiting, stomach ache, or fever) are sent home with his/her parent/guardian after receiving permission for dismissal from the Health and Safety Coordinator or other Area Coordinator. Please refer to Exclusion Guidelines for guidance on which illnesses require the child to be sent home.

Early Head Start children who become ill while in attendance are checked by Provider or Health & Safety Coordinator. Very young children can become seriously ill very quickly; it is important that medical attention be obtained if needed.
If an injury, incident, or illness occurs, the guidelines listed below will be followed without fail. Failure to report appropriately any injury, incident, or illness, will result in disciplinary action.

Procedure:

Illness - Head Start & Early Head Start
1. If a child shows symptoms of illness, the Provider promptly isolates the child from the group, while maintaining appropriate supervision of all children (e.g., place infant or child in their crib or on a cot, away from other children). Arrangements are immediately made to provide responsible adult supervision while waiting for the parent/guardian to arrive. All children must be properly supervised at all times.
2. Provider immediately notifies the parent of the child's illness and request that the child be picked up.
3. The Provider notifies the Health and Safety Coordinator as soon as possible.
4. The Provider may authorize dismissal from the program until diagnosis/treatment and a Return to Child Care authorization is obtained in accordance with the Exclusion Guidelines.

Reporting Illness or Injury
1. Any illness or injury that occurs while child is in child care, and requiring emergency medical treatment, must be reported to the Department of Human Resources within 24 hours after occurrence, followed by a written report (DHR – CDC – 1950) within 5 days. The report must be made by the licensee, or the person responsible for the child.

2. In addition to the form listed in #1 (above), all injuries or incidents are also documented on the Childcare Injury Report. This form is immediately submitted to the Health and Safety Coordinator.

JCCDC EHS-HS FCC
Injury/Illness Report

DHR–CDC-1950

Any illness or injury that occurs while child is in child care, and requiring emergency medication treatment, must be reported to the Department of Human Resources within 24 hours after occurrence, followed by a written report (DHR – CDC – 1950) within 5 days. The report must be made by the licensee or the person responsible for the child care at the child care facility.

Name of Licensee: Type of Childcare Facility: ____ Home ____ Center	Address of child care facility: Street: _____ City: _____ Co: Jefferson
Child's Name:	Child's date of birth:
Date injury/illness occurred:	Time injury/illness occurred:
Name of child's parent/guardian:	Time parent/guardian was contacted:
Describe the injury/illness, including type, severity, and location. If reporting an injury, describe how it occurred.	
Give the following information regarding the physician or emergency medical personnel contacted:	
Name: _____ Address: _____ Phone number: _____	
Time contact made: _____ Date: _____	
Physicians comments:	
Was the Department of Human Resources notified within 24 hours? ____ Yes ____ No	
Signature of staff person/caregiver in charge:	Date:

JCCDC EHS-HS FCC
Childcare Injury or Incident Report

Name of Provider: _____

Address of Provider: _____

Name of child injured: _____

County: Jefferson

Date of injury: _____ Injury time : _____ AM PM

Child date of birth: _____ Gender: **M**ale **F**emale

Parent/Guardian Notified: **Y**es **N**o Name/Relationship: _____

Notified by whom: _____

Time notified: _____ AM PM Date notified: _____

Was child in custody of parent at time of injury? **Y**es **N**o

Where did injury occur? *(Circle response below)*

During transportation In FCC Home On field trip On playground
Other: _____

During what activity?

Bathroom time	Curriculum activity	Going up/down stairs
Indoor free play	Meal/snack time	Outdoor free play
Organized outdoor play	Play equipment	Traveling to/from FCC Home
Water play	Other: _____	

Equipment involved?

Balance beam	Climber	Crawl through	Fence/gate
Indoor fixture	Merry-go-round	Playhouse	Seesaw
Slide	Swings	Vehicles	Wheeled toy
Disabilities equipment	Other: _____		N/A

Type injury?

Burn	Choke/strangle	Fall/blow	Inserted object
Laceration/wound	Poisoning	Other: _____	

Were other children involved? **Y**es **N**o

If yes, who? _____

Result of Injury (Observed symptom):

Breathing problems	Cut/wound requiring stitches	Dental injury
Foreign object in body	Human bite	Minor cut/wound
Muscular/skeletal (bruise/sprain)	Sting/bite	Swelling
Unconscious	Vomiting	Other: _____

Body Area Injured: *(Circle and note if injury is to the <u>child's</u> Left or Right)*

Head	Face	Eye L / R	Ear L / R	Mouth	Nose
Neck	Chest	Back	Stomach	Buttocks L / R	Genitals
Arm L / R	Hand L / R	Leg L / R	Foot L / R		

Narrative of first aid rendered to child:

By whom?_____

Medical attention required? **Y**es **N**o (If yes, go to next item.)

Medical attention & severity of injury:
Parent contacted, child remained in FCC Home
Paramedics came
Transported to hospital by ambulance
Parent reported taking child to Dr/clinic
Parent reported taking child to Emergency Room
Child admitted to hospital
Parent reported taking child home

Supervisors notified:
Name/Title: _____ Date: _____

How notified? Written memo telephone in person other: _____

Name/Title: _____ Date: _____

How notified? Written memo telephone in person other: _____

Describe outcome, as reported by parent:
(Example: Bone set (cast), stitches, return to school date, etc.)

Comments:

Person reporting injury: _____
Reported to: _____ Date: _____

Witnesses to injury:

Print name	Signature
_____	_____
_____	_____

Emergency Contact

Regulation Reference:
(2016) 45 CFR 1302.41; 1302.47(b-5,iv)(7-v)
(2001) Alabama DHR Minimum Standard H.4.b(1)

Policy:
JCCDC EHS-HS FCC maintains a current listing of each child's emergency contacts; names of persons to whom the child may be released; and name, address and phone number of the child's health care provider.

Procedure:

1. The computer-generated Emergency Contact Release report is updated each time there is a change in a child's information. The PFCE staff or Health & Safety Coordinator assures that each Provider has an updated report.

2. The first report is generated from information obtained from the application form. Subsequent changes are forwarded to the PFCE Staff on a Change of Status form. Updated reports are distributed ASAP if there has been a change in the information for that particular Provider.

3. A copy of this report is maintained by each Provider, and a copy is also maintained by the Health & Safety Coordinator.

4. Providers have a "ready to go" file with all necessary emergency information on all children. This file is separate from the individual children's files and is "ready to go" in case of immediate evacuation or emergency. This files is clearly marked and maintained in the front of the file drawer containing child files or Survival Kits.

Authorization to Administer Medication or Medical Procedures

Regulation Reference:
(2016) 45 CFR 1302.41; 1302.47(b-4, i,C)(7,iv)
(2001) Alabama DHR Minimum Standards D.6.5.a-f; H.4.b.4

Policy:

1. To administer any medication or medical procedure, EHS-HS FCC must have a written parental request that is signed and dated and includes the time/date of the last dose taken. Prescription drugs and any **authorized** over-the-counter medications (including medications such as insect repellent, sunscreen, diaper cream, and Vaseline) are in the original container clearly labeled with the child's name, name of the drug, and directions for administering.

2. Medication is administered by the trained Provider. All medications are stored under lock and key, and refrigerated, if necessary.

Procedure:

1. The Health and Safety Coordinator, in collaboration with the Advisory Committee, annually evaluates guidelines for administration of medication in the Provider Home.

2. Providers receive training and written information regarding these guidelines and procedures.

3. Providers may administer medication if the following conditions are met:

   - Medicine is prescribed by a licensed health professional; this applies to both prescription and over-the-counter products. Written instructions by the health professional on how to give the medicine must accompany the medication.
   - The parent records this information on, and signs/dates, form DHR-CDC-1949 as official documentation for authorization of medication administration.
   - The Provider is trained to administer the medication.
   - The medicine is brought in its original labeled container
   - The Provider informs the Health and Safety Coordinator that a parent has requested administration of medication.

7. If refrigeration is required, medication is stored in a locked box, separate from food storage.

Provider's must:

4. Be trained to administer the medication or medical procedure, including any specialized training required. The Health and Safety Coordinator documents this training.

5. Use a dose specific measuring devise (e.g., medicine spoon, medicine syringe). If a specific devise is required, the parent provides this instrument.

6. Know and record potential reactions or side effects to the medication; and how to response to such reactions.

7. Know when and how to contact parents, pharmacists, or health providers to clarify the need and instructions for medication administration.

8. Keep a log of each medication dose given, date and time given, and any adverse reactions of the child. The Medication Administration Record is used for documentation.

9. Assure safe storage of medication in a locked container.

10. Check the expiration date and assure that all medications are within "use by" date.

JCCDC EHS-HS FCC
Authorization to Administer Medication/Medical Procedures
DHR-CDC-1949

Provider: _____**Date:** _____

Dear Parent/Guardian,

Your written permission is required to administer medication or medical procedures to your child. Any prescription drug or over the counter drug sent to the child care facility (home or center) must be in its original container and must be clearly labeled with your child's name, the name of the drug, and directions for administering the drug. A new authorization form is needed each week. If it is absolutely necessary for your child to be given medication while at the child care facility, **please complete the following information**.

Child's Name _____

Prescription Number _____

Name of Medication _____

Amount of medication to be given at each dosage _____

Instructions (How to give or apply, such as give by mouth, apply to skin, inhale, drops in eyes, etc.) _____

Time for last dosage given at home _____

Time(s) of dosage(s) to be given at the child care facility _____

Please give my child the above-named medication at the time(s) and in the amount(s) indicated.

Signature of parent/guardian _____ Date _____

To be completed by licensee/staff/caregiver:

Date medication given	Time medication given	Signature of person giving medication

Instructions:

- Staff person should complete or assist parent in completing this form;
- Complete a separate form for each prescription medication

JCCDC EHS-HS FCC
Prescription Clarification for Administering Medication

Parent: Please give this form to your child's health care provider

Date:_____ Child's Name:_____

Dear Health Care Provider:

The child listed above is a JCCDC EHS-HS FCC participant who has been prescribed medication by your office. To accurately administer this medication in accordance with State of Alabama, *Department of Human Resources (DHR) Minimum Standards for Day Care Centers* regulations and the *Baby Douglas Law, Alabama Act No. 2004-538,* please provide **specific instructions** (e.g., dosage, times to be given or the conditions/symptoms under which to be given) for administering the medication for the item(s) checked below.

___ Name of Medication:_____

___ Dosage/amount:_____

___ Time(s) to be administered:_____

___ Conditions/symptoms under which medication is to be administered:_____

_____

_____

Thank you for this additional information, and please return this form to the parent so that these instructions can be attached to the child's prescription. If you have questions, please feel free to contact me at 205-379-6059.

Health and Safety Coordinator

Provider's Name (*please print):* _____

Provider's Signature: _____ Date:_____

Provider's Address:_____Phone:_____

JCCDC EHS-HS FCC
Staff Observation: After Administering Medication

Provider,
If you note any changes in a child's behavior that may have implications for the medication dosage or type, please record the observed behavior changes below:

Child's Name: _____

Prescription Number: _____

Name of Medication: _____

Amount/dosage of medication given: _____

Date Medication given	Time Medication Given	Observed changes in a child's behavior that may have implications for the medication dosage or type	Signature of person who gave the child the medication

_____ _____
Signature of person who observed change(s) in child's behavior Date

JCCDC EHS-HS FCC
Evaluation: Staff Administering Medication

Provider Name:_____
(Please Print)

Provider Signature:_____

Date of Evaluation:_____

Evaluator: Please circle *yes* or *no* below to indicate that you have observed the following:

Authorization to administer medication is current and signed? YES NO
Comments: _____

Right child is receiving the medication? YES NO
Comments: _____

Right medication is being administered? YES NO
Comments: _____

Right dosage is being administered? YES NO
Comments: _____

Medication is administered at the right time? YES NO
Comments: _____

Right method is used to administer the medication? YES NO
Comments: _____

Medication is under lock and key? YES NO
Comments: _____

To Be Completed By The Evaluated Provider:

Did you receive sufficient training to administer medication? YES NO
□ □
If no, have you been offered an opportunity for more training? YES NO

Provider Signature:_____ Date:_____

Health & Safety Coordinator Signature:_____ Date:_____

Cleaning and Sanitation

Regulation Reference:
(2016) 45 CFR 1302.22(d); 1302.47(a)(b, 1-2)(4,i,)(6)
(2001) Alabama DHR Minimum Standards C.4.l(1-2); C.8.e.(4); D.2.b (1-13); D.6.b.1 (a-f); D.6.b.2 (a-c); D.6.b.3

Policy:
Daily and weekly cleaning practices help prevent the spread of communicable diseases in the FCC Home. All cribs, cots, tables, and chairs are disinfected daily, and thoroughly cleaned and disinfected once every week. If a crib, cot, or chair becomes soiled with urine, vomit, or other contaminant, it is cleaned and disinfected immediately.

The Provider will inspect cots, tables, and chairs daily for cleanliness. The Health & Safety Coordinator or Education Staff will conduct inspections periodically.

1. Providers, staff, and children follow Standard Precautions to avoid direct contact with blood or body fluids containing blood. Staff members will wear non-porous disposable gloves for first aid, diapering, wiping noses, or other procedures which place the child or staff member at risk of direct contact with blood or body fluids.
2. Each year, the Advisory committee reviews the Standard Precautions procedures; and the Health & Safety Coordinator provides training to Providers.

The Health & Safety Coordinator assures that all JCCDC employees and Providers receive training on Standard Precautions and Blood Borne Pathogens. Training includes, but is not limited to, the following:

- Hand washing procedures
- Use of personal protective equipment (e.g., gloves, face mask)
- Cleaning and sanitation
- Response to exposure to blood or body fluids

Procedure:

1. Providers, staff, and children wash hands thoroughly at specified times and as needed (see Hand washing procedures).
2. Provider Home environments are cleaned daily with an appropriate cleaner and disinfected with bleach and water solution.
    - The bleach/water solution is:
        - ¼ cup bleach to 1-gallon water, or
        - 1 tablespoon bleach to 1 quart of water.
        - For areas soiled with blood and/or body fluids, the solution will be ¼ cup bleach to 1-quart water (rather than to 1-gallon water).

- New solutions are mixed each morning. Bleach solution is mixed in a spray bottle clearly marked for that purpose. Bottles previously used for other chemicals (e.g., Fantastic or 409 bottle) are not used because of labeling
- The daily bleach solution is stored “out of children’s reach” but is accessible for staff members to use frequently during the day.

Daily Cleaning:

1. Every day after naptime, the Providers:
   - Spray cots and cribs with the bleach and water solution.
   - Wipe off solution with a clean cloth.
   - Clean cribs with bleach and water solution at the end of each day.
   - The mattress is placed upright in the crib to dry.
2. Every day after mealtime or snack time, the Providers wipe off tables and chairs with a clean cloth and disinfecting solution.

Trash and Garbage:

1. All trash and garbage is stored and disposed of in a safe, sanitary manner.
2. Garbage bags are used in all trash cans.
3. NOTE: To prevent child injury or suffocation, extra garbage bags are stored in a locked cabinet.

Documentation:

Documentation of the daily/monthly cleaning is to be entered on the EHS-HS FCC Health and Safety Checklist.

Standard Precautions:

1. Providers, staff, and children avoid direct contact with blood and body fluids containing blood, by wearing non-porous disposable gloves for first aid, and washing hands after the gloves are removed. Examples include the following:
   - If giving immediate first aid to a bleeding child and gloves are not readily available, use the child’s own uninjured hand to apply direct pressure to stop bleeding until you are able to put on non-porous disposable gloves.
   - If a child gets a nosebleed, put on latex disposable gloves before holding a child’s nose to apply direct pressure and stop the nosebleed. If the child is old enough, give him/her disposable paper towels or tissues to catch the first flow of blood until you can wash your hands and put on gloves.
   - Once the injury or nosebleed has been treated, while still wearing the disposable gloves, put all used cleaning materials (towels, tissues, cotton swabs or balls,

gauze, etc.) soiled with blood into a sealable plastic bag. Seal it and place it into an outside trash container.

- All areas, both indoors and outdoors, that have been soiled with blood or other body fluids are to be cleaned thoroughly using a disinfectant or using bleach/water solution. The area is allowed to air dry. Any tools and equipment used to clean spills or bodily fluid are cleaned and disinfected immediately. Other blood contaminated materials are disposed of in a plastic bag with a secure tie.
- (Example: If a child becomes injured while in the play area outside, look over the area for sticks, glass, or stones that may become soiled with blood. While still wearing the disposable gloves, place any such objects into a sealable plastic bag. Dispose of materials in an outside trash container.)

2. Avoid direct contact with other body fluids by using latex gloves for assisting with diapering/diarrhea, drooling, nasal discharges, toileting, or vomiting.
3. Children or staff members with open, draining sores on the skin have the sores covered with gauze bandages, and sores are seen by a physician. Children are taught not to pick at scabs.
4. Do not allow “blood brother/sister,” “spit and shake pacts,” or other blood/body fluid sharing games among children.
5. Do not allow sharing of the following items: toothbrushes, teething toys, baby bottles/nipples, or other mouthed objects.
6. Toys are of sturdy, resilient materials that can be cleaned. Avoid soft plush toys or other objects which cannot be disinfected daily.
7. Any soiled personal clothing is sent home in a sealed plastic bag to be washed.
8. Staff members keep non-porous disposable gloves, tissues, and a plastic trash bag (e.g., plastic grocery bag) available at all times.
9. If a person gets blood or other body fluids in an opening in the skin, the Health and Safety Coordinator assures that all necessary blood testing is done with all parties involved to ascertain any exposure to potentially infectious body fluids.

JCCDC EHS-HSFCC PROGRAM HEALTH AND SAFETY CHECKLIST

Provider: _____
Month/Year:_____
Week of_____

Post in childcare area. Provider's document cleaning and sanitation practices daily as required. Refer to Standard Precautions Procedures in your policy and procedures handbook. Clean and sanitize all child care during childcare hours.

Checklist	Mon	Tue	Wed	Thurs	Fri
___before breakfast ___after breakfast ___before lunch ___after lunch ___before snack ___after snack ___before activities ___after activities	___breakfast ___lunch ___snack ___activities	___breakfast ___lunch ___snack ___activities	___breakfast ___lunch ___snack ___activities	___breakfast ___lunch ___snack ___activities	___breakfast ___lunch ___snack ___activities
Hand washing area: Daily and when soiled					
Floors/carpet: Daily and when soiled (after each use). Clean carpet monthly as needed.					
Toys: clean after each use Mouthed toys cleaned after each use. **Dirty toys put in germ bucket""					
Sleeping cots, cribs, mattresses: • Clean after each child's use and before • Used by another child.					
Helmets and hats: Sanitized after each child use.					
Cubbies: Daily and when soiled.					
Playground equipment: Equipment must be free of dirt, pollen, and insects before children have access	____a.m. playground checked ____p.m. playground checked	____a.m. playground checked ____p.m. playground checked	____a.m. playground Checked ____p.m. playground checked	____a.m. playground checked ____p.m. playground checked	____a.m. playground checked ____p.m. playground checked
Outdoor play area: Clean of debris and hazardous materials before children have access.	____a.m. playground checked ____p.m. playground checked	____a.m. playground checked ____p.m. playground checked	____a.m. playground checked ____p.m. playground checked	____a.m. playground checked ____p.m. playground checked	____a.m. playground Checked ____p.m. playground checked
Smoke detectors and CO Detectors: Check batteries monthly; replace every 6 months.					
Fire and Tornado Drills: Post procedures. Conduct drills monthly. **To be sent to Health & Safety.					

Provider Signature:_____
Date:_____
Approved by JCCDC Executive Board and Policy Council

Hand Washing

Regulation Reference:
(2016) 45 CFR 1302.47 (b-6,i)
(2001) Alabama DHR Minimum Standards D.2.b.(6-8); D.2.3.(a-e); D.3.c; D.3.3.(a-e); D.6.b.1.(a-f)

Policy:
Staff, Providers, and Volunteers will follow standard precautions, and will teach and assist children to wash their hands thoroughly and whenever necessary.

Procedure:
Adults and children will wash their hands thoroughly and frequently throughout the day. At a minimum, hand washing with liquid soap and running water is done by staff members and children at the following times:

- On arrival for the day.
- Before eating, feeding, or handling food.
- After toileting or diapering (wash the child's hands after the diaper is changed).
- After outdoor play.
- After handling pets or other animals.
- After coughing or sneezing into hands or into a tissue.
- Before and after giving medicine or medical procedures.
- Before and after giving first aid.
- Before and after caring for a sick child.
- After wiping noses, mouths, bottoms, or sores.
- After cleaning spills or other cleaning activities.
- After cleaning surfaces soiled with body fluids (blood, mucous, vomit).
- After taking off disposable gloves.
- Before and after sand and water play.

1. All JCCDC facilities and all Provider Homes have bathroom facilities for children, staff, Providers, and Assistants to wash their hands with soap and warm running water.
2. Providers demonstrate and assist children in thorough hand washing techniques. This includes washing the palms and back of the hands, between fingers, the wrists, and under fingernails.
3. Providers teach children to conserve water and paper towels, and to keep the area neat and clean by wiping soapsuds off the sink and handles.
4. If hand washing facilities are not available (e.g., field trips), pre-moistened towelettes/baby wipes are used. Upon return to the EHS-HS FCC Home, all children and adults will wash their hands with soap and warm running water.

Toileting and Diapering

Regulation Reference:
(2016) 45CFR 1302.47(b-6,i)
(2001) Alabama DHR Minimum Standards D.2.b.(1-13); D.2.e.3.(a-e); D.3.c; D.3.3.a-e; D.6.b.1.(a-f); D.6.2.(a-c); 4.E

Policy:
Providers and staff follow Standard Precautions to avoid direct contact with body fluids when assisting children with toileting and when diapering children.

When diapering an older child (e.g., child with disabilities), procedures are executed in a manner that provides the child with privacy and dignity. Toileting and diapering time is also used as an opportunity to teach children about hygiene and health.

Procedure:
Toileting

1. Providers supervise both boys and girls using the restroom. Providers must position themselves so they can see all children at all times.

2. Providers ensure that children flush toilets after each use.

3. Providers wash their hands after assisting the children with toileting. Providers also help children wash their hands thoroughly with soap and water after toileting.

4. Children do not sit on the floor in the bathroom.

5. The lights in the bathroom remain ON during program hours.

Toilet Training

When assisting a child with toileting (including potty chairs):

1. Wash hands with soap and water.

2. Put on disposable gloves.

3. Assemble all needed supplies within reach of toilet.

4. As necessary, assist child with removing clothing, and sitting on toilet or potty chair.

5. Stay with the child the entire time the child is toileting.

6. As necessary, assist child with wiping/cleansing.

7. As necessary, assist child with hand washing, while washing your own hands. Return child to childcare area.

Use of and Cleaning Potty Chairs

1. While wearing gloves, empty the potty-chair waste container into the toilet and wipe clean with tissue. If solid waste is present, add water for easy removal.

2. Sanitize the potty chair waste container with the bleach solution. Dry with a disposable cloth. Place waste container back into potty chair.

3. Dispose of gloves in waste container with lid.

4. Wash hand thoroughly with soap and running water.

Diapering

1. Disposable diapers will be used. Cloth diapers will be used only if the child is allergic to material in disposable diapers. Allergies must be confirmed with written documentation from the child's Physician.

2. Wash hands with soap and water. Put on disposable gloves.

3. Check child's diaper every 2 hours when awake or when the child awakens from nap.

4. Assemble all needed supplies within reach for diapering and out of reach of the child.

5. Place the child on the clean changing surface (pad) and secure the child so that he/she will not fall off the surface. Keep one hand on the child the entire time the child is on the changing table.

6. Remove clothing and soiled diaper, folding the soiled surface inward. If diaper pins are used, close them immediately and keep them out of the child's reach. Place the soiled diaper in a plastic bag.

7. Cleanse the child's skin with a disposable cloth, moving front to back. Remove all soil, checking skin creases and folds. Dry well. If prescribed by a physician, apply ointment or medication.

8. Put on a clean diaper.

9. Dispose of soiled diaper and clothing (see procedures below).

10. Remove gloves. Wash your hands and the child's hands. Return the child to the group area.

Disposal of Diapers

1. Dispose of soiled diapers in a waste container with a lid.

2. Soiled cloth diapers are emptied into the toilet and place the diaper into a plastic bag along with soiled clothes. Store in a labeled second plastic bag and return to parent at the end of the day.

3. Clean and sanitize the table top with bleach/water cleaning solution.

4. Remove disposable gloves. Wash hands with soap and running water.

Diapering Equipment and Supplies

1. **Changing surface**: Should be moisture-resistant and easily cleaned and sanitized (e.g., vinyl). Must be inaccessible to children. For extra protection, use disposable single service paper pads (e.g., paper towels or paper roll) between each changing.

2. **Hand washing**: Sink should be equipped with both hot and cold running water mixed through one faucet; hot water not to exceed 120 degrees F. Sink should within reach of the diapering surface, and have liquid soap and paper towels nearby. Use paper towels to dry hands and to turn off faucet.

3. **Diapers**: Clean diapers should be handled as little as possible, and stored in manner to prevent contamination from accidental contact with dirty diapers.

4. **Skin-care lotions**: Use only if written prescription from child's physician. Keep supplies nearby, but out of children's reach.

5. **Waste containers**: Use a tightly covered plastic container with a foot-operated lid. Line container with a disposable trash bag. Keep waste container away from children. Remove trash and soiled diapers daily.

6. **Potty Chairs**: Chair frames should be smoothed and easily cleaned; waste container should be removable. Sanitize the chair and frame after each use.

Naptime

Regulation Reference:
(2016) 45 CFR 1202.47(b-2)
(2001) Alabama DHR Minimum Standards C.4.i.7; C.8.c.(4-5); D.2.c.(1-6); D.2.d.(1-6); D.3.b.(1-4); D 2.c.(1-6)

Policy:

Each child will have a cot, liner, and top sheet labeled with his/her name. Providers will clean and disinfect each cot daily. Parents will wash their child's sheets weekly. All cots will be covered with a liner or sheet when in use.

Procedure:

Head Start

1. The Provider provides one cot for each child. The cot is labeled with the child's name.

2. The child's parent provides two sheets, labeled with the child's name. One sheet is used as a liner, and the second sheet is used as a cover.

3. At naptime, Providers place the cots for the children. Cots are place at least 3 feet apart to avoid spreading contagious illness and to allow for easy access to each child. Providers arrange cots so that all children can be observed at all times.

4. Children get the sheets from their cubbies. Providers assist children in placing them on the cot.

6. After naptime, Providers assist children in folding their sheets. Children store their sheets in the individual cubbies.

7. The Provider sends each child's sheets home to be washed every Friday. Parents wash the sheets and return them on Monday morning.

8. The Provider inspects all cots during the daily cleaning and disinfecting procedures and make or request any needed repairs. Providers are responsible for providing a clean, safe cot for each child.

9. NOTE: Providers should keep additional clean sheets or towels in their childcare area to use in case a child does not have his or her own sheet.

Early Head Start

3. Early Head Start provides a crib or cot for each child. The cribs and cots are labeled with each child's name.

4. Early Head Start parents provide sheets and blankets for all children twelve months and older. For infants under 12 months, clean bottom sheets are provided daily and as needed. Crib sheets must fit the mattress snugly.

5. Naptime for infants (12 months and under) varies until they develop a sleeping pattern of their own. Providers always place infants on their back in the crib.

6. Cribs must be free of soft materials and objects (e.g. blankets, pillows, comforters, stuffed animals, etc.)

7. Older toddlers get their sheets and blankets from their cubbies. Providers assist them in placing them on the cots.

8. Providers assure that for toddlers who walk, their shoes remain on their feet during naptime.

9. After naptime, infants are immediately changed and fed.

10. After naptime, the Provider assists older toddlers in folding their sheets and storing them in their cubbies.

11. Providers are responsible for providing clean and safe cribs/cots for infants and toddlers. The Provider inspects all cribs and cots during the daily cleaning and disinfecting procedure and make or request needed repairs.

12. Additional sheets, wash clothes, towels and blankets are kept in the Provider's home. JCCDC EHS-HS FCC also has extra supplies. Providers may complete a Health Supply Request form as needed.

Requesting Health Supplies

Regulation Reference:
(2001) Alabama DRH Minimum Standards D.7.b

Policy:
All health supplies will be distributed through the Health and Safety Coordinator.

Procedure:
1. When health or first aid supplies are needed, the Provider completes the Supply Request Form or emails a list of the needed supplies and submits it to the Health and Safety Coordinator.

2. The Health and Safety Coordinator reviews and signs the form, and prepared supplies for pick up or delivery via JCCDC staff.

3. The Provider signs Form given with supplies and gives/sends it back to the Health and Safety Coordinator

4. The Health and Safety Coordinator maintains a file of completed forms.

JCCDC EHS-HS FCC
Supply Request Form

Please check: ____ Early Head Start ___ Head Start

Please check the appropriate component:
____ Health ____ Disability ____ Education

Provider: _____ Date: _____

Material Requested	Planned Activity/Reason	Date Of Activity

Is this a request for a specific child: ____ Yes ____ No

Child's Name:
Purpose:

Provider Signature: _____

All requests must be submitted and approved by the Health & Safety Coordinator or Administrative Staf

**** For Office Staff ****

Date received: _____ **Approved: Yes No**

JCCDC Health & Safety Coordinator: _____

or

JCCDC Administrative Staff: _____

Report of Allergies & Health Concerns

Regulation Reference:
(2016) 45 CFR 1302.47(b-7,vi)
(2001) Alabama DHR Minimum Standards D.3.h

Policy:
Health Care Plans of children affected by allergies or other health concerns will be given to Providers and appropriate Specialists.

Procedure:

1. If a parent informs a staff member that his or her child has a particular allergy or other health problem(s), the staff member requests that the parent provide official documentation from the child's physician. This documentation must be submitted to the Health and Safety Coordinator for input, in the child's official file, and in the child's Provider Home file.

2. Any staff member receiving such documentation forwards it to the family PFCE staff.

3. If children develop such problems after enrollment, the information must be documented on the respective form, a copy is maintained in the office file, and a copy is sent to the Provider.

4. When children leave or transfer from one Provider to another Provider, all health records are given to the new Provider.

JCCDC EHS-HS FCC
Asthma Health Care Plan

Child's name: _____ DOB:_____

Parent's/Guardian's Name:_____

Emergency phone numbers: Mother: _____ Father: _____

Primary health provider's name: _____ Phone: _____

Asthma Specialist's name: _____Phone: _____

:

Medication	Dosage

Note: Parent must sign authorization for administering medication/medical procedures.

Specific concerns: _____

_____

_____

Known triggers for this child's asthma (*Please circle all that apply*):

Colds	Tree pollen	Exercise	Mold	Flowers
House dust	Strong odors	Grass	Smoke	Animals
Room deodorizers	Weather changes	Excitement		

Foods (specify): _____

Other (specify): _____

Has the child needed special attention in the past for any of the following situations (Please circle all that apply)?

Field trip to see animals	Art projects with chalk, glues or fumes	Sitting on carpet
Running hard	Pesticides in facility	Gardening
Jumping in leaves	Painting or renovations in facility	
Cold or windy days	Freshly cut grass	

Other (specify): _____

Asthma Health Care Plan - Page 2

How often has this child needed urgent care from a doctor for an attack of asthma?

In the past 12 months? _____ In the past 3 months? _____

Typical signs and symptoms of the child's asthma attack *(Please circle all that apply)*:

Fatigue	Face red, pale or swollen	Grunting
Breathing faster	Wheezing	Sucking in chest/neck
Restlessness, agitation	Dark circles under eyes	Persistent coughing
Chest pain/tightness	Gray or blue lips or fingernails	
Flaring nostrils, mouth open (panting)	Difficulty playing, eating, drinking, and talking	

EMERGENCY REMINDERS, IF THERE IS AN ATTACK:

1. Notify parents immediately if emergency medication or medical attention is required.

2. **Get emergency medical help by calling 911, if:**

____the child **does not** improve 15 minutes after treatment and family cannot be reached.

____after receiving a treatment for wheezing, the child…. *(Please circle all that apply)*:

is working hard	won't play
is breathing fast at rest (>50/min)	has gray or blue lips or fingernails
has trouble walking or talking	cries more softly and briefly
has nostrils open wider than usual	is hunched over to breathe
has chest or neck sucked in with breathing	is extremely agitated or sleepy

Comments: _____

_____

_____

_____ _____

Parent's Signature Date

_____ _____

Interviewer's Signature Date

JCCDC EHS-HS FCC
Health Care Plan

Child's name: _____DOB:_____

Parent's/Guardian's name: _____

Emergency phone numbers: Mother: _____ Father: _____

Primary health provider's name: _____ Phone: _____

Medical Condition/Diagnosis: _____

Specific Health/Emergency Concerns	Specific Actions

:

:

Medication	Dosage

Note: Parent must sign authorization for administering medication/medical procedures.

List any allergies child has: _____

_____

IF CONDITION IS SEVERE, CALL 911

Is permission given to post this plan in childcare if appropriate? Yes No

Parent comments: _____

Parent signature: _____Date:_____

Interviewer signature: _____ Date: _____

JCCDC EHS-HS FCC
Tooth Brushing Procedures

CHILD HEALTH RECORD: **FORM 5, DENTAL HEALTH**

(COMPLETE AT INTERVIEW)

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

HEAD START CENTER:_____ PHONE:_____

ADDRESS:_____

1. IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride*
   - Topical Fluoride Application? No____Unknown____Yes____
   - Fluoridated water? No____Unknown____Yes____
   - Fluoride Supplement diet? (tablets____, liquid____) No____Unknown____Yes____

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?

PART I. TO BE COMPLETED BY HEAD START STAFF

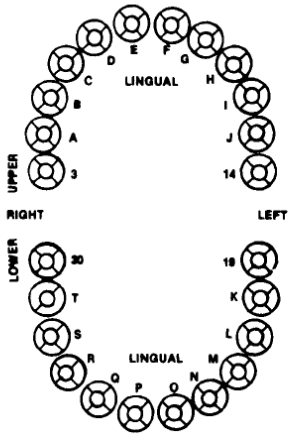
3. CHILD (___HAS, ___HAS NOT) PREVIOUSLY SEEN A DENTIST. Dentist's name_____Date last visit_____
4. CHILD (___IS, ___IS NOT) UNDER A PHYSICIAN'S CARE. Physician's name_____
5. CHILD (___IS, ___IS NOT) RECEIVING MEDICATION. Type_____
6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

	YES	NO		YES	NO
Allergies	___	___	Liver Dis.	___	___
Asthma	___	___	Rheumatic Fever	___	___
Bleeding	___	___	Sickle Cell Dis.	___	___
Diabetes	___	___	Other (List Below)	___	___
Epilepsy	___	___	_____		
Heart/Vascular Dis.	___	___	_____		

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT/Medicaid
   - ☐ Federal, State, or local Agency _____
   - ☐ Head Start
   - ☐ In-kind Provider_____
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party)_____
8. PRIORITY GROUP
   - ☐ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

9. ORAL CONDITIONS BEFORE TREATMENT: *missing (⊗), decayed (▨), or filled (■); indicate restorations you perform in Item 10.*



10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed MO.	DAY	YR.	A.D.A. Procedure Number	Actual Charges (Fee)	

11. DENTAL NEEDS *(Check one or more and return 3 copies to Head Start after first visit).*
   - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☐ B. CLEANING
   - ☐ C. FLUORIDE
   - ☐ D. OTHER
   - ☐ E. NO PROBLEMS

Approximate number of visits_____. Approximate cost_____.

12. CHILD ORAL HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
All planned treatment (___Is, ___Is not) complete. If not, explain here, as well as items checked.

_____

_____

- ☐ a. Routine recall visits
- ☐ b. Special home emphasis, oral hygiene
- ☐ c. Dietary problem(s)
- ☐ d. Developmental problem(s)
- ☐ e. Harmful oral habits
- ☐ f. Needs fluoride supplement

I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.

Signature_____ Date_____

INTERVIEWER: GO TO FORM 6

1. Tooth care and oral hygiene is an important part of children's health. All EHS-HS FCC Homes are located in areas which have fluoridated water supplies.
2. Each Provider is supplied with toothbrushes (one per child, labeled with child's name), toothbrush covers (one per child, labeled with child's name), toothbrush holder, toothpaste, and disposable cups. Toothbrushes and covers are issued to the Provider at least twice per year and/or upon request.
3. Tooth brushing is part of the daily child care experience. All children brush their teeth at least once a day in the Provider Home. The Provider or Assistant supervises and/or assists children with this activity.
4. The Provider assists children by "smear" (less than pea-sized) amount of fluoridated toothpaste on the toothbrush. To prevent contamination, each child is assigned a different toothbrush and his/her own toothpaste.
5. Children are taught to brush using a circular motion to the front and back of teeth. After brushing teeth, children brush their tongues and spit into the toilet/sink.
6. Providers also brush their teeth to model good oral hygiene.
7. The Provider assures sanitation by:
    - Helping children rinse the toothbrush under warm running water.
    - Storing toothbrushes in the holder to allow to air dry.
    - Toothbrushes are stored with the brush head up, and not touching another toothbrush.
    - Toothbrush covers and holders are sanitized in warm chlorine-water and air-dried weekly. Washing in a dishwasher is <u>not</u> recommended; high drying temperatures may warp the materials.

Vision Screening and Referral

Regulation Reference:
(2016) 45 CFR 1302.41; 1202.42 (b-2)(d,1-2)

Policy:
All children enrolled in Head Start will be screened for vision and eye disorders. The first screening will be part of the child's physical or the agency's screening and will be completed within 45 calendar days of enrollment. All children enrolled in Early Head Start will be screened for vision and eye disorders. The first screening is part of the child's EPSDT (Early Periodic Screening Diagnosis Treatment) completed within 45 days. Children who fail the screening will be referred for a full eye examination.

Procedure:
Screening:

For Head Start children, vision screening is part of the annual Mass Screening. Children who do not participate in the Mass Screening (e.g., children who enroll after this date), will receive screening procedures on an individual basis.

For Early Head Start infants and toddlers, vision screening is part of the child's EPSDT.

In addition, Providers will observe infants for any indication of possible vision problems. For example:

- Holding the child, place the child on his/her back and put your face 12 inches above the child's face. The child actually looks at you.
- Place a toy that the child seems to enjoy on the table a little out of reach. The child tries to get the toy by reaching or stretching his/her arm or body toward the toy.
- The child reaches toward or moves toward an object he/she desires to play with.

Referrals:

1. After the examination, children in need of more extensive examination and/or glasses are referred directly to the appropriate community health agency. The parents must take the child to this.
2. Results of the referral examination are returned to the Health & Safety Coordinator with findings and recommendations for each child. The findings are shared with the designated PFCE Specialist.
3. If glasses are prescribed for the child, they may be purchased with the child's medical insurance.

Hearing Screening and Referral

Regulation Reference:
(2016) 45 CFR 1202.42(b-2)(d,1-2)

Policy:
All children enrolled in Head Start will be screened for hearing. The screening will be part of the child's physical or the agency's Mass Screening and will be completed within 45 calendar days of enrollment. All children enrolled in Early Head Start will be screened for hearing. The first screening is part of the child's EPSDT (Early Periodic Screening Diagnosis Treatment) completed within 45 days.

Procedure:
Screening:

1. For Head Start children, hearing screening is part of the annual Mass Screening. Children who do not participate in the Mass Screening (e.g., children who enroll after this date), will receive screening procedures on an individual basis.
    - Hearing is assessed in children 3 years and older using the audiometer (depending on the child's understanding and cooperativeness). If unable to test using the audiometer, hearing is assessed as described for younger children (see below).
    - If the enrolled child wears a hearing aid, the PFCE staff first obtain a release of information from the parent, then request the child's doctor to send a report to the Health & Safety Coordinator. This report includes information regarding the extent of hearing loss. The hearing aid is noted in the child's health history and the DSS is called to discuss the child's hearing deficit with the parent. Information about maintenance and use of the hearing aid is also noted. The Health & Safety Coordinator flags the child's Provider Home file to indicate to the Provider that there are special health concerns.
2. For Early Head Start infants and toddlers, hearing screening is part of the child's EPSDT. Providers will observe infants for any indication of possible hearing problems. For example:

    Voice - With the child not facing you, stand behind the child 6-8 inches of either ear, place your hand between you and the child so the infant/child does not respond to feeling your breath; whisper the child's name. Repeat with the other ear. (Hearing is normal if the child turns to the direction of the voice for each ear).
    - Bell and rattle - Hold the bell/rattle to the side and behind the child's ear, ring the bell/shake the rattle softly. **Try again.** If no response, repeat with the other ear. Hearing is normal if the child responds by an eye movement, change in expression, breathing rate or activity.

Referrals:

4. After the examination, children failing the hearing screening are given a second screening prior to referral for a follow-up assessment. Once the child's possible hearing problem is identified, the Health & Safety Coordinator schedules an appointment with a community partner (usually the Sparks Clinic), or the parent can choose to schedule an appointment with their own ENT doctor.
5. The Health & Safety Coordinator notifies parents and provides specific instructions for taking their child for the appointment. The parents must attend this appointment with his/her child.
6. Results of the referral examination are recorded by the Sparks Clinic or the child's doctor and returned to the Health & Safety Coordinator with findings and recommendations for each child. The Health & Safety Coordinator forwards this information to the Data Entry Specialist. If hearing aids are prescribed for the child, they may be purchased with the child's Medicaid or other medical insurance. If the child has no medical coverage, the Health and PFCE staff assist the family in obtaining hearing aids or hearing related services.