Public Health
Seattle & King County

Early Learning Program Health Policy

(For programs caring for infants)

Child Care Center Name: Imagination Station LLC

Director: Sheri Absher

Hours of operation: Monday -Friday 6am to 6pm

Ages served: 4 weeks to 9 years old

Address: 39184 SE Epsilon Street
Snoqualmie, WA 98065

Cross Street: Schusman Ave SE

Telephone: 425-831-1916
Email: sheri@imaginationstation.care
Website: Imaginationstation.care

Emergency telephone numbers:

	Phone
Fire/Police/Ambulance	**911**
Poison Center	**1-800-222-1222**
C.P.S.	**1-800-609-8764**
Animal Control	**206-296-7387**
DCYF	**1-866-482-4325**

Other important telephone numbers:	Contact	Phone
Public Health – Seattle & King County Child Care Health Program (To consult with a Registered Dietitian, Public Health Nurse, Community Health Professional, or Mental Health Consultant)	CCHP.Support@kingcounty.gov	(206) 263-8262
Infant Nurse/Registered Nurse Consultant	Caitlin Young, BSN, RN	425-888-3347
DCYF Licensor	Carol Artz	425-677-0409
Communicable Disease/Immunization Hotline (Recorded Information)		(206) 296-4949
Communicable Disease Report Line		(206) 296-4774
Out-of-Area Emergency Contact	Hannah Absher	360-348-8624

PURPOSE AND USE OF HEALTH POLICY

This health policy is a description of **our** early learning program's health and safety practices.

Our policy was prepared by Sheri Absher, Executive Director

Staff will be oriented to our health policy by Kaitlyn Absher, Director upon hiring and whenever there are changes to policies and procedures.

Our policy is accessible to staff and parents and is located in each classroom and at the sign-in desk.

This health policy does not replace these additional policies required by WAC:

- Pesticide Policy
- Blood borne Pathogen Policy
- Behavior Policy
- Disaster Policy
- Animal Policy and/or Fish Policy (if applicable)

Information on accessing relevant materials or resources is noted in text boxes throughout the document.

CLEANING, SANITIZING, DISINFECTING AND LAUNDERING

Cleaning, rinsing, and sanitizing/disinfecting are required on most surfaces in child care facilities. This includes tables, counters, toys, diaper changing areas, etc. This 3-Step Method helps maintain a more sanitary child care environment and healthier children and staff.

Definitions:

- **Sanitizers** are used to reduce germs from surfaces, but not totally get rid of them. Sanitizers reduce the germs from surfaces to levels that are considered safe.

- **Disinfectants** are chemical products that destroy or inactivate germs and prevent them from growing. Disinfectants are regulated by the U.S. Environmental Protection Agency (EPA).

Rationale:

1. **Cleaning** removes a large portion of germs, along with organic materials - food, saliva, dirt, etc. – this removal increases the effectiveness of the sanitizing/disinfecting.
2. **Rinsing** further removes the above, along with any excess detergent/soap.
3. **Sanitizing or Disinfecting** kills the vast majority of remaining germs.

3-Step Method

1. **Clean** – Spray with a dilution of a few drops of liquid dish detergent and water, then wipe surface with a paper towel.
2. **Rinse** – Spray with clear water and wipe with a paper towel.
3. **Sanitize or Disinfect** – Spray with proper dilution of bleach and water (see Method for Mixing Bleach table below), leave on surface for a minimum of 2-minutes, then wipe with a paper towel.

Storage

Our cleaning and sanitizing supplies are stored in a safe manner in the Laundry Room. All such chemicals are:

- Inaccessible to children;
- In their original container;
- Separate from food and food areas (not above food areas);
- Kept apart from other incompatible chemicals (for example, bleach and ammonia create a toxic gas when mixed); **and**
- In a secured cabinet, to avoid a potential chemical spill in an earthquake. The preferred place to store bleach solutions is in a laundry or utility room. If not available, solutions may be stored in a lower cabinet that is locked to prevent exposure to a spill.

Method for Mixing Bleach

(Adapted from WA DOH Guidelines for Mixing Bleach Solutions, 9/2015)

Sanitizing using bleach concentrations of sodium hypochlorite 2.75 – 8.3%

Solution for **sanitizing** on Food Surfaces, in Kitchen and Classrooms	Amount of Bleach	Amount of Water	Contact time
7.25-8.3%	**¼ teaspoon**	1 quart	2 minutes
	1 teaspoon	1 gallon	2 minutes
5.25-6.25%	**½ teaspoon**	1 quart	2 minutes
	2 teaspoons	1 gallon	2 minutes
2.75%	**1 teaspoon**	1 quart	2 minutes
	1 tablespoon	1 gallon	2 minutes

Disinfecting using bleach concentrations of sodium hypochlorite 2.75 – 8.3%

Solution for **disinfecting** for Body Fluids, Bathrooms and Diapering	Amount of Bleach	Amount of Water	Contact time
7.25-8.3%	**1½ teaspoons**	1 quart	2 minutes
	2 tablespoons	1 gallon	2 minutes
5.25-6.25%	**2¼ teaspoons**	1 quart	2 minutes
	3 tablespoons	1 gallon	2 minutes
2.75%	**1½ tablespoons**	1 quart	2 minutes
	⅓ cup *plus* 1 tablespoon	1 gallon	2 minutes

Note: Use only plain, unscented bleach. Please ensure that the concentration of bleach matches labels on classroom spray bottles.

Bleach Preparation

- Bleach solutions are prepared using the correct proportions on the "Method for Mixing Bleach" table (see table on previous page).

- To avoid cross-contamination, two sets of spray bottles are used: one set for disinfecting bottles and one set for sanitizing bottles.

- Bleach solutions are prepared in the laundry room. The preferred place to prepare bleach solutions is in a laundry or utility room. If not available, solutions may be prepared in a bathroom or kitchen.

- **It is best practice to mix the bleach in a gallon-sized container then fill classroom spray bottles from the bleach solution in gallon-sized container.**

- Bleach solutions are made up daily by Andrea Fredell, School Age lead or Camise Gohlke, cook, using protective equipment. It is required by Labor and Industries that workers have an emergency eye wash station and wear personal protective equipment. This includes safety goggles, rubber gloves, and an apron. Using correct measuring tools is required. *It is recommended that two people are designated to mix bleach at the center. This creates consistency in the process and reduces employee exposure to undiluted bleach.*

For more information, refer to "Bleach Solution Preparation Procedure" and the "3-Step Cleaning Method" poster, which are both available on the Child Care Health Program (CCHP) website.

Cleaning, Sanitizing & Disinfecting Specific Areas and Items

Bathrooms

- Sinks, counters, and floors are cleaned, rinsed, and disinfected daily or more often if necessary.
- Toilets are cleaned, rinsed, and disinfected daily or more often if necessary. Toilet seats are kept sanitary throughout the day and cleaned immediately if visibly soiled.

Cots and mats

- Cots and mats are washed, rinsed, and sanitized weekly, before use by a different child, after a child has been ill, **and** as needed.

Door handles

- Door handles are cleaned, rinsed, and disinfected daily, or more often when children or staff members are ill.

Drinking Fountains

- Drinking fountains are cleaned, rinsed, and disinfected daily or as needed.

Floors

- Solid-surface floors are swept, washed, rinsed, and sanitized daily.
- Carpets and rugs in all areas are vacuumed daily and cleaned using a carpet shampoo machine or steam cleaner every six months or as necessary. Carpets are not vacuumed when children are present *(due to noise and dust).*
- If caring for infants, large rugs and/or carpets are cleaned using a carpet shampoo machine or steam-cleaned at least once per month or more often if visible stains are present.
- Carpets or area rugs soiled with bodily fluids must be cleaned and disinfected with high heat or an EPA registered product. An early learning provider must limit exposure to blood and body fluids during cleanup.

Furniture

- Upholstered furniture is vacuumed daily and cleaned using a carpet shampoo machine or steam cleaner twice a year or as necessary.
- Painted furniture is kept free of paint chips. No bare wood is exposed; paint is touched up as necessary. *(Bare wood cannot be adequately cleaned and* sanitized*.)*

Garbage

- Garbage cans are lined with disposable bags and are emptied daily or when full.
- Outside surfaces of garbage cans are cleaned, rinsed, and disinfected daily. Inside surfaces of garbage cans are cleaned, rinsed, and disinfected as needed.
- Food-waste cans must have tight-fitting lids and be hands-free. Garbage cans for paper towels must be hands-free.

Kitchen

- Kitchen counters and sinks are cleaned, rinsed, and sanitized daily.
- Food preparation surfaces are cleaned, rinsed, and sanitized before and after each use.
- Equipment (such as blenders, can openers, and cutting boards) is washed, rinsed, and sanitized after each use. No wooden cutting boards are used.
- Refrigerators and freezers are cleaned, rinsed, and sanitized monthly or as needed.
- Kitchen floors are swept, washed, rinsed, and sanitized daily.

Laundry

- Cloths used for cleaning or rinsing are laundered after <u>each</u> use.

- Child care laundry is done on site or by a commercial service (it is not washed in a private home).
- Laundry is washed above 140^0F (60^0C) to heat needed to sanitize items. If the hot water tank is set to 120^0F (48.9^0C), then you must use bleach to sanitize laundry according to equipment manufacturer's instructions.

Tables and high chairs

- Tables are cleaned, rinsed, and sanitized before and after snacks or meals.

Mops

- Mops are cleaned, rinsed, and disinfected in a utility sink, then air dried in an area with ventilation to the outside and inaccessible to children.

Toys

- Only washable toys are used.
- Cloth toys and dress-up clothes are laundered weekly and as necessary.
- Pre-school and school-aged toys are washed, rinsed, and sanitized weekly and as necessary.
- Infant and toddler toys are washed, rinsed, and sanitized daily and as necessary.

Sensory Play Tables

- Children wash hands before and after sensory table play.
- Children with open cuts or sores on their hands should not use sensory tables.

Water Tables

- Water tables are not used during an illness outbreak.
- Children with open cuts or sores on their hands should not use water tables.
- Water play tables, water toys, and equipment are cleaned and disinfected before a new group begins water play or at the end of the day.

❖ **General cleaning of the entire facility is done as needed.**

❖ **There are no strong odors of cleaning products in our facility.**

❖ **Air fresheners and room deodorizers are not used.**

A cleaning schedule and a handout for cleaning toys can be found on the CCHP website.

HAND HYGEINE

Liquid soap, warm running water (120ºF (48.9^{0}C), or below), and paper towels or single-use cloth towels are available for staff and children at sinks, at all times.

All **staff** wash hands with soap and running water at the following times/circumstances:

a. Upon arrival at the site and when leaving at the end of the day
b. Before and after handling foods, cooking activities, eating, or serving food
c. Before preparing bottles
d. After toileting self or children
e. Before, during (with wet wipe - this step only), and after diaper changing
f. After handling or coming in contact with body fluids such as mucus, blood, saliva, or urine
g. After giving first aid
h. Before and after giving medication, or applying topical ointments or creams
i. After attending to an ill child
j. After smoking or vaping
k. After being outdoors and/or gardening activities
l. After handling or feeding animals, handling an animal's toys or equipment, or cleaning up after animals
m. After handling garbage and garbage receptacles
n. As needed or required by circumstances

Children are assisted or supervised in handwashing at the following times/ circumstances:

a. Upon arrival at the site and when leaving at the end of the day
b. Before and after meals and snacks or food activities, including setting the table (in handwashing, not in food prep sink)
c. After toileting or diapering
d. After handling or coming in contact with body fluids such as mucus, blood, saliva, or urine
e. After outdoor play or gardening activities
f. After touching animals and handling their toys or equipment
g. Before and after water table or sensory play
h. As needed or required by circumstances

Hand Sanitizers may be used by adults and children over 24 months of age with proper supervision only when handwashing facilities are not available and hands are not visibly soiled. An alcohol-based hand sanitizer must contain 60 to 90% alcohol to be effective.

Hand sanitizers may not be used in place of proper handwashing, as required above.

Handwashing Procedure

The following handwashing procedure is followed:

1. Turn on water and adjust temperature.
2. Wet hands and apply a liberal amount of liquid soap.
3. Rub hands in a wringing motion from wrists to fingertips for at least 20 seconds.
4. Rinse hands thoroughly.
5. Dry hands using an individual paper towel, a single-use cloth towel, or a hand dryer.
6. Use hand-drying towel to turn off water faucet(s) (unless the faucet turns off automatically) and open any doorknob/latch before properly discarding.
7. Staff can apply lotion, if desired, to protect the integrity of skin.

Handwashing procedures are posted at each sink used for handwashing.

POLICY AND PROCEDURE FOR EXCLUDING ILL CHILDREN

All children are observed for signs of illness when they arrive at the early learning program and throughout the day.

Children with any of the following symptoms are not permitted to remain in care:

- **Fever:** A fever is defined by the American Academy of Pediatrics as 100.4˚F (38˚C) or above. Methods for taking a temperature include using a digital forehead scan thermometer (temporal scan) or digital thermometer placed under the arm (axillary method).
    - Children older than 2 months with a fever **accompanied by** one or more of the following:
        - Diarrhea or vomiting
        - Earache
        - Headache
        - Signs of irritability or confusion
        - Sore throat
        - Rash
        - Fatigue, crankiness, or illness that limits participation in daily activities.
    - Children 2 months or younger with a fever of 100.4ºF (38ºC) or above should be seen by their health care provider before returning to care, regardless of accompanying symptoms.

  No rectal or ear temperatures are taken. Oral temperatures may be taken for preschool through school age children if single use covers are used over the thermometer. Glass thermometers contain mercury, a toxic substance, and are therefore not to be used.

- **Vomiting:** 2 or more occasions within the past 24 hours

- **Diarrhea:** 2 or more loose or watery stools more than normal for the child in a 24 hour period; or any blood or mucus in stool

- **Rash:** Body rash (not related to allergic reaction, diapering, or heat)

- **Open or oozing sores** (unless properly covered with a waterproof dressing **and** 24 hours has passed since starting antibiotic treatment if antibiotic treatment is necessary) or mouth sores with drooling.

- **Lice:** Children can remain in care until the end of the day head lice are found. Children may return after they have received their first treatment. Parents should consult with a child's health care provider for the best treatment plan for the child. The life cycle of a louse is about 25 to 30 days, so sometimes treatments need to be repeated 7 to 12 days after the first treatment to kill newly hatching lice.

- **Scabies or ringworm:** Children can remain in care until the end of the day scabies or ringworm are found. A child with scabies may return after he/she has received his/her first treatment. Children should see their health care provider to be assessed and get an appropriate prescription for treatment and instructions on its proper use.

- **Sick appearance, not feeling well, and/or not able to keep up with program activities.**

Children with any of the above symptoms/conditions are separated from the group and cared for in the office. Parent/guardian or emergency contact is notified to pick up child.

Following exclusion, children are readmitted to the program when they no longer have any of the above symptoms and/or Public Health exclusion guidelines for child care are met.

We notify parents and guardians when their children may have been exposed to a communicable disease or condition (other than the common cold) and provide them with information about that disease or condition. We notify parents and guardians of possible exposure by posting a letter and sending out an email

We follow the WA DOH Guidance to Prevent and Respond to COVID-19 in K-12 Schools and Child Cares (wa.gov) for COVID-19 specific guidance and recommendations.

Communicable Disease Fact Sheets are available on the CCHP website

When a child has illness symptoms or a condition, individual confidentiality is maintained, as not to single out children and/or families.

In order to keep track of contagious illnesses (other than the common cold), an Illness Log is kept. Each entry includes the child's name, classroom, and type of illness. We maintain confidentiality of this log.

An "Illness Log" template is available on the CCHP website.

Staff members follow the same exclusion criteria as children.

IMMUNIZATIONS

To protect all children and staff, children attending child care are required to be vaccinated or show proof of acquired immunity against the following vaccine-preventable diseases:

- Diphtheria, Tetanus, Pertussis (DTaP/DT)
- Polio (IPV)
- Measles, Mumps, Rubella (MMR)
- Hepatitis B
- *Haemophilus influenzae* type b (Hib) *until age 5*
- Varicella (Chicken Pox)
- Pneumococcal bacteria (PCV) *until age 5*

Immunization records are reviewed and updated monthly by Kaitlyn Absher, Director to ensure all children and staff are up to date on all eligible immunizations.

Documentation and Reporting

As of August 1st, 2020, each child enrolled in our program is required to have medically verified documentation of immunizations **before** attending. Any one of the following is an accepted form of documentation:

- A Certificate of Immunization Status (CIS) printed from the Immunization Information System (IIS)
- A physical copy of the CIS form with a healthcare provider signature
- A physical copy of the CIS filled out and signed by the parent and verified and signed by child care or early learning program administrator. For this option, the CIS needs to have medical immunization records from a healthcare provider attached
- A CIS printed from MyIR (families can create an account on MyIR and print this form themselves)

CIS forms are available on the WA DOH website

A new CIS form is required each year to re-certify the child's immunization records. When a child disenrolls or transfers from our program, we return the original CIS or Certification of Exemption (COE) or a legible copy of the document to the parent/guardian. **We cannot withhold this documentation for any reason.**

- All employees and volunteers at the program are required to provide an immunization record indicating that they have received the MMR vaccine or proof of immunity. (See **STAFF HEALTH** section for more information on staff requirements.)
- We submit an immunization status report to DOH by November 1st of each year (or 30 days after the first day of school if a program starts after October 1st).

Requirements for Attending Early Learning and Child Care Programs

A child may begin child care **only if***:

- They get all the required vaccine doses they are eligible to receive, AND
- The parent/guardian has submitted medically verified immunization records (see above) **on or before the first day** of attendance. **Children without immunization paperwork should not start child care until the paperwork is turned in**.

***Foster Care or Homelessness Exception:**
A child in foster care or who is identified as experiencing homelessness and is lacking medically verified immunization records MUST be enrolled immediately and allowed to participate in all program activities. The child's family, caseworker, or health care provider must, however, offer written proof that they are in the process of obtaining the child's immunization records.

Attending While in Conditional Status:
Children may attend child care while in **conditional status** if/when:

- They have received all vaccine doses they are eligible to receive **before** starting child care, however they need additional doses to complete the series.
- The parent/guardian must sign the Conditional Status statement on the CIS form.
- Children may remain in care while waiting until the next dose becomes due, *plus* 30 calendar days for the parent/guardian to turn in medically verified, updated records showing they received the missing dose(s).
- **If the 30 days expire without updated records, the child must be excluded from further attendance.**

For examples and more information, reference:
Frequently Asked Questions About Conditional Immunization Status (wa.gov)

Exemptions (please choose one below)

☐ We have a written policy stating we **do not** accept children into our child care program who are exempted from immunization, **unless it is due to** a health condition protected by the ADA or WLAD and we have a completed COE signed by a licensed medical professional on file. (WAC 110-300-0210 (8))

- The child's health care provider must sign the COE form for a medical exemption.

☒ We accept children into care who may have an exemption from immunization. If a parent/guardian chooses to exempt their child from immunization requirements, they must complete and sign the COE form, which accompanies the CIS form.

- The child's health care provider must also sign the COE form for a medical, religious belief, or personal/philosophical exemption.
- A health care provider's signature is not required for a "religious membership" exemption.

- **As of July, 2019 personal and philosophic exemptions for the MMR vaccine are not permitted, per WA state law.** Only medical and religious exemptions for MMR are allowed.

A current list of exempted children is maintained **at all times.**

Children who are not fully immunized may also be excluded from care during an outbreak of a vaccine-preventable disease if they have any type of immunization exemption for the disease or do not have vaccine documents. This is for the protection of the unimmunized child and to reduce the spread of the disease. This determination will be made by Public Health's Communicable Disease and Epidemiology division.

More immunization information is available on the WA DOH website

STAFF HEALTH

- Our early learning program complies with all recommendations from the local health jurisdiction.

- Staff members who have a communicable disease are expected to remain at home until no longer contagious. Staff are required to follow the same guidelines outlined in EXCLUSION OF ILL CHILDREN in this policy.

- Staff members are encouraged to consult with their health care provider regarding their susceptibility to vaccine-preventable diseases.

- **Staff who are pregnant or considering pregnancy are encouraged to inform their health care provider that they work with young children. When working in child care settings, there is a risk of acquiring infections which can harm a fetus or newborn.** These infections include Chicken Pox (Varicella), CMV (cytomegalovirus), Fifth Disease (Erythema Infectiosum), and Rubella (German measles or 3-day measles). In addition to the infections listed here, other common infections such as influenza and Hand Foot and Mouth disease can be more serious for pregnant women and newborns. Good handwashing, avoiding contact with ill children and adults, and cleaning of contaminated surfaces can help reduce those risks.

Adult immunization recommendations are available at: http://www.doh.wa.gov/YouandYourFamily/Immunization

Tuberculosis (TB) testing requirements

There are two types of FDA-approved tuberculosis (TB) tests available in Washington State; the tuberculin skin test and a type of blood test known as an Interferon Gamma Release Assay (IGRA).

Prior to working onsite at the child care program, new staff, volunteers, or family home members over 14 years must have documentation of a TB test or treatment signed by a health care professional within the last 12 months (unless not recommended by a licensed health care provider). This documentation must consist of either:

a. A negative TB symptom screen and negative TB risk assessment;
b. A previous positive TB test, a current negative (normal) chest x-ray, and documentation of clearance to safely work or reside in an early learning program; or
c. A positive symptom screening or a positive risk assessment with documentation of:
    (i) a current negative TB test; or a
    (ii) positive (previous or current) TB test and a current negative (normal) chest x-ray and documentation of clearance to safely work or reside in an early learning program.

Staff members do not need to be retested for TB unless they have been notified of a TB exposure by the local health jurisdiction.

For more information from DOH regarding TB testing for employees in Washington State see: https://doh.wa.gov/you-and-your-family/illness-and-disease-z/tuberculosis-tb/clients-and-public/where-do-i-get-tb-test

Measles, Mumps, and Rubella (MMR) requirements

All licensed child care center staff and volunteers must provide either:

a. An immunization record showing they have received at least one dose of MMR vaccination.

b. Proof of immunity to measles disease (also known as a blood test or titer).

c. Documentation from a health care provider that the person has had measles disease sufficient to provide immunity against measles; or

d. Written certification signed by a licensed health care practitioner that the MMR vaccine is, in the practitioner's judgment, not advisable for the person.

A personal/philosophical or religious exemption for MMR is no longer allowed for child care staff.

Staff Safety

- Adult-sized chairs will be provided for staff.
- Staff will not step over gates or other barriers.

NOTIFIABLE CONDITIONS AND COMMUNICABLE DISEASE REPORTING

Licensed child care providers in Washington are required to notify their DCYF licensor, parents or guardians of the enrolled children, and public health authorities at their local health jurisdiction, within 24 hours, when they learn that a child, staff member, volunteer, or household member is suspected or confirmed to have certain contagious conditions or diseases. **These are referred to as 'Notifiable Conditions', and are listed below:**

Immediately notifiable conditions in **bold** should be reported when suspected or confirmed

- Acquired immunodeficiency syndrome (AIDS) (including AIDS in persons previously reported with HIV infection)
- **Animal bites (when human exposure to rabies is suspected)**
- **Anthrax**
- Arboviral disease (West Nile virus disease, dengue, Eastern and Western equine encephalitis, St Louis encephalitis, and Powassan)
- **Botulism (foodborne, wound and infant)**
- Brucellosis (Brucella species)
- ***Burkholdier mallei* (Glanders) and *pseudomallei* (Melioidosis)**
- Campylobacteriosis
- Chancroid
- Chlamydia trachomatis infection
- **Cholera**
- **Coronavirus (MERS-CoV, SARS, Other Novel Coronavirus)**
- Cryptosporidiosis
- Cyclosporiasis
- **Diphtheria**
- **Disease of suspected bioterrorism origin**
- **Domoic acid poisoning**
- ***E. coli* - Refer to "Shiga toxin producing *E. coli*"**
- **Emerging condition with outbreak potential**
- Giardiasis
- Gonorrhea
- Granuloma inguinale
- ***Haemophilus influenzae* (invasive disease, children < age 5)**
- Hantavirus pulmonary syndrome
- Hepatitis A, acute infection
- Hepatitis B, acute
- Hepatitis B, chronic (initial diagnosis/previously unreported cases)
- Hepatitis B, surface antigen positive pregnant women
- Hepatitis C, acute^{3d} and chronic^{Mo} (initial diagnosis only)
- Hepatitis D (acute and chronic infections)
- Hepatitis E (acute infection)
- Herpes simplex, neonatal and genital (initial infection only)
- HIV infection
- Immunization reactions (severe, adverse)
- **Influenza, novel or untypable strain**
- Influenza-associated death (lab confirmed)
- Legionellosis
- Leptospirosis
- Listeriosis
- Lyme disease
- Lymphogranuloma venereum
- Malaria
- **Measles (rubeola) acute disease only**
- **Meningococcal disease (invasive)**
- **Monkeypox**
- Mumps (acute disease only)
- **Outbreaks of suspected foodborne origin**
- **Outbreaks of suspected waterborne origin**
- **Paralytic shellfish poisoning**
- Pertussis
- **Plague**
- **Poliomyelitis**
- Prion disease
- Psittacosis
- Q fever
- **Rabies (confirmed human or animal)**
- **Rabies, suspected human exposure**
- **Relapsing fever (borreliosis)**
- **Rubella (including congenital rubella syndrome) (acute disease only)**
- Salmonellosis
- **SARS**
- **Shiga toxin-producing *E. coli* infections (including but not limited to *E. coli* 0157:H7)**
- Shigellosis
- **Smallpox**
- Syphilis (including congenital)
- Tetanus
- Trichinosis
- **Tuberculosis**
- **Tularemia**
- **Vaccinia transmission**
- Vancomycin-resistant *Staphylococcus aureus* (not to include vancomycin intermediate)
- Varicella-associated death
- Vibriosis
- **Viral hemorrhagic fever**
- **Yellow fever**
- Yersiniosis
- Other rare diseases of public health significance
- Unexplained critical illness or death

Rev. July 2021

Reporting:

To report confirmed cases of any of the above conditions, call Public Health at 206-296-4774. Identify yourself as a child care provider.

Please note the child care and early learning WAC requires programs to **report varicella (chickenpox)**, along with other vaccine-preventable diseases.

Even though a disease may not require a report, you are encouraged to consult with a Child Care Health Program Public Health Nurse at (206) 263-8262 or CCHP.Support@kingcounty.gov for information about childhood illness or disease prevention.

In addition, providers should notify their Public Health Nurse when an unusual number of children and/or staff are ill (for example >10% of children in a center, or most of the children in the toddler room), even if the disease is not on the above list or has not yet been identified.

More information about communicable disease reporting can be found at:
https://www.kingcounty.gov/depts/health/communicable-diseases/health-care-providers/disease-reporting.aspx

MEDICATION POLICY

Medication is given **only** with prior **written** consent of a child's parent/guardian. A completed **Medication Authorization Form** indicates written consent and includes **all of the following:**

- Child's full name;
- Name of the medication;
- Reason for the medication;
- Dosage;
- Medication expiration date
- Method of administration (route);
- Frequency (**cannot** be given "as needed"; must specify **time** at which **and/or symptoms** for which medication should be given);
- Duration (start and stop dates);
- Special storage requirements;
- Any possible side effects (from package insert or pharmacist's written information)
- Any special instructions; **and**
- Parent/guardian signature and date signed

The "Medication Authorization Form" is available on the CCHP website.

Prescription medications:
Prescription medications can be administered to a child in care by an early learning provider only if the medication meets all of the following requirements:

a. Prescribed by a health care provider with prescriptive authority for a specific child;
b. Include a label with:
    - Child's first and last name;
    - Date prescription was filled;
    - Prescribing health provider's name and contact information;
    - Expiration date;
    - Dosage amount;
    - Length of time to give the medication; and
    - Instructions for administration and storage;
c. Accompanied with a completed Medication Authorization Form signed by a parent/guardian;
d. Only given to the child named on the prescription.

Over-the-counter (non-prescription) medications:
If following the instructions on the label and dosage recommendations for the child's age on an over-the-counter medication, it can be administered to a child in care by an early learning provider **only if** the medication meets all of the following criteria:

a. It is in its original packaging;
b. Labeled with the child's first and last name; and
c. Accompanied with a completed Medication Authorization Form signed by the parent/guardian.

If an over-the-counter medication's label instruction doesn't include age, expiration date, dosage amount, and/or length of time to give the medication/product, as is often the case for **vitamins, herbal supplements, fluoride supplements, homeopathic or naturopathic medication, and teething gel or tablets,** it must be:

a. Accompanied with a completed Medication Authorization Form that is signed by the health care provider with prescriptive authority.

An over the counter-medication is given only to the child named on the label provided by the parent/guardian.

Non-medical products:
A parent/guardian must provide written annual consent (valid for up to 12 months) for the following non-medical products to be given or applied to a child by the early learning provider:

a. **Diaper ointment** (used according to manufacturer's instructions);
    - Please note: As with all medications, label directions must be followed. Most diaper ointment labels indicate that rashes that are not resolved, or reoccur, within 5-7 days should be evaluated by a health care provider.
b. **Sunscreen** for children over 6 months of age;
c. **Lip balm or lotion**;
d. **Hand sanitizers or hand wipes with alcohol** (only to be used on children over 24 months); and
e. **Fluoride toothpaste** for children 24 months and older.

Amber bead necklaces are **not** allowed.

Parent/guardian instructions (for duration, dosage, amount, frequency, etc.) on the Medication Authorization Form are required to be consistent with any label recommendations, prescription, or instructions from a health care provider.

Medication and non-medical products are **not** accepted if they are **expired**.

Written consent for medications covers only the course of illness or specific time-limited episode.

Medication is added to a child's food or liquid only with the **written consent of health care provider.**

Homemade medication, such as diaper cream or sunscreen, cannot be accepted by an early learning provider or given to a child in care.

Medication Storage
Medication is stored: In the child's classroom in a labeled container in the cupboard and is:

- Inaccessible to children;
- Separate from food;
- Separate from staff medication;
- Protected from sources of contamination;
- Away from heat, light, and sources of moisture;
- At temperature specified on the label (i.e., at room temperature or refrigerated);
- So that internal (designed to be swallowed, inhaled, or injected) and external (applied to outside of body) medications are separated; and
- In a sanitary and orderly manner.

Rescue medication (e.g., EpiPen® or inhaler) is stored in the "Grab and Go" bag

Controlled substances (such as ADHD medication) are stored in a locked container or cabinet which is inaccessible to children. Controlled substances are counted and tracked with a controlled substance form.

The "Controlled Substance Medication Form" is available on the CCHP website.

Medications no longer being used are promptly returned to parents/guardians, or discarded in accordance with the Food and Drug Administration (FDA) recommendations for medication disposal. (Medications are not disposed of in sink or toilet.) See www.takebackyourmeds.org for more information on safe disposal.

Staff medication is stored In labeled container in each classroom in the cupboard, out of reach of children. Staff medication is clearly labeled as such.

Emergency supply of critical medications
For children's critical medications, including those taken at home, we ask for a 3-day supply to be stored on site along with our disaster supplies. Staff are also encouraged to supply the same. Critical medications – to be used only in an emergency when a child has not been picked up by a parent, guardian, or emergency contact – are stored in the Grab and Go bag.

Medication is kept current (not expired).

The "3 day Critical Medication Authorization Form" is available on the CCHP website.

Staff Administration and Documentation
Before administering medication to children, staff members must first be a) oriented to the early learning program's medication procedure and policy; and b) complete the department standardized training course in medication management and administration or an equivalent training. A record of the training is kept in staff files.

The parent/guardian of each child requiring medication involving special procedures (e.g., nebulizer, inhaler, EpiPen®) trains staff on those procedures. Documentation of the training must be signed by the early learning care provider and the child's parent/guardian. A record of trained staff is maintained on/with the Medication Authorization Form.

Staff giving medications keeps a written medication log on the back of the Authorization Form that includes:

- Child's first and last name;
- Name of medication that was given to the child;
- Dose amount that was given to the child;
- The time and date the medication was given; and
- Each time a medication is given, staff member prints name and full signature.

Although the current WACs do not require documentation when administering non-medical items, such as diaper creams/ointments and sunscreen, the Child Care Health Program recommends documenting applications of these items. This provides record for the child care providers and families, in case a rash, irritation, or sunburn do occur or persist.

☐ We document application of diaper creams and sunscreens, each time they are applied, on a written medication log on the back of the Authorization form.

☒ We do not document applications of diaper creams or ointments and sunscreen.

Any observed side effects are documented by staff on the child's Medication Authorization Form and reported to parent/guardian. Notification is documented.

If a medication is not given, a written explanation of why is provided on the Medication Authorization Form.

Outdated Medication Authorization Forms are promptly removed from the classroom and placed in the child's file.

All information related to medication authorization and documentation is considered confidential and is stored out of general view.

Self-Administration by Child
A school-aged child is allowed to administer his/her own medication when the above requirements are met **and**:

- A written statement from the child's health care provider and parent/legal guardian is obtained, indicating the child is capable of self-medication without assistance.
- The child's medications and supplies are inaccessible to other children.
- Staff supervises and documents each self-administration.

Medication Administration Procedure
The following procedure is followed each time a medication is administered:

1. **Wash hands** before preparing medications.

2. Carefully read all relevant instructions, including labels on medications, noting:
    - Child's name;
    - Name of the medication;
    - Reason for the medication;
    - Dosage;
    - Method of administration;
    - Frequency;
    - Duration (start and stop dates);
    - Expiration date
    - Any possible side effects; and
    - Any special instructions.

Information on the label must be consistent with the individual Medication Authorization Form.

3. Prepare medication on a clean surface away from diapering or toileting areas.
    - Do not add medication to child's bottle/cup or food without health care provider's written consent.
    - For liquid medications, use clean and sanitized medication spoons, syringes, droppers, or medicine cups with measurements provided by the parent/guardian (not table service spoons).
    - Bulk medication is dispensed in a sanitary manner (sunscreen, diaper ointment)
4. Administer medication.
5. **Wash hands** after administering medication.
6. Observe the child for side effects of medication and document on the child's Authorization Form.
7. Document medication administration.

FIRST AID

Training

At least one staff person with current training and certification in Cardio-Pulmonary Resuscitation (CPR) and First Aid is present with each group or classroom **at all times**.

First Aid and CPR Training must:

- Be delivered in person.
- Include a hands-on component for first aid and CPR that is demonstrated in front of an instructor who is certified by a nationally recognized certification program (such as the American Red Cross, American Heart Association, etc.).
- Include child and adult CPR.
- Include infant CPR, if applicable.

Documentation of staff training is kept in personnel files.

First Aid Kits

Our first aid kits are inaccessible to children and located in each "Grab and Go" bag, in each classroom, as well as in the Director's office.

First aid kits are labeled and identified by a First Aid Sign.

Each of our first aid kits contains all the following items:

- Disposable gloves (non-porous, non-latex, such as nitrile or vinyl)
- Thermometer (disposable or mercury-free that either uses disposable sleeves or is cleaned and sanitized after each use)
- Either a CPR barrier with one-way valve OR an adult/pediatric and an infant CPR mask with a one-way valve
- Band-Aids (different sizes)
- Ice packs (chemical, non-toxic ice)
- Current first-aid guide/ manual
- Small scissors
- Triangular bandage or sling
- Adhesive tape
- Tweezers for surface splinters
- Hand sanitizer (for adult use only)
- Sterile gauze pads (different sizes)
- Elastic wrapping bandage

Our first aid kits do **not** contain medications, medicated wipes, or medical treatments/ equipment that would require written permission from parent/guardian or special training to administer.

Travel First Aid Kit(s)

A fully stocked first aid kit is taken on all field trips and playground trips and is kept in each vehicle used to transport children.

Travel first aid kits should **also** contain:

- Liquid soap & paper towels
- Water w/ small paper cups and/or infant bottles
- Cell phone or walkie-talkies
- Copies of completed ‘Consent for Emergency Treatment’ & ‘Emergency Contact’ forms

All first aid kits are checked and restocked monthly or sooner if necessary. The First Aid Kit Checklist is used for documentation and is kept in each first aid kit.

A “First Aid Kit Checklist” template is available on the Child Care Health Program website.

INJURY PREVENTION

- Proper supervision is maintained at all times, both indoors and outdoors. Staff will position themselves to observe the entire play area.

- Staff will review their rooms and outdoor play areas daily for safety hazards and remove any broken/damaged equipment.

  Hazards include, but are not limited to:
  - Security issues (unsecured doors, inadequate supervision, etc.)
  - General safety hazards (broken toys & equipment, standing water, chokeable & sharp objects, etc.)
  - Strangulation hazards
  - Trip/fall hazards (rugs, cords, etc.)
  - Poisoning hazards (plants, chemicals, etc.)
  - Burn hazards (hot coffee in child-accessible areas, unanchored crock pots, etc.)
  - Windows within the reach of children

- Hazards are reported immediately to the Director. The Director will ensure hazards are removed, made inaccessible or repaired immediately to prevent injury.

- The playground is inspected daily to ensure to remain compliant with Consumer Product Safety Commission (CPSC) guidelines and/or American Society for Testing and Materials (ASTM) standards and is free of broken equipment, environmental hazards, garbage, and animal contamination. The playground and the surrounding environment will be inspected by Kaitlyn Absher, Director

- Toys are age and developmentally appropriate, safe (lead and toxin free), and in good repair. Broken toys are discarded. Mirrors are shatterproof.

- Rooms with children under 3 years old are free of push pins, thumbtacks, and staples.

- Cords from window blinds/treatments are inaccessible to children. (Many infants and young children have died from strangling in window cords. The CPSC recommends cordless window treatments.)

  See the Window Covering Safety Council's website, www.windowcoverings.org, for more information.

- Ensure firearms, guns, weapons, and ammunition are not on premises of child care program and are safely locked and inaccessible to children if located in family home.

- Staff does not step over gates or other barriers while carrying infants or children.

- Children will wear helmets when using riding equipment. Helmets will be removed prior to other play.

- Recalled items will be removed from the site immediately. Our program routinely receives updates on recalled items and other safety hazards on the CPSC website: http://www.cpsc.gov.

- Children will always be properly supervised when interacting with or near water. (Drowning is the leading cause of injury related death for children ages 1-4 years old and drowning can happen in less than 2 inches of water.)

- Any motor vehicle used to transport children will have properly installed, age appropriate car seats and working seat belts. Any driver transporting children will refrain from distracted driving (e.g., cell phone use). Children will not be left alone in the motor vehicle at any time.

- The Incident/Injury Log is monitored monthly by the Director to identify accident trends and implement a plan of correction.

An "Incident/Injury Log" template is available on the CCHP website.

Sensory and Water Tables

- All materials should be nontoxic and should not be of a size or material that could cause choking.
    - Sand is "sterilized" natural sand labeled for use in children's sandboxes or as play sand.
    - Water is from a clean source.
    - Water beads are not allowed.

- Sensory tables should not be used by children under 18 months because it is not developmentally appropriate due to potential ingestion of materials.

- Children are supervised during sensory play.

- Children are not allowed to drink the water from a water table. Avoid using bottles, cups, and glasses as these can encourage children to drink the water.

- The floor and surface around the water table are dried during and after play.

PROCEDURES FOR INJURIES AND MEDICAL EMERGENCIES

1. Assess the injured child and obtain appropriate supplies.

2. Staff trained in first aid will refer to the First Aid Guide, located in every first aid kit, for more information if needed.

3. Administer first aid. Non-porous, non-latex gloves (i.e. nitrile or vinyl*) are used if blood is present. If the injury or medical emergency is life threatening, one staff person stays with the injured/ill child, administers appropriate first aid, and starts CPR, while another staff person calls 911 and brings the AED. If only one staff member is present, that person assesses the child for breathing and circulation.

    - If **collapse is un-witnessed**: First perform 2 minutes of CPR, then call 911 and bring an AED to the child.
    - If **collapse is witnessed**: First call 911 and bring an AED, then start CPR.

4. Staff calls parent/guardian or designated emergency contact if necessary. For major injuries or medical emergencies, a staff person stays with the injured/ill child until a parent/guardian or emergency contact arrives, including during transport to a hospital.

5. Staff record the injury or medical emergency on an accident/injury report form. The report includes:
    - Date, time, place and cause of the injury/medical emergency (if known),
    - Treatment provided,
    - Name(s) of staff providing treatment, and
    - Persons contacted.

    Staff provide a copy of the form to the parent/guardian the same day, and place a copy in the child's file. For major injuries/medical emergencies, the parent/guardian signs upon receipt of the form, and staff sends a signed copy to the licensor.

6. The designated staff person immediately calls the childcare licensor when serious injuries/incidents that require medical attention occur.

7. Record any injury on the site "Incident/Injury Log." Every entry will include the child's name, name(s) of staff involved, and a brief description of the incident. The site injury log is confidential.

The "Incident/Injury Log" template is available on the CCHP website.

***Please note: Always wash hands after glove removal.**

BLOOD/BODY FLUID CONTACT OR EXPOSURE

Even healthy people can spread disease through direct contact with body fluids. All body fluids – including blood, urine, stool (feces), drool (saliva), vomit, drainage from sores/rashes (pus) – may be infected with contagious disease. To limit risk of infection associated with blood and body fluids, our site always takes the following precautions:

- **Non-porous, non-latex gloves are always used when blood or wound drainage is present.**
- Any open cuts or sores on children or staff are kept covered.
- Whenever a child or staff comes in contact with a body fluid, the exposed area is washed immediately with soap and water, rinsed, and dried with paper towels.
- Surfaces that come in contact with blood/body fluids are cleaned immediately with detergent and water, rinsed, and disinfected with an appropriate EPA approved disinfectant, such as bleach in the concentration used for disinfecting body fluids (refer to "Methods for Mixing Bleach"). The site's "Bloodborne Pathogen Exposure Control Plan" (BBP ECP) includes details on how to clean and disinfect specific surfaces (carpets, smooth surfaces, etc).

  A BBP ECP template is available on the CCHP website

- A child's clothing soiled with body fluids is removed as soon as possible, put into a plastic bag, securely tied or sealed, then put into another plastic bag that is securely tied or sealed and sent home with the child's parent/guardian. A change of clothing is available for children in care, as well as for staff.
- Any equipment (mops, brooms, dustpans, etc.) used to clean-up body fluids is cleaned with a disinfectant according to manufacturer's instructions and air-dried.
- Gloves, paper towels, and other first aid materials used to wipe up body fluids are put in a plastic bag, tied closed, and placed in a plastic-lined waste container with lid.
- Hands are always washed after handling soiled laundry or equipment, and after removing gloves.

Blood Contact or Exposure

If staff or a child comes into contact with blood (e.g. staff providing first aid for a child who is bleeding) or is exposed to blood (e.g. blood from one person enters a cut or scrape or the mucous membrane (eye, nose, or mouth) of another person), the staff informs the Director immediately. If a child is exposed to blood or other body fluid, parent/guardian will be notified by the Director and an appropriate report will be completed (see BBP ECP for more details).

We follow current guidelines set by Washington Industrial Safety and Health Act (WISHA) when reporting exposures, as outlined in our BBP ECP. We review the BBP ECP with our staff annually, or more often if changes occur. We document the content summary of the review, as well as names and job titles of staff who attend.

DISASTER PREPAREDNESS

Plan and Training

Our early learning program has developed a Disaster Preparedness Plan/Policy. The plan includes responses to different disasters our site is vulnerable to, as well as procedures for on- and off-site evacuation and shelter-in-place. Each classroom has evacuation routes and a copy of our disaster preparedness plan/policy posted. Our disaster preparedness plan/policy is also posted in our parent information area.

An "Emergency/Disaster Preparedness Plan" template is available on the CCHP website.

Staff is oriented to our disaster policy upon hire and annually. Families are oriented to our disaster policy upon enrollment and annually. The site maintains an orientation documentation file on site.

Staff receive fire extinguisher training. The following staff members have received utility control training (how to turn off gas, electric, water): Taylor Mosier, Kim Fredell, Gina Fredell, Kaitlyn Absher, . Documentation of disaster and earthquake preparation and training filed on site.

Supplies

Our early learning program maintains a supply of food and water on site for children and staff sufficient for at least 72 hours, in case parents/guardians are unable to pick up children at the usual time. Kaitlyn Absher, Director is responsible for stocking supplies. We check food, water, and supply expiration dates at least annually and rotate supplies accordingly. We maintain essential prescribed medications and medical supplies on hand for individuals who need them. Each room has a fully stocked "Grab and Go" bag.

The "Grab and Go" bag supply list is available on the CCHP website.

Hazard Mitigation

We have taken action to make our space earthquake/disaster-safe. We have safely secured bookshelves, tall furniture, refrigerators, crockpots, and other potential hazards to wall studs as appropriate. We continuously monitor all rooms and offices for anything that could fall and hurt someone or block an exit, and take corrective action as needed. Kaitlyn Absher, Director is the primary person responsible for hazard mitigation. It is the program's expectation that all staff members be aware of the environment and make changes as necessary to increase safety.

Drills

We conduct and document monthly fire drills. Shelter-in-place, lockdown and disaster drills are conducted quarterly.

The "Disaster Drill Record" template is available on the CCHP website.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Our center is committed to meeting the needs of all children. This includes children with special health care needs such as asthma, allergies, children with emotional or behavior issues, or chronic illness and disability. Inclusion of children with special needs enriches the child care experience and all staff, families, and children benefit.

- Confidentiality is assured with all families and staff in our program.
- According to WAC110-300-0300, we are required to notify our licensor when a child with special health care needs is enrolled or identified in our program. We maintain confidentiality when reporting this by not revealing names or diagnoses.
- All families will be treated with dignity and with respect for their individual needs and/or differences.
- Children with special needs will be accepted into our program under the guidelines of the Americans with Disabilities Act (ADA).
- Children with special needs will be given the opportunity to participate in the program to the fullest extent possible. To accomplish this, we may consult with our public health nurse consultant and other agencies/organizations, as needed.
- An individual plan of care is developed for each child with a special health care need. The plan of care is kept in the child's file and includes information and instructions for:
    - Daily care
    - Potential emergency situations
    - Evacuation and care during and after a disaster

  For a complete list of on what is required to be included in an individual plan of care, please reference WAC110-300-0300.

  Completed plans are requested from health care provider annually or more often if there is a change in the child's special needs.

- Children with special needs are not present without an individual plan of care on site.

- All staff receives general training on working with children with special needs. Any staff that is involved in the care of a child with special needs receives updated training, as needed, around implementing the child's care plan. Verification that staff has been trained is kept in the child's file.

- Teachers, cooks, and other staff will be oriented to any special needs or diet restrictions by the Director.

A "Care Plan Tracking Form" and an "Individual Plan of Care" template are available on the CCHP website.

HEALTH RECORDS

Each child's health record is maintained in a confidential manner and will contain the following:

- Health, developmental, nutrition, and dental histories or conditions
- Date of last physical and dental exams
- Name and phone number of health care provider and dentist
- Consent for emergency care
- Current "Certificate of Immunization Status" (CIS), "Certificate of Exemption" (COE), or a current immunization record from the Washington state immunization information system (WA IIS);
- Preferred hospital

If applicable to the child, the health record will also contain**:**

- Consent for services provided by any health professionals who work with the program
- Allergy information and food intolerances
- Individualized care plan for child with special health care needs (medical, physical, developmental or behavioral)

  Note: In order to provide consistent, appropriate, and safe care, a copy of the plan should also be available in child's classroom.
- List of current medications
- Injury report
- Any assistive devices used (e.g., glasses, hearing aids, braces)
- Documentation of any food or health related illness reports made by provider to appropriate agency/body

The above information will be updated annually or sooner for any changes.

DIAPERING

Children are **never** left unattended on the diaper-changing table. Safety belts are not used on the diaper changing table. (They are neither washable nor safe.) **The diaper changing table and area are used only for diapering.** Toys, pacifiers, papers, dishes, blankets, etc., are not placed on diapering surface or in the diapering area.

Diaper changing pads are replaced when they become worn or ripped. No tape is present on diaper changing pad. Diaper changing pads have a smooth, cleanable, moisture-resistant surface with no ridges, grooves or stitching.

The following diapering procedure is posted and followed at our early learning program:

1. Wash Hands.
2. Gather necessary materials. If using bulk diaper ointment, put a dab of ointment on paper towel.
3. Put on disposable gloves, if desired.
4. Place child gently on table and unfasten diaper. Do not leave child unattended.
5. Clean the child's diaper (peri-anal) area from front to back, using a clean, damp wipe for each stroke.
6. Dispose of dirty diaper and used wipes in a plastic-lined, hands-free container with lid (foot pedal type).
7. **Wash hands.** If wearing gloves, remove gloves and wash hands. Please note: A wet wipe or damp paper towel may be used for this handwashing only. Do not leave child unattended.
8. If parent/guardian has completed a medication authorization for diaper cream/ointment/lotion, put on clean gloves and apply to area. Remove gloves.
9. Put on a clean diaper (and protective cover, if cloth diaper used). Dress child.
10. Wash child's hands with soap and running water (or with a wet wipe for very young infants).
11. Place child in a safe place. Do not touch toys, play equipment, etc. and return to the diaper area for step 12.
12. Use 3-Step method on changing pad where diaper change has occurred:
    a. Clean with soap and water.
    b. Rinse with water.
    c. Disinfect with bleach solution: Refer to: "Method for Mixing Bleach." Allow the bleach solution to air dry or to remain on the surface for at least 2 minutes before drying with a paper towel.
13. **Wash Hands.**

Please note: Even if gloves are used, all of the above handwashing must still be done.

STAND-UP DIAPERING FOR OLDER CHILDREN

☒ We do stand-up diapering as appropriate.

Stand-up diaper changing takes place in the diapering area.

Diaper changing procedure is posted in stand-up diaper changing area. Stand-up diaper changing procedure is followed:

1. **Wash hands.**
2. Gather necessary supplies (diaper/pull-up/underpants, wipes, cleaner and disinfectant bleach solution, paper towels, gloves, plastic bag).
3. Put on disposable gloves, if desired.
4. Coach the child in pulling down pants and removing diaper/pull-up/underpants (and assist as needed).
5. Put soiled diaper/pull-up in covered, hands-free, plastic-lined garbage can with lid or put soiled underpants in plastic bag to be returned to family at end of the day.
6. Coach the child in cleaning diaper area front to back using a clean, damp wipe for each stroke (and assist as needed).
7. Put soiled wipes in plastic bag (or assist child in doing so) and dispose of plastic bag into covered, hands-free, plastic-lined trash can with lid.
8. Remove gloves, if worn.
9. **Wash hands** (in bathroom/handwashing sink) and coach child in doing the same.
10. If a signed medication authorization indicates, apply topical cream/ointment/lotion using disposable gloves then remove gloves.
11. Coach the child in putting on clean diaper/pull-up/underpants and clothing.
12. Use 3-Step method on floor where change has occurred:
    1. Clean with soap and water.
    2. Rinse with water.
    3. Disinfect with bleach solution: Refer to: “Method for Mixing Bleach”. Allow the bleach solution to air dry or to remain on the surface for at least 2 minutes before drying with a paper towel.
13. **Wash hands** (in bathroom/handwashing sink).

TOILET TRAINING

Toilet training is a major milestone in a young child's life. Because children spend much of their day in child care, you may recognize signs that a child is ready to begin toilet training. As a provider, you can share your observations with the family and offer suggestions and emotional support. Working together with the family, you can help make toilet training a successful and positive experience for their child.

- When the child is ready for training, discuss toilet training procedures and develop a toilet training routine that is developmentally appropriate in agreement with the parent or guardian.

- Develop a detailed written plan of communication between the child care program and the family. Keep daily records of successes and concerns to share with the family.

- Follow the same procedure in child care as in the child's home. Use the same words (pee-pee, poop, etc.), so the child does not become confused about what is required. Pretend play with a doll using the same vocabulary and talk through expectations.

- Develop routines that encourage toilet use. Watch for those non-verbal signs that suggest a child has to use the toilet. Suggest bathroom visits at set times of the day, before going out to play, after lunch, etc.

- Encourage the family to dress the child in easily removable clothing. Keep an extra set of clothing on hand for accidents.

- Encourage the child with positive reinforcement (which may not include food items) and culturally sensitive methods.

- Expect relapses and treat them matter-of-factly. Praise the child's successes, stay calm, and remember that this is a learning experience leading to independent behavior.

- The noise made by flushing a toilet may frighten some children. Try to flush after the child has left until they become accustomed to the noise.

- Take time to offer help to the child who may need assistance in wiping, etc.

The full "Toilet Training brochure" is available in the "Behavior Handbook" and on the CCHP website.

INFANT CARE

Infants learn through healthy and ongoing relationships with primary caregivers and teachers. Providers must understand infant cues and respond in a reliable way to encourage the development of a secure attachment with the infant.

- **Always** respond by comforting a baby who is crying. When you let a baby cry without comfort, they experience their world as a sad and lonely place.

- **Rather** than distract babies when they are feeling sad or upset, talk with them about their feelings and provide lots of hugs.

- **Spend time** playing back and forth games with the babies in your care. This serve and return helps establish close, positive relationships.

Program and Environment

The infant room is street-shoe-free to reduce infant exposure to dirt, germs, dangerous heavy metals, chemicals, and pesticides. All staff and other adults entering the room wear socks, slippers, inside-only shoes, or shoe covers over their street shoes and will not enter room with bare feet.

The infant room has areas where all infants have the opportunity to experience floor-time activity without restriction. *(Floor time encourages brain and muscle development.)* All infants are given at least three 5-minute periods of supervised tummy time each day, increasing the amount of time as the baby shows interest.

Infants do not spend more than 15 minutes per day in restrictive devices such as swings, bouncers, infant seats or saucers. Use directions for all equipment must be strictly followed at all times.

Nursing pillows: infants will not be propped on nursing pillows. Free movement will be promoted for all infants.

A child care health consultant visits the infant room monthly. Per WAC 110-300-0275, the consultant is a currently licensed registered nurse (RN) with training and/or experience in Pediatric Nursing or Public Health in the last five years. This nurse provides consultation that is consistent with the health consultant competencies described in the current version of *Caring for Our Children*.

INFANT SLEEP

- Each infant is allowed to follow his/her individual sleep pattern. Providers look for and respond to cues as to when an infant is sleepy.
- Infants are within sight and hearing range, including when an infant goes to sleep, is sleeping, or is waking up. Providers visibly check on sleeping infant every 15 minutes. Lighting must be sufficient to observe skin color and breathing patterns.
- Following the current best practice from American Academy of Pediatrics, our program practices safe sleep to reduce Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death Syndrome (SUIDS) risk, including:
    - Infants are always placed to sleep on their back up to 12 months of age. If an infant rolls over while sleeping, the provider must return the infant to his or her back until the infant is able to independently roll from back to front and front to back.
    - Any alternate sleep position must be specified in writing by the parent/ guardian and the child's health care provider. The order must be in the infant's file.
    - Infants do not sleep in car seats, swings, strollers, or infant seats. Any child who arrives at the program asleep in a car seat or stroller, or who falls asleep in a swing or infant seat, is immediately moved to a crib or mat. (Sleeping in infant seats or swings makes it harder for infants to breathe fully and may lead to head and neck issues.)
    - Blankets, sleep sacks, bumper pads, pillows, soft toys, sleep position devices, cushions, sheepskins, bibs or similar items are not on nap mats, in cribs, or on crib rails if occupied by a resting or sleeping infant.
    - One piece sleep sacks can be used in lieu of blankets. Sleep sacks must be unweighted and allow for infant arms to be free and allow for unrestricted movement.
    - Swaddling is not necessary nor recommended in a child care setting. If infants are swaddled, they should always be placed on their back. Swaddling should be snug around the chest but allow for ample room at the hips and knee to prevent hip injury. When an infant exhibits signs of attempting to roll over, swaddling is no longer used because this could increase the risk of suffocation if the swaddled infant rolls to their belly. Consider that infants, on average, start to roll at 3 to 4 months of age, but this may occur earlier.
    - Weighted swaddle clothing, weighted sleep sacks, or weighted objects within these items are not safe and therefore are not recommended or used.
    - Do not let an infant get too warm during sleep. Temperature of the room should be comfortable for a lightly clothed adult. (Overheating during sleep is associated with an increased risk of SIDS).
    - Bibs, hats, necklaces, and garments with ties or hoods will be removed before placing an infant to sleep.

- Cribs and other sleep surfaces meet current Consumer Product Safety Commission (CPSC) standards or American Society for Testing and Materials (ASTM) International safety standards.
- Mattress are firm, flat, snug fitting, intact, and waterproof.
    - Crib sheets fit mattress snugly, but do not cause mattresses to curl up at corners.
    - Mattresses are not inclined, as sleep surfaces with inclines of more than 10 degrees are unsafe.
- Cribs are spaced at least 30 inches apart or separated by Plexiglas barrier.
- Nap mats are separated by at least 18 inches. Children are placed head-to-toe or toe-to-toe.
- Sleeping equipment is not located next to windows (unless windows are constructed of safety glass). Window blinds/draperies can pose a risk of suffocation and/or strangulation.
- Nothing is stored above sleeping equipment unless securely attached to wall. Mobiles should not be placed above cribs.
- Crib wheels are locked in order to prevent movement in an earthquake.

Additional information on SIDS and Child Care is available on the CCHP website.

Safe Sleep Training

All staff and volunteers working in a facility licensed for infants (even if they do not work directly with infants) must have documentation of safe sleep training approved by the Washington State Department of Children, Youth, and Families.

- If working directly in a classroom with infants, this training needs to be completed prior to working in the infant room and again annually.
- If not working in a classroom with infants, the staff person or volunteer has up to three months to complete the training, as long as they are not required to go into that classroom. They must also complete the training each year thereafter.

Evacuation Cribs

- Evacuation cribs are available for all infants (max. 4 infants per crib).
- Evacuation cribs have:
    - wheels - preferably 4 inches or larger - capable of crossing terrain on evacuation route
    - a reinforced bottom
- A clear pathway is kept between evacuation cribs and emergency exits at all times.
- Nothing is stored below or around evacuation cribs that would block immediate exit of cribs.

TODDLER AND PRESCHOOL SLEEP

- Children 29 months of age or younger follow their individual sleep patterns.
- Alternate quiet activities are provided for a child who is not napping (while others are doing so).
- To allow for easy observation, toddlers are within sight and hearing range of providers while asleep. Lighting must be sufficient to observe skin color and breathing patterns.
- Not allowing a blanket, bedding, or clothing to cover any portion of a toddler's head or face while sleeping and readjusting these items when necessary.
- Nap mats are separated by at least 18 inches to reduce germ exposure and allow early learning providers' access to each child. In addition, children are placed head-to-toe or toe-to-toe.
- Sleeping equipment is not located next to windows (unless windows are constructed of safety glass). Window blinds/draperies can pose a risk of suffocation and/or strangulation.
- Nothing is stored above sleeping equipment unless securely attached to a wall.

FOOD SERVICE

☒ We do not use catered foods at our early learning program.

☐ We use **catered foods** at our early learning program, and

☒ We prepare meals and snacks at our early learning program.

☐ We prepare only snacks at our early learning program.

Food handler permits are required for staff that prepare full meals and are encouraged for all staff. An "in charge" person with a food handler permit is onsite during all hours of operation, to assure that all food safety steps are followed. Documentation is posted in the kitchen on the bulletin board and in staff files.

Orientation and training in safe food handling is given to all staff and documented.

Ill staff or children do not prepare or handle food. Food workers may not work with food if they have:

- Diarrhea, vomiting or jaundice
- Diagnosed infections that can be spread through food such as *Salmonella*, *Shigella*, *E. coli* or hepatitis A virus
- Infected, uncovered wounds
- Continual sneezing, coughing or runny nose

Child care cooks do not change diapers or clean toilets**.**

Staff wash hands with soap and warm running water prior to food preparation and service in a designated handwashing sink – never in a food preparation sink. The handwashing sink should have an eight-inch-high splash guard or have 18 inches of space between the handwashing sink and any open food zones (such as preparation tables and food sink).

Hair restraints, such as hairnets, hats, barrettes, ponytail holders or tight braids, are used by employees preparing food.

Gloves are worn or utensils are used for direct contact with food. Wash hands before donning gloves and change gloves when you handle a new type of food (No bare hand contact with ready-to-eat food is allowed.) Gloves must also be worn if the food preparation person is wearing fingernail polish or has artificial nails. We highly recommend that food service staff keep fingernails trimmed to a short length for easy cleaning. (Long fingernails are known to harbor bacteria).

Refrigerators and freezers have thermometers placed in the warmest section (usually the door). If storing breast milk/human milk, thermometers stay at or below 39ºF (3.9ºC) in refrigerator or 0ºF (-17.8ºC) in freezer. If not storing breast milk/human milk, thermometers stay at or below 41ºF (5ºC) in the refrigerator and 10ºF (-12.2ºC) or less in the freezer. Temperature is logged daily.

Microwave ovens, if used to reheat food, are used with special care. Food is heated to 165ºF (73.9ºC), stirred during heating, and allowed to cool at least 2 minutes before serving. Due to the additional staff time required, and potential for burns from "hot spots," use of microwave ovens is not recommended.

Chemicals and cleaning supplies are stored away from food and food preparation areas.

Dishwashing complies with safety practices:

- Hand dishwashing is done with three sinks or basins (wash, rinse, sanitize).
- Dishwashers have a high temperature sanitizing rinse (140ºF (60ºC), residential or 160ºF (71.1ºC) commercial) or chemical sanitizer.

Thawing frozen food: frozen food is thawed in the refrigerator 1-2 days before the food is on the menu, or under cold running water. Food may be thawed during the cooking process if the item weighs less than 3 pounds. If cooking frozen foods, plan for the extra time needed to cook the food to the proper temperature. Microwave ovens cannot be used for cooking meats but may be used to cook vegetables.

Food is cooked to the correct internal temperature:

Ground Beef 158ºF (70ºC)	Fish 145ºF (60ºC)
Pork 160ºF (71.1ºC)	Poultry 165ºF (73.9ºC)

Holding hot food: hot food is held at 135ºF (57.2ºC) or above until served.

Holding cold food: food requiring refrigeration is held at 41ºF (5ºC) or less.

A digital thermometer is used to test the temperature of foods as indicated above, and to ensure foods are served to children at a safe temperature.

Cooling foods is done by one of the following methods:

- Shallow Pan Method: Place food in shallow containers (metal pans are best) that are 2 inches deep or less on the top shelf of the refrigerator. Leave uncovered and then either put the pan into the refrigerator immediately or into an ice bath or freezer (stirring occasionally).
- Size Reduction Method: Cut cooked meat into pieces no more than 4 inches thick.

Foods are covered once they have cooled to a temperature of 41ºF (5ºC) or less.

Leftover foods *(foods that have been below 41ºF (5ºC) or above 135ºF (57.2ºC) and have not been served)* are cooled, covered, dated, and stored in the refrigerator or freezer in original containers or in airtight food containers. Leftover food is refrigerated immediately and is not allowed to cool on the counter.

Reheating foods: foods are reheated to at least 165ºF (73.9ºC) in 30 minutes or less.

Food substitutions, due to allergies or special diets and authorized by a licensed health care provider, are provided within reason by the early learning program.

When children are involved in cooking projects our early learning program assures safety by:

- Closely supervising children,
- Ensuring all children and staff involved wash hands thoroughly,
- Planning developmentally-appropriate cooking activities (e.g., no sharp knives),
- Following all food safety guidelines.

Perishable items in lunches brought from home are refrigerated upon arrival.

Fruits and vegetables grown on-site in a garden may be served to children as part of a meal or snack. Prior to serving:

- produce is thoroughly washed and scrubbed in running cold water to remove soil and other contaminants;
- damaged or bruised areas on the produce are removed; and
- produce that shows sign of rotting is discarded.

NUTRITION

This early learning program serves meals and snacks which meet the daily nutritional requirements of the USDA Nutrition Standards for the Child and Adult Care Food Program (CACFP) or the National School Lunch and School Breakfast Program.

More information available at: https://ospi.k12.wa.us/policy-funding/child-nutrition/child-and-adult-care-food-program

- Menus are posted in advance and dated. Posting menus in a prominent area and distributing them to parents/guardians helps to inform parents/guardians about proper nutrition. The early learning program uses a 4 week cycle menu, with no repeated meal/snack combinations to ensure variety. If needed, substitutions of comparable nutrient value may be made and any changes will be recorded on the menu.

- Menus list specific types of fruits, vegetables, crackers, etc. that are served, per CACFP requirement.

Meal and Snack Schedule
Food is offered at intervals not less than 2 hours and not more than 3 hours apart unless the child is asleep.

☐ Our early learning program is open 5 to 9 hours; we provide

- ☐ one meal and two snacks
- ☐ two meals and one snack

☒ Our early learning program is open over 9 hours; we provide

- ☒ two meals and two snacks
- ☐ one meal and three snacks

The following meals and snacks are served by the early learning program:

Time	Meal/Snack
7:30-8:45	Breakfast
11:15-12:00	Lunch
2:30-3:00	Snack
5:00-5:15	Snack

- Breakfast or morning snack is made available to any child in care.

- A snack is provided to children who arrive after school.

- Each snack or meal includes a liquid to drink:
    - Water can be served with every meal and snack.
    - Unflavored milk must be served with every meal (breakfast, lunch, and dinner), even if water is served.
    - 100% fruit/vegetable juice may be served at snack, 4 to 6 ounces, or less, per day for children over 12 months.

- Breast milk/human milk may be served in place of cow's milk for children over 12 months if it is the parent's preference (no note is required). If not serving breast milk/human milk to the child:
    - only pasteurized whole milk is served to children between 12 and 24 months old, unless the child's parent/guardian and health care provider have requested low-fat milk in writing. (Low-fat diets for children under age 2 may affect brain development.)
    - only pasteurized 1% or nonfat milk is served to children over 2 years.
    - Soy milk may be substituted for cow's milk with a written request from child's parents/guardians if the child is over 12 months.

- Cereals served contain no more 6 grams of sugar per 1 dry ounce serving.

- Yogurts do not contain more than 23 grams of total sugar per 6 ounce serving.

- At least one whole grain-rich item is served per day.

- At least one snack per day contains a fruit or vegetable.

- Foods high in fat, added sugar and salt are limited.

- Meals include foods that vary in color, flavor and texture.

- Ethnic and cultural foods are incorporated into the menu.

- Menus are followed. Necessary substitutions are noted on the permanent menu.

- Families who provide their child's lunch are notified in writing of the food requirements for mealtime. We have available food supplies to supplement food brought from home that **does not meet** the nutrition requirements.

- Children have free access to drinking water throughout the day, indoors and outdoors (using individual reusable drinking containers or disposable cups).

- Children with food allergies or medically-required special diets have diet prescriptions signed by a health care provider on file.

- Children with severe and/or life-threatening food allergies have a completed individual care plan signed by the parent and health care provider.

- Diet modifications for special diets, food allergies, religious and/or cultural beliefs are accommodated and posted in the kitchen and eating area and will be kept confidential. All food substitutions are of equal nutrient value and are recorded on the menu or on an attached sheet of paper.

- Plastic eating and drinking equipment does not contain BPA or have cracks or chips.

Mealtime Environment and Socialization

Mealtime and snack environments are developmentally appropriate and support children's development of positive eating and nutritional habits.

- Staff sit with children (and preferably eat the same food that is served to the children in care) and have casual conversations with children during mealtimes.
- Children are not coerced or forced to eat any food.
- Children decide how much and which foods to choose to eat of the foods available.
- Food is not used as a reward or punishment.
- Foods are served "family style" to allow each child to practice skills such as passing shared serving bowls, pouring from a pitcher, and serving themselves.
- Staff provide healthy nutritional role modeling (serving sizes of foods, appropriate mealtime behavior and socialization during mealtime).

Staff don't consume coffee, tea, energy drinks, or soda pop while children are in their care in order to prevent scalding injuries and/or role model healthy eating.

Sweet Treat Policy

Special "treats" for celebrations should be limited; this should be coordinated and monitored by the classroom teacher. For example, consider having one celebration for all the birthdays in a month instead of having each family bringing in treats for their child's birthday. Items that are health promoting should always be encouraged; information is available for parents with ideas for birthday, holiday or special occasion "treats". Sweetened treats are highly discouraged. If provided by the guardian/parent, portion sizes should be small.

☐ We allow food to be brought from home for celebrations. These food items are limited to store-bought food, uncut fruit and vegetables or food pre-packaged in original manufacturer's containers.

☒ We allow food prepared at home by parents and have received written permission from each child's parent or guardian stating their child may consume food prepared, cooked, or baked by another child's parent or guardian.

Programs are responsible for reading food labels of items provided by parents to determine if the food is safe for children with food allergies to consume.
Examples of more nutrition sweet treats include:

- Muffins or bread made with fruit or vegetables
- Cobblers and pies made with lightly sweetened fruits
- Plain or vanilla yogurt
- Waffles or pancakes topped with crushed fruit
- Bars made with whole grains and seeds
- Cookies modified for fat and sugar content
- Frozen juice popsicles
- Vegetable juice
- Fruit salad with vanilla yogurt

For infants and toddlers (ages 6 months to 3 years), the dessert items should not contain nuts, seeds (like pumpkin), dates, peanut butter, or large pieces of fresh fruit or vegetables that may cause choking. Honey and items containing honey should not be given to infants under one year of age.

Cultural and ethnic food items that are considered dessert or special “treat” may be served to honor cultures represented in the program. Examples may include sticky rice and sweet rice such as banh bo, noodle-based dessert, lefse, flan, sweet potato pie (modified for fat and sugar), bean dessert items, sambusa or “mush-mush”. Recipes or directions from parents could be shared with food service staff who prepares the item. Use of non-food items to celebrate special occasions is encouraged. Examples of these types of items include: stickers, pencils, birthday “hats” or crowns, bubble solution, or piñatas filled with these items.

INFANT BOTTLE FEEDING

Breastfeeding/Chestfeeding Support

- Our early learning program encourages, supports, and accommodates breastfeeding/chestfeeding parents.
    - Staff are a resource for breastfeeding/chestfeeding parents.
    - The infant room has a quiet, private space set aside for breastfeeding/chestfeeding as well as a space for pumping.
    - We provide educational materials and resources to support breastfeeding/chestfeeding parents.
    - Staff are trained on the safe handling of expressed breast milk/human milk.
    - Staff discuss the breastfed/chestfed infant's feeding pattern with parent/guardian regularly.

- Infants are only fed breast milk/human milk or iron-fortified infant formula until they are one year old.

- Written permission from the child's licensed health care provider is required if an infant is to be fed an electrolyte solution *(e.g., Pedialyte®)* or a special formula prescribed by a health professional.

- No medication, cereal, supplements, or sweeteners are added to breast milk/human milk or formula without written permission from the child's licensed health care provider.

- Juice is not offered to children under 12 months old.

- Children are transitioned to a cup when developmentally ready.

Storage

- All bottles are labeled with infant's **full name and date**.

- Filled bottles are capped and refrigerated upon arrival or after being mixed, unless being fed to an infant immediately, to reduce risk of contamination.

- Bottles are stored in the coldest part of the refrigerator, not in the refrigerator door.

- A thermometer is kept in the warmest part of the refrigerator (usually the door). breast milk/human milk must be stored at or below 39ºF (3.9ºC). If not storing breast milk/human milk, the refrigerator should be kept at or below 41ºF (5ºC). The refrigerator temperature is logged daily. (It is recommended that the

refrigerator be adjusted between 30ºF and 35ºF (-1ºC and 1.7ºC) to allow for a slight rise when opening and closing the door.)

- Unused, refrigerated, not previously frozen, bottles or containers of breast milk/human milk are labeled “do not use” and then returned to the parent at the end of the day. Unused, previously frozen (thawed) breast milk/human milk is labeled “do not use” and returned to the family when the child leaves at the end of their day. Families may choose to provide their own insulated cooler bag with ice pack (to be kept in the child’s cubby area) to keep partially consumed breast milk/human milk bottles cool until the child is picked up at the end of the day.

- Frozen breast milk/human milk pouches/containers are labeled with the **child’s full name and date it was received**, stored at 0ºF (-17.9ºC) or less and for no longer than 30 days. Unused frozen breast milk/human milk is returned to the parent/guardian after 30 days.

Bottle Preparation

1. A minimum of eight feet is maintained between the food preparation area and the diapering area. (If this is not possible, a moisture-proof, transparent 24-inch high barrier – such as Plexiglas - must be installed.)

2. Preparation surfaces are cleaned, rinsed, and sanitized before bottles are prepared.

3. Staff wash hands in the hand-washing sink before preparing bottles. The food preparation sink is not used for hand-washing or general cleaning.

4. Frozen breast milk/human milk is thawed in the refrigerator, under warm running water, in warm water (water under 120ºF (48.9ºC) or in a bottle warmer before feeding. Thawed breast milk/human milk must be kept in the refrigerator at a temperature of 39ºF (3.9ºC). Thawed breast milk/human milk is not refrozen.

5. Bottles of formula are prepared with cold water from the cold water tap from the following clean source: Infant sink. Water from a hand-washing sink is **not** used for formula preparation. (Hot tap water can be contaminated with lead. Only cold water should be taken from the tap for cooking or drinking.)

6. Formula containers are dated when opened and used within 30 days.

7. Formula is mixed as directed on the container and not used past expiration date.

8. Gloves are worn when scooping powdered formula from its container. Gloves used for bottle preparation are kept in food preparation area.

9. Glass or stainless steel bottles, or plastic bottles labeled with recyclable symbol “1”, “2”, “4” or “5” on bottle are used. A plastic bottle must not contain the chemical bisphenol-A (BPA) or phthalates.

Bottle Warming

1. Bottles are **not** warmed in a microwave.

2. Bottles are warmed using one of the following methods:

☐ We place bottles in a container of water.

☐ We place bottles under warm, running water (<120ºF or 48.9ºC).

☒ We use a bottle warmer and:

- Bottle warmer is secured to the counter or wall.
- Bottle warmer is cleaned, rinsed, and sanitized daily.

☐ We use a crock pot (not recommended, as temperature is difficult to control), and:

- Water temperature in crock pot is monitored and kept below 120ºF or 48.9ºC.
- Crock pot **contains no more than 1½ inches** of water. (Crock pots pose a risk of scalding.)
- Crock pot is secured to the counter or wall.
- Crock pot is cleaned, rinsed, and sanitized daily.

3. Temperature is checked before bottle is fed to infant (wrist method).

Bottle Feeding

1. Infants are fed on cue. Staff watches for and respond appropriately to **hunger cues** such as: **fussiness/crying, opening mouth as if searching for a bottle/breast, hands to mouth, turning to caregiver, hands clenched.**

1. Staff watches for and responds appropriately to **fullness cues** such as: **falling asleep, decreased sucking, arms, and hands relaxed, pulling or pushing away and disengaging.**

2. Staff receives training on infant feeding cues.

3. The name on each bottle is checked before the bottle is offered to an infant to makes sure that the correct formula or breast milk/human milk is given to each infant.

4. Bottles are **labeled with time feeding begins**.

5. During bottle feeding, care providers hold infants in a nurturing way so that they can make eye contact with and talk to infants. Bottles are not propped.

6. Older infants who can sit and hold a bottle independently are either held or placed in a high chair or chair that allows the feet to touch the floor at an appropriately-sized table.

7. **Infants are not allowed to walk around with bottles and are never given a bottle while lying down or in a crib.**(Lying down with a bottle puts a baby at risk for baby bottle tooth decay, ear infections, and choking.)

8. The leftover contents of unconsumed bottles of formula are discarded into a sink after one hour to prevent bacterial growth. (Bacteria begin to multiply once bottles are taken from the refrigerator and warmed.)

9. Bottles that have been served, including partially consumed bottles, do not go back in refrigerator.

10. Breast milk/human milk that has not been served or consumed is labeled “do not use”, kept refrigerated, and returned to the family at the end of the day.

11. Families are advised to send several small bottles or portions, enough for one day only, to minimize the amount of breast milk/human milk or formula that is discarded.

12. Staff are encouraged to work closely with the same infant over time to increase familiarity with infant’s feeding cues.

Bottle Cleaning
Used bottles and dishes are not stored within eight feet of the diapering area or placed in the diapering sink.

☒ Bottles are not reused at our early learning program. Families provide a sufficient number of bottles to meet the daily needs of the infant; or

☐ We reuse bottles during the day (or from day-to-day without sending them home). Between uses, bottles, bottle caps, and nipples are placed in a tub for dirty dishes (or directly into dishwasher), then:

- ☐ Washed in dishwasher.
- ☐ Washed, rinsed, and boiled for one minute.

INFANT AND TODDLER SOLID FOODS

- Food is introduced to infants when they are developmentally ready for pureed, semi-solid and solid foods. Food, other than formula or breast milk/human milk, is introduced to infants no sooner than four, and preferably, six months unless there is a written order by a health care provider.
- No honey *(botulism risk)* is given to children less than 12 months of age. (This includes other foods containing these ingredients such as honey graham crackers.)
- Cups and spoons are encouraged at mealtime by six months of age.
- Chopped, soft table foods are encouraged after 9 months of age. Foods are cut into pieces one-quarter inch or smaller to prevent choking.
- When parents provide food from home, it is labeled with the child's full name and the date. Perishable foods are stored at or below 41ºF (5ºC).
- Before food is prepared, preparation surfaces are cleaned, rinsed, and sanitized.
- Staff wash their hands in the handwashing sink before preparing food. The handwashing sink should have an eight-inch-high splash guard or have 18 inches of space between the handwashing sink and any open food zones (such as preparation tables and food sink).
- Staff serve commercially packaged baby food from a dish, not from the container. Foods from opened containers are discarded or sent home at the end of the day.
- Gloves are worn or utensils are used for direct contact with food. (No bare hand contact with ready-to-eat food is allowed.) Gloves used for food preparation are kept in food preparation area. Hands are washed prior to and after using gloves.
- Children eat from plates and utensils. Food is not placed directly on table unless a high chair is used. High chair tray functions as a plate for seated children. The tray is washed and sanitized before and after use. Food is not served using polystyrene foam (styrofoam) cups, bowls, or plates.
- Infants or toddlers are not left more than 15 minutes in high chairs waiting for meal or snack time, and child is removed as soon as possible after finishing meal.
- Children are not allowed to walk around with food or cups.
- Teachers sit with infants and young children when eating, engage in positive social interaction, and observe each child eating.
- Infants or toddlers are prevented from sharing the same dish or utensil.
- Teachers are encouraged to eat the same foods the toddlers are served from the menu to model eating a variety of foods and demonstrate safe usage of eating utensils and eating behaviors.
- If there is uneaten food in a serving container that's been on, or passed around the table, it cannot be served after the intended meal.

For allergies or special diets, see the NUTRITION section of this policy.

PHYSICAL ACTIVITY AND SCREEN TIME

Adequate physical activity is important for optimal physical development and to encourage the habit of daily physical activity. Active play time includes a balance of a few teacher-directed activities as well as child-initiated play. The structured activities help contribute to skill building and promote fitness. The focus is on fun and interactive games and movement that also serve to enhance social and emotional skill development. Children have ample opportunity to do moderate to vigorous activity (running, jumping, skipping, and other gross motor movement) to the extent of their ability.

Outdoor play

- A variety of age-appropriate activities and play equipment for climbing, pulling, pushing, riding, and balancing are available outdoors.
- All children go outside in all weather (rain, snow, etc, …) unless it is dangerous or unhealthful.
- Our early learning program provides shaded areas in outdoor play space provided by ☐ trees, ☒ building, and/or ☒ shade structures.
- Infants spend 20 minutes per every 3 hours of programming outdoors, as tolerated.
- Toddlers spend 20 minutes per every 3 hours of programming outdoors. If they are in care for a full day, they are allowed 60 to 90 minutes of moderate to vigorous activity, of which 30 minutes may be indoor activities.

Preschool-age and older spend 30 minutes per every 3 hours of programming outdoors. If they are in care for a full day, they are allowed 90-120 minutes per day of moderate to vigorous activities, of which 30 minutes may be indoor activities.

Screen Time

Screen time includes media viewed on cell phones, tablets, computers, TVs, videos, film, and DVDs.

- Children under 2 years do not get any screen time.
- For children 2-5 years, screen time is limited to 1 hour per day (this includes screen time at home) and viewed with an adult who can help explain what they are learning in relation to the world around them.
- Children over 5 years may need to use screens to complete homework. That screen time does not take the place of healthy activities such as physical activity, sleep, and social interaction, including during meal and snack time.
- There is no screen time during scheduled meal or snack time. Screens should not be used during nap or rest times.
- Children are not required to participate in screen time activities.

TOOTH BRUSHING

Tooth brushing decreases the colonization of bacteria on teeth by disrupting the formation of plaque. The use of fluoridated toothpaste strengthens tooth enamel, making it more resistant to the acid produced by bacteria. Tooth brushing in the classroom improves the child's oral health, teaches children basic hygiene and health promotion, and helps establish a lifelong prevention habit.

We offer at least one opportunity each day for tooth brushing after a snack or a meal. Parents/guardians are given a chance to opt out of this activity for their child by signing a written form.

Tooth brushing is supervised to ensure:

- Establishment of a routine which enhances learning
- Proper toothpaste usage and excess is spit out
- Good tooth-brushing technique
- Toothbrushes are not shared and are handled properly
- Children do not walk with toothbrushes in their mouths

Toothbrushes are:

- Small, with soft, rounded nylon bristles that are short and even.
- Provided for each child and labeled with the child's name clearly marked on the handle with marker. No sharing or borrowing is allowed.
- Replaced every 3 months or sooner if the bristles become splayed or the toothbrush is contaminated.
- Not sanitized or put in the dishwasher.
- Stored to in a manner to prevent cross-contamination:
    - open to air with the bristles up
    - unable to drip on one another
    - in a labeled, designated spot/slot on a storage rack, not in contact with any other toothbrush or another child's storage slot

The WAC requires parents/guardians give permission **each year** for children age 2 years and older to use fluoride toothpaste. The WAC does not explicitly state the type of toothpaste to use for children under two years, but best practice, according to American Academy of Pediatrics (AAP) and American Dental Association (ADA), is that all children with teeth should brush using fluoride toothpaste.

For children who have teeth but are not yet 2 years old, our program brushes teeth using:

☒ Water only (no toothpaste) and an infant-sized toothbrush. No "Toothpaste Authorization Form" needs to be signed by parent/guardian for this option.

☐ Non-fluoride toothpaste and an infant-sized toothbrush. The "Toothpaste Authorization Form" must be signed by a parent/guardian if choosing this option.

☐ Fluoride toothpaste, as recommended by the ADA. The "Toothpaste Authorization Form" must be signed by a parent/guardian AND a dentist or health care provider if choosing this option.

Amount of toothpaste

The ADA recommends using a small smear (size of a grain of rice) of fluoride toothpaste as soon a child gets teeth until they are 3 years old, and a pea-sized amount of fluoride toothpaste for children who are older than 3 years.

Tooth brushing Procedure:

We use the following procedure for tooth brushing at our early learning program:

☒ **Tooth brushing at a Table (recommended)**

1. Teacher(s) assisting with tooth brushing wash hands.
2. As children finish eating, they are given a small paper cup with a small amount of water in the bottom and their toothbrush.
3. To eliminate cross-contamination, teacher dispenses toothpaste: pea size dot on rim of paper cup/plate. (how; i.e. via pea-sized dots of toothpaste around rim of a paper plate or cup).
4. Child begins brushing on the biting surface, and then moves from area to area (left-to-right and top-to-bottom) around the mouth.
5. Brushing continues for 2 minutes. (Exposure to fluoridated toothpaste is beneficial even with unsatisfactory brushing technique).
6. Child takes small sip of water from the cup and then spits water and toothpaste residue back into paper cup.
7. If desired, child may be given a drink of water from a different cup.
8. Child holds the toothbrush over the designated rinse container and the teacher pours water from a clean water source over the toothbrush to rinse it.
9. Child hands the toothbrush to the teacher, who puts it in the drying rack.
10. Child throws the paper cup away.
11. Table is cleaned with the 3-step process (clean, rinse, disinfect).

☐ **Tooth brushing at a Classroom Handwashing Sink:**

1. Classroom handwashing sink and faucet are cleaned, rinsed, and disinfected.
2. Teacher(s) assisting with tooth-brushing wash hands.
3. Water from a clean water source is obtained.
4. Teacher hands each child a small paper cup of clean water and his/her toothbrush.

5. To eliminate cross-contamination, teacher dispenses toothpaste: pea size dot of toothpaste on rim of cup.
6. Child begins brushing on the biting surface, and then moves from area to area (left-to-right and top-to-bottom) around the mouth.
7. Brushing continues for 2 minutes. (Exposure to fluoridated toothpaste is beneficial even with unsatisfactory brushing technique).
8. Child spits excess toothpaste into sink and rinses his/her mouth with a drink from the cup of water.
9. Child holds the toothbrush over the sink and the teacher pours the clean source of water over the toothbrush to rinse it.
10. If desired, child may be given a cleansing drink of water in their cup from a clean source of water.
11. Child hands the toothbrush to the teacher, who puts in the drying rack.
12. Child throws the paper cup away.
13. Classroom handwashing sink is cleaned with 3-step process (clean, rinse, disinfect) after all the children are finished brushing.

SOCIAL-EMOTIONAL CARE

Establishing positive relationships with children and their families is extremely important. Children need a consistent and supportive connection with their teachers to grow and learn. Childcare professionals must role model the social-emotional behavior they want to see develop in their students, such as empathy, appropriate interactions with others, and self-regulation. Children come from many different kinds of families and with many different experiences. Some children will come to you affected by a variety of stressors, while some children may have even been deprived of the relationships they needed to thrive. Other children may have the benefit of adequate resources. Regardless of what experiences children may bring to your class, they all require your warmth and attention.

- Always address children with respect and a calm voice.
- See yourself as a learning partner, not a power figure.
- Allow children to have a voice in solutions to their problems.

Program and Environment

- Teachers work to establish a respectful, warm, and nurturing relationship with each child in the classroom, including with parents and colleagues.
- Teachers provide children with the comforts of routine and structure that are flexible so as to meet the needs of a wide range of children.
- Teachers spend time at floor/eye level with the children.
- A responsive problem-solving approach is used with children. Guidance techniques such as coaching, modeling, offering choices, and/or redirection may be used to lead developmentally appropriate conflict resolution.
- Children's feelings are named and acknowledged to help a child learn and feel validated.
- Transitions are treated as learning opportunities for children within a developmentally appropriate time frame, and expectations are clearly communicated.
- Teachers can comfort children through conversation, sitting with children, and/or holding infants or toddlers when they are unhappy.
- Discipline is seen as an opportunity to teach children self-control and skill building.

- Behavior policies focus on problem solving with all concerned parties, rather than listing negative behaviors to be punished by disenrollment.

- When a child has a behavioral/social/emotional difficulties, outside resources will be accessed and a plan made to support the child and family.

- Should the program decide they cannot meet the needs of a child due to serious safety concerns, outside resources will be used to help the parent find services and placement that meets the child's and family's needs.

The "Behavior Handbook" is available on the CCHP website.

DEVELOPMENTAL CARE

Early learning for children is anchored in the respect for the developmental needs, characteristics, and cultures of the children and their families. Supporting the success of developmental tasks for children is necessary for their social-emotional health. Providers are in a unique position to encourage a child's development in a healthy and safe environment.

- Classrooms have curriculum and a variety of early learning materials that meet developmental and cultural needs for each age group of children served. Curriculum enhances the development of self-control and social skills, with opportunities for children to exercise choice and share ideas.

- Materials should promote imagination, creativity, language development, numeracy and spatial ability, as well as discovery and exploration.

- Lead teachers or family home early learning providers should be given regularly scheduled time to plan and develop curriculum and activities.

- Providers must discuss with parents or guardians the importance of developmental screenings for each child and offer available resources if screenings are not done on-site.

Center for Disease Control (CDC) Watch Me! Celebrating Milestones and Sharing Concerns online training modules are available for staff to learn ways to encourage and monitor growth and development milestones in their classrooms.

CHILD ABUSE AND NEGLECT

Child care providers are state mandated reporters of child abuse and neglect; we immediately report suspected or witnessed child abuse or neglect to Child Protective Services (CPS). The phone number for King County CPS is 1-800-609-8764. Please refer to your region's local intake number if not within King County.

Signs of child abuse and/or neglect are documented. The information is kept confidentially in the Director's office.

Training approved by DCYF on identifying and reporting child abuse and neglect is provided to all staff and documentation kept in staff files.

Licensor is notified of any CPS report made within 48 hours.

"NO SMOKING, NO VAPING" POLICY

- Staff will not smoke or vape while at work in the presence of children or parents.

- There will be no smoking or vaping of any substance on site or in outdoor areas within 25 feet of an entrance, exit, operable window, or vent in the building. This policy is in use at all times, regardless of whether or not children are on the premises. (Rationale: residual toxins from smoking can trigger asthma and allergies when children do use the space).

- There is no smoking or vaping of any substance allowed in any vehicle that transports children.

- If staff members smoke or vape, they must do so away from the school property, and out of sight of parents and children. They should make every attempt to not smell of smoke when they return to the classroom. Wearing a smoking jacket that is not brought into the building is helpful.

- Public Health Department staff will be available to provide trainings and resources regarding the effects of tobacco to families as requested by the early learning program.

- Using, consuming, or being under the influence of cannabis on licensed space is prohibited at all times.

- The program will post "no smoking or vaping" signs that are clearly visible and located at each building entrance used as a part of the early learning program.

Public Health will provide resources for staff interested in quitting smoking and/or vaping. In King County, visit https://kingcounty.gov/en/dept/dph/health-safety/safety-injury-prevention/tobacco-vaping/quit-smoking for more information.

ANIMALS IN EARLY LEARNING

☐ We have no animals on site.

☒ We have the following animals on site: Fish, Spiders, Hermit Crabs

☒ We have animal visitors: ☐ regularly ☒ occasionally. Please list animal visitors below:

Pigs, bunnies, goats, Reptile Man

- We have an animal policy, which is located in our policy handbook and above the animals tanks.
- Animals at or visiting our early learning program are carefully chosen in regards to care, temperament, health risks, and appropriateness for young children.
- We do not have the following animals as part of our early learning program activities:
    - Birds of the parrot family, which may carry psittacosis, a respiratory illness.
    - Reptiles or amphibians, which frequently carry *Salmonella* and pose a risk to children who may put unwashed hands in their mouths.
    - Chickens and ducks, which may excrete *E. coli*, *Salmonella*, and *Campylobacter*, and *S. paratyphoid* in their waste, all of which are bacteria that can cause serious diarrheal disease in humans, with more severe illness and complications in children.
- Parents are notified in writing when/if animals will be on the premises. Children with an allergic response to animals are accommodated.
- Any animal that shows signs of illness, disease, pests, worms, or parasites will be removed from the licensed space until it is seen and treated for the condition.
- Animals, their cages, and any other animal equipment are never allowed in the kitchen, food preparation, or eating areas.
- Children and adults wash hands after feeding animals or touching/handling animals or animal home or equipment.

PEST CONTROL AND PESTICIDE USE

☒ We do not routinely use pesticides on site, except in the event of an emergency.

☐ We do use pesticides on site. When pesticide is applied,

- ☐ our **center** complies with chapter **17.21** RCW.
- ☐ our **family home** complies with pesticide manufacturer's instructions.

We have a pesticide policy, which is located at Parent Sign in desk

Our pesticide policy emphasizes integrated pest management, such as:

- Nonchemical pest control methods (e.g., removing food sources, sanitation, repairs, etc.)
- Pest population monitoring, inspection, and reporting
- Low-toxicity methods used after non-toxic options have been utilized first

Notification of pesticide use

Notification of pesticide use will be posted no less than 48 hours prior to application and will specify the type of pesticide applied and location of application.

Pesticides will be applied in licensed space only when children are not present.

Emergency pesticide use

Pesticides used in the event of an emergency (e.g., wasp nest) may be applied prior to the 48-hour notification, but the notification will be posted as soon as possible and provide all necessary information.

Documentation

All pests found in licensed spaces will be identified and we will document:

- Date and time
- Type of pest
- Location/area
- Non-pesticide and/or pesticide methods used to remove or exterminate the pests