



CHILDREN'S VILLAGE

Early Learning Center

HEALTH POLICY

Early Learning Program Name:	Children's Village
Policy approved by:	Larry Benedict, RN
Date approved:	10/25/2022

Children's Village, Burton Road

2904 NE Burton Road
Vancouver, WA 98662
(360) 944-0123
Director: Erin Walker

Children's Village, Salmon Creek

1900 NE 129th Street
Vancouver, WA 98686
(360) 573-1144
Director: Janelle Quiroz

Hours of operation: Monday - Friday 6:30 am - 6:00 pm

Ages served: Birth - 12 years, 11 months

Emergency telephone numbers:

	Phone
Fire/Police/Ambulance	911
Poison Center	800-222-1222
Child Protective Services	800-609-8764
Animal Control	564-397-2488

Other important telephone numbers:

	Name	Phone
DCYF Licensor	Christine Lewis	360-836-2341
Infant Room Nurse Consultant	Larry Benedict, RN	
Communicable Disease/ Immunization Hotline (Recorded Information)	Clark Cnty.	564-397-8403
Communicable Disease Report Line	Clark Cnty.	564-397-8182
Out-of-Area Emergency Contact		

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 Angela Benedict, Executive Director.

Staff will be oriented to our health policy by Tori Garrow 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, staff room and on our website

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)*

CLEANING, SANITIZING, DISINFECTING AND LAUNDERING

Cleaning, rinsing, and sanitizing/disinfecting are required on most surfaces in childcare facilities. This includes tables, counters, toys, diaper changing areas, etc. This 3-Step Method helps maintain a more sanitary childcare 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/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 the surface with a paper towel.
2. **Rinse** – Spray with clear water and wipe with a paper towel.
3. **Sanitize/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 utility room. All such chemicals are:

- Inaccessible to children;
- In their original containers;
- Separate from food and food areas (not above food areas);
- Kept apart from other incompatible chemicals;

(e.g., bleach and ammonia create a toxic gas when mixed); **and**

- In a secured cabinet, to avoid a potential chemical spill in an earthquake.

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 kitchen.
- Bleach solutions are made up daily by the opening staff, 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.

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 daily, 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.
- Dirty diaper waste cans must have tight-fitting lids and 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 each use.
- Child care laundry is done on site.

- Laundry is washed above 140°F due to heat needed to sanitize items. If the hot water tank is set to 120°F, then you must use bleach to sanitize laundry according to the 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.

Water Tables

- Water tables are emptied, cleaned, rinsed, and sanitized after each use and as necessary.
- Children wash hands before and after water table play.

- ❖ **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.**

HAND HYGIENE

Liquid soap, warm running water (120°F 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 hand washing 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 the water and adjust the 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 a hand-drying towel to turn off water faucet(s) (unless the faucet turns off automatically) and open any door knob/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 of 100.4° F or above, as read using a digital forehead scan thermometer (temporal scan) or digital thermometer placed under the arm (axillary method),
- **Diarrhea or vomiting** - 2 or more occasions within 24 hours
- **Earache-**
- **Headache** - to the degree the child can not participate in program
- **Signs of irritability or confusion**
- **Sore throat**
- **Rash** - Body rash (not related to allergic reaction, diapering or heat)
- **Fatigue, crankiness, or illness that limits participation in daily activities**

- **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 lice nits are found. If live lice are found, children will be sent home for the day. 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.

Children with any of the above symptoms/conditions are separated from the group and cared for in the Health Room at the front desk area. Parent/guardian or emergency contact is notified to pick up the child. Because of limited space for ill children, we ask that families pick up their children within one hour of being called.

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 a posted notice and through messaging via ProCare.

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.

Staff members follow the same exclusion criteria as children.

IMMUNIZATIONS

To protect all children and staff, each child in our program has a completed and signed Certificate of Immunization Status (CIS) or current record from the Washington State Immunization Information System (WA IIS) on site. The official CIS form or a copy of both sides of that form is required (Other forms/printouts are not accepted in place of the CIS form.)

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.)

Children 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 quarterly..

If a parent/guardian chooses to exempt their child from immunization requirements, they must complete and sign the Certificate of Exemption (COE) form, which accompanies the CIS form. The child's health care provider must also sign the COE form for a

medical, religious, or personal/philosophical exemption. No health care provider signature is required for a “religious membership” exemption.

As of July 2019, state law prohibits personal and philosophical exemptions for the MMR vaccine. Medical and religious exemptions are allowed for children.

Children who are not immunized may not be accepted for care during an outbreak of a vaccine-preventable disease. 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.

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

STAFF HEALTH

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 healthcare 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.

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.

- 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 they are 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.*
- Staff who are out ill 3 or more days will be need to provide a Dr.'s note upon their return.
- Adult-sized chairs will be provided for staff.
- Staff will not step over gates or other barriers.

NOTIFIABLE CONDITIONS and COMMUNICABLE DISEASE REPORTING

Licensed childcare providers in Washington are required to notify Public Health Communicable Disease/Epidemiology, within 24 hours, when they learn that a child, staff member, volunteer, or household member has been diagnosed with one of the communicable diseases listed below. **In addition, providers should also notify their Public Health Nurse when an unusual number of children and/or staff are ill (e.g. >10% of children in a center, or most of the children in the toddler room), even if the disease is not on this list or has not yet been identified.**

To report any of the following conditions, call Public Health CD/EPI at (206) 296-4774.

Acquired immunodeficiency syndrome (AIDS)

Animal Bites

Anthrax

Arboviral disease (for example, West Nile virus)

Botulism (foodborne, wound, and infant)

Brucellosis

Burkholder mallei and pseudomallei

Campylobacteriosis

Chancroid

Chlamydia

Cholera

Cryptosporidiosis

Cyclosporiasis

Diphtheria

Diseases of suspected **bioterrorism origin**

Diseases of suspected **foodborne origin**

Diseases of suspected **waterborne origin**

Domoic acid poisoning

Enterohemorrhagic *E. coli*, (including *E. coli* O157:H7 infection)

Giardiasis

Gonorrhea

Granuloma inguinale

***Haemophilus influenzae* invasive disease**

Hantavirus pulmonary syndrome

Hemolytic uremic syndrome

Hepatitis A, acute

Hepatitis B, acute

Hepatitis B, chronic

Hepatitis C, acute, or chronic

Hepatitis, unspecified (D, E)

HIV infection

Immunization reactions, (severe, adverse)

Influenza, novel or untypable strain

Legionellosis

Leptospirosis

Listeriosis

Lymphogranuloma venereum

Malaria

Measles

Meningococcal disease

Monkeypox

Mumps

Paralytic shellfish poisoning

Pertussis

Plague

Poliomyelitis

Prion disease

Psittacosis

Q fever

Rabies and Rabies Exposures

Rare diseases of public health significance

Relapsing fever

Rubella

Salmonellosis

SARS

Sexually Transmitted Diseases (chancroid, gonorrhea, syphilis, genital herpes simplex, granuloma inguinale, lymphogranuloma venerium, *Chlamydia trachomatis*)

Shigellosis

Smallpox

Tetanus

Trichinosis

Tuberculosis

Tularemia

Vaccinia transmission

Vancomycin resistant *S. Aureus*

Typhus

Unexplained critical illness or death

Vibriosis

Viral hemorrhagic fever

Yellow fever

Yersiniosis

Rev. February 2011

Even though a disease may not require a report, you are encouraged to consult with a Child Care Health Program Public Health Nurse at 564-397-8182 for information about childhood illness or disease prevention.

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

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 the 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: at the front desk 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 or: in backpacks in the classroom.

Controlled substances (e.g., 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.

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 the sink or toilet.) See www.takebackyourmeds.org for more information on safe disposal.

Staff medication is stored in their locked staff lockers, out of the 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 at the front desk(where).

Medication is kept current (not expired).

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/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.

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 a child's bottle/cup or food without the 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 (i.e. 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 classroom, as well as the front desk area.

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

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

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

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. These travel first aid kits **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.

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 it remains 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 staff before taking the children outside.
- 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 window cords. The CPSC recommends cordless window treatments.)*
- Ensure firearms, guns, weapons, and ammunition are not on premises of child care programs and are safely locked and inaccessible to children if located in a 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.

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/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/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/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 licenser.
6. The designated staff person immediately calls the child care licenser 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.

**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 disinfectants, 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 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.

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): All supervisors.

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. Staff, as assigned, are 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.

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. Steve Mills 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 (*how often? minimum quarterly, monthly recommended*).

CHILDREN WITH SPECIFIC HEALTH CARE NEEDS

Our center is committed to meeting the needs of all children. This includes children with specific health care needs such as asthma, allergies, children with emotional or behavior issues, or chronic illness and disability. Inclusion of children with varying 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 specific needs will be accepted into our program under the guidelines of the Americans with Disabilities Act (ADA).
- Children with varying 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 what is required to be included in an individual plan of care, please reference [WAC110-300-0300](#).

Completed plans are requested from health care providers 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 receive general training on working with children with specific needs. Any staff that is involved in the care of a child with specific 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.

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 the 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 the diapering surface or in the diapering area.

Diaper changing pads are replaced when they become worn or ripped. No tape is present on the 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 a paper towel.
3. Put on disposable gloves, if desired.
4. Place the child gently on the table and unfasten the diaper. *Do not leave a 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 hand washing only. Do not leave a child unattended.*
8. If the parent/guardian has completed a medication authorization for diaper cream/ointment/lotion, put on clean gloves and apply to the area. Remove gloves.
9. Put on a clean diaper (and protective cover, if cloth diaper used). Dress child.
10. **Wash the child's hands** with soap and running water (or with a wet wipe for very young infants).
11. Place the 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.

Stand-Up Diapering for Older Children

x We do stand-up diapering as appropriate.

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

Diaper changing procedure is posted in the 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 a soiled diaper/pull-up in a covered, hands-free, plastic-lined garbage can with lid or put soiled underpants in a plastic bag to be returned to the family at the end of the day.
6. Coach the child in cleaning the diaper area front to back using a clean, damp wipe for each stroke (and assist as needed).
7. Put soiled wipes in a plastic bag (or assist a child in doing so) and dispose of the plastic bag into a covered, hands-free, plastic-lined trash can with a lid.
8. Remove gloves, if worn.
9. **Wash hands** (in bathroom/hand washing sink) and coach children 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 a 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/hand washing 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.

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 the 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 infants 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, or infant seats. Any child who arrives at the program asleep in a car seat, 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, 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 sleepers or sleep sacks can be used in lieu of blankets. Sleep sacks must allow for infant arms to be free and allow for unrestricted movement.
 - Swaddling is not necessary nor recommended in a child care setting.
 - 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, necklaces, and garments with ties or hoods will be removed before placing an infant to sleep.

- Cribs meet current Consumer Product Safety Commission (CPSC) standards or American Society for Testing and Materials (ASTM) International safety standards.
- Mattresses are firm, snug fitting, intact, and waterproof.
 - Crib sheets fit the mattress snugly, but do not cause mattresses to curl up at corners.
- Cribs are spaced at least 30 inches apart or separated by Plexiglas barrier.
- Nap mats are separated by at least 36 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 the wall. Mobiles should not be placed above cribs.
- Crib wheels are locked in order to prevent movement in an earthquake.

Safe Sleep Training

Before caring for infants, staff and volunteers working in the infant room must have annual documentation of safe sleep training approved by the Washington State Department of Children, Youth, and Families.

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 36 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/drapes can pose a risk of suffocation and/or strangulation.
- Nothing is stored above sleeping equipment unless securely attached to a wall.

FOOD SERVICE

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

We keep “back up” food available to serve, should the food arrive out of the proper temperature range. Good items to have on hand include tuna fish and baked beans.

x We prepare meals and 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 (*where; in the kitchen area and/or 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
- Continuous 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 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, thermometers stay at or below 39°F in the refrigerator or 0°F in the freezer. If not storing breast milk, thermometers stay at or below 41°F in the refrigerator and 10°F or less in the freezer. Refrigerator and freezer temperature is logged daily.

Microwave ovens, if used to reheat food, are used with special care. Food is heated to 165 degrees, 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 (140° F residential or 160°F 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 155° F

Fish 145° F

Pork 145° F

Poultry 165° F

Holding hot food: hot food is held at 135° F or above until served.

Holding cold food: food requiring refrigeration is held at 41°F 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 41° F or less.

Leftover foods (*foods that have been below 41 °F or above 135 °F 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 165° F 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 signs 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.

- 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 3 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 requirements.

Meal/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 three snacks
 - one meal and three snacks

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

<u>Time</u>	<u>Meal/Snack</u>
7:00 – 8:00 am	Breakfast
9:15 - 9:45 am	Morning Snack
11:30 - 12:15 am	Lunch
2:30 - 3:15 pm	Afternoon Snack
5:00 - 5:30 pm	Late Snack

- A snack is provided to children who arrive after school.
- Each snack or meal includes a liquid to drink:
 - Unflavored milk must be served with every meal.
 - 100% fruit/vegetable juice may be served as a snack, limited to 4 oz. or less per day for children over 12 months.
 - Water may also be served.
- Breast 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 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 the child's parents/guardians if the child is over 12 months.
- Cereals served contain no more than 6 grams of sugar per 1 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.
- 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 promote self-regulation.
- 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 to no more than twice a month; this should be coordinated and monitored by the classroom teacher. Items that are health promoting should always be encouraged; information is available for parents with ideas for birthday, holiday or special occasions “treat”.

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

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 prepare 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 Support

- Our early learning program encourages, supports and accommodates breastfeeding mothers.
 - Staff are a resource for breastfeeding mothers.
 - The infant room has a quiet, private space set aside for breastfeeding as well as a space for pumping in a separate room.
 - We provide educational materials and resources to support breastfeeding mothers.
 - Staff are trained on the safe handling of expressed breast milk.
 - Staff discuss the breastfed infant's feeding pattern with parent/guardian regularly.
- Infants are only fed breast 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 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 the 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 the 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 must be stored at or below 39° F. If not storing breast milk, the refrigerator should be kept at or below 41° F. The refrigerator temperature is

logged daily. *(It is recommended that the refrigerator be adjusted between 30 °F and 35 °F to allow for a slight rise when opening and closing the door.)*

- Unused, refrigerated, not previously frozen, bottles or containers of breast milk are labeled “do not use” and then returned to the parent at the end of the day. Unused, previously frozen (thawed) breast 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 an ice pack (to be kept in the child’s cubby area) to keep partially consumed breast milk bottles cool until the child is picked up at the end of the day.
- Frozen breast milk pouches/containers are labeled with the **child’s full name and date it was received**, stored at 0°F or less and for no longer than 30 days. Unused frozen breast 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 is thawed in the refrigerator, under warm running water, in warm water (water under 120°F) or in a bottle warmer before feeding. Thawed breast milk must be kept in the refrigerator at a temperature of 39°F. Thawed breast milk is not refrozen.
5. Bottles of formula are prepared with cold water from the cold water tap from the following clean source: Kitchen. 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 the food preparation area.
9. Glass or stainless steel bottles, or plastic bottles labeled with recyclable symbols “1”, “2”, “4” or “5” on bottles 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 the following method:
 - x We use a bottle warmer and:
 - Bottle warmer is secured to the counter or wall.
 - Bottle warmer is cleaned, rinsed, and sanitized daily.
 3. Temperature is checked before the bottle is fed to the infant (wrist method).

Bottle Feeding

1. Infants are fed on cue. Staff watches for and responds 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.**
2. 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.**
3. Staff receive training on infant feeding cues.
4. The name on each bottle is checked before the bottle is offered to an infant to make sure that the correct formula or breast milk is given to each infant.
5. Bottles are **labeled with time feeding begins.**
6. 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.
7. 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.

8. **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.*)
9. 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.*)
10. **Bottles that have been served, including partially consumed bottles, do not go back in the refrigerator.**
11. Breast 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.
12. Families are advised to send several small bottles or portions, enough for one day only, to minimize the amount of breast milk or formula that is discarded.
13. Staff are encouraged to work closely with the same infant over time in order to increase familiarity with the 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.

- x 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 the 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, is introduced to infants

no sooner than four, and preferably, six months unless there is a written order by a healthcare 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 8 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 41° F.
- 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 the food preparation area. Hands are washed prior to and after using gloves.
- Children eat from plates and utensils. Food is not placed directly on the 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 for more than 15 minutes in high chairs waiting for meal or snack time, and the child is removed as soon as possible after finishing the 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 the 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 LIMITATIONS

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 x trees, x building, and/or x shade structures.
- Infants spend 20 minutes per every 3 hours of programming outdoors, as tolerated.
- Toddlers spend 20 minutes 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

- **Children under 2 years do not get any screen time.**
- Children over 2 years are limited to 30 minutes of educational viewing per week, if at all. Computer use is limited to 15 minute increments of play time, except when children are completing homework or school lessons. - NA
- There is no screen time during scheduled meals or snacks.

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.

As recommended, **fluoridated toothpaste is not used by children under 2 years old** or those who are unable to spit out toothpaste after brushing. The American Dental Association (ADA) recommends that for children 2 to 3 years old, a grain of rice-sized amount of fluoridated toothpaste should be used. The ADA recommends for children 3 to 6 years old, a pea-sized amount of fluoridated toothpaste should be used.

Tooth brushing is supervised to ensure:

- A routine which enhances learning
- Proper toothpaste usage
- 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 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

Tooth brushing Procedure:

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

x Tooth brushing at a Table (recommended)

1. Teacher(s) assisting with tooth brushing and washing 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, the teacher dispenses toothpaste: on the rim of a portion 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 a small sip of water from the cup and then spits water and toothpaste residue back into paper cups.
7. If desired, the 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 hand washing 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:
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 the 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, the 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 it in the drying rack.
12. Child throws the paper cup away.
13. Classroom handwashing sink is cleaned with a 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 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.

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.

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 CPS is 1-800-END-HARM.

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.

Licensors are notified of any CPS report made within 24 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 training 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.

ANIMALS IN EARLY LEARNING

- We have no animals on site.
- We have the following animals on site:
- X We have animal visitors: regularly X occasionally. Please list animal visitors below: Dogs

PEST CONTROL AND PESTICIDE USE

- We do not routinely use pesticides on site, except in the event of an emergency.
- x 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 the front desk (*where*).

Our pesticide policy emphasizes integrated pest management, such as:

- Non Chemical 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