Introduction

The Ohio Department of Job and Family Services (ODJFS), the Ohio Department of Health (ODH) and the Ohio Department of Education prepared this booklet to provide information to child care providers about communicable diseases, measures to take to control the spread of diseases and related child health issues. This course will fulfill the staff in-service requirement of prevention, recognition and management of communicable disease. The curriculum is based upon Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care and Infectious Disease Control Manual, and is produced by ODH.

For further information or clarification of the child care licensing rules, instructors may call the ODJFS Helpdesk at 866-886-3537 (option 4) or the Web site for service providers http://www.jfs.ohio.gov/cdc/providers.stm

For further information on the content included in this course, instructors may call ODH at 614-644-8389.
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Infections — How Diseases are Spread

A communicable disease is a disease that can be spread from one person to another. Germs cause communicable diseases. Most germs are very small and can be seen only with a microscope. “Germ” is a commonly used word that refers to more specific terms such as bacteria, virus, fungus or parasite.

Infants and toddlers are highly susceptible to contagious diseases. They have not yet been exposed to many of the most common germs. Therefore, they have not yet built up resistance or immunity to them. Also, young children have many behaviors that promote the spread of germs. For example, they often put their fingers and other objects in their mouths. This way, germs enter and leave the body and can then infect the child or be passed on to other children.

In order for communicable diseases to be transmitted from one person to another, certain conditions are necessary for the germs to be spread from person to person. The conditions involved in the spread of communicable disease are called the chain of infection below and include the following:

1. Germs or agents must be present in sufficient numbers to cause illness.
2. Reservoir is the source where the germ lives. This is frequently in or on a human, but can also be from an animal, in the air or on a surface.
3. A place to exit must be present for the germ to leave the source (reservoir). Examples of exit places are: the mouth or nose of person sneezing or coughing, skin lesions filled with fluid or pus, feces, vomitus, urine or blood.
4. A route of transmission is needed for the germ to enter the mouth, nose, blood or skin of another person.
5. Germs must enter the body of another person (entry).
6. Host refers to the person who receives the germ. Any person may become a host. Some people have the ability to fight off some infection and may not always get sick when a germ enters their body.

The Chain of Infection

As the table on the following page shows, diseases are spread in the following ways:

Direct contact by touching fluid from another person’s infected sores.

Mouth and nose (respiratory): sneezing, coughing and runny nose by someone who has germs allows the germs to spread to other people.

Fecal-oral (intestinal tract) infections, including some types of diarrhea, usually are spread through exposure to germs in bowel movements (feces). This means germs leave the body of the infected person in feces and enter the body of another person through the mouth. In most situations, this happens when objects (such as toys, fingers or hands) which have become soiled with invisible amounts of feces are placed in the mouth. Fecal-oral transmission can also occur if food or water is contaminated with invisible amounts of human or animal feces and then is eaten or drunk. Undercooked foods made from animals (for example meat, milk and eggs) are often the sources of infection with E. coli O157:H7 and Salmonella.

Blood infections are spread when blood (and sometimes other body fluids) enter the blood stream of another person. The germ enters the body through cuts or openings in the skin: the mucous membrane that lines body cavities such as the nose and eye; or directly into the bloodstream, as with a needle.
Transmission of Disease
How Some Infectious Diseases are Spread

<table>
<thead>
<tr>
<th>Direct Contact (with infected person's skin or body fluid)</th>
<th>Mouth and Nose Transmission (from the lungs, throat or nose of one person to another person through the air)</th>
<th>Fecal-oral Transmission (touching feces or objects contaminated with feces and then the mouth)</th>
<th>Sexual Transmission</th>
<th>Blood Transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickenpox*      Cold Sores  Conjunctivitis  Head Lice  Impetigo  Ringworm  Scabies  Influenza*  Measles*  MRSA  Mumps*  Pertussis*  Pneumonia*  Rubella*</td>
<td>Chickenpox*  Common Cold  Diphtheria*  Fifth Disease  Bacterial meningitis  Hand-Foot-Mouth Disease  Impetigo  Pinworms  Polio*  Salmonella**  Shigella</td>
<td>Campylobacter**  E.Coli O 157:H7**  Enterovirus  Giardia  Hand-Foot-Mouth Disease  Hepatitis A  Infectious Diarrhea</td>
<td>Chlamydia  Hepatitis B*  Hepatitis C  HIV Infection</td>
<td>Cytomegalovirus  Hepatitis B*  Hepatitis C  HIV Infection</td>
</tr>
</tbody>
</table>

*Vaccines available for preventing these diseases.
**Often transmitted from infected animals through foods or direct contact.
***Head lice are not infectious but rather communicable.

Employee Safety-Use of Standard Precautions in Child Care

“Standard precautions” is the term used to describe steps for child care staff to use to protect themselves from potentially infectious diseases. The concept of “standard precautions” recognizes that any body fluid may hold contagious germs. In the 1980s the term “universal precautions” described guidelines developed by the Centers for Disease Control and Prevention (CDC) to reduce the spread of infection to health care providers and patients in health care settings. Standard precautions expanded the universal precautions, recognizing that any body fluid may hold contagious germs. They are still primarily designed to prevent the spread of blood-borne disease (disease carried by blood or other body fluids), but are also excellent measures to prevent the spread of infectious disease in group care settings such as child care facilities. Child care facilities must follow standard precautions.

NOTE: In ODJFS Ohio Administrative Code (OAC) rules “basic precautions.” means the same as “standard precautions in child care.” Both terms refer to the same precautions in this manual.

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

**What do standard precautions consist of?**

Standard precautions include the following:

**Hand washing**
- After diapering or toileting children.
- After handling body fluids of any kind.
- Before and after giving first aid (such as cleaning cuts and scratches or bloody noses).
- After cleaning spills or objects contaminated with body fluids.
- After taking off your disposable gloves.
- Remember, wearing gloves does not mean you don’t have to wash your hands.

**Latex (or vinyl) gloves should be worn**
- During contact with blood or body fluids which contain blood (such as vomit or feces which contain blood you can see).
- When staff members have cuts, scratches or rashes which cause breaks in the skin of their hands.

Environmental sanitizing should be done regularly and as needed. These requirements are described in the Environmental Control section, which explains routine sanitizing and the procedure for sanitizing after spill of blood or bodily fluid containing blood.

Proper disposal of materials that are soaked in or caked with blood requires bagging in plastic bags that are securely tied. Send these items home with the child. Items used for procedures on children with special needs (such as lancets for finger sticks or syringes for injections given by parents) require a special container for safe disposal. Parents should provide what is called a “sharps” disposable container. This is a container made out of durable, rigid material which safely stores the lancets or needles until the parent can take them home for disposal. Sharps containers must be stored out of the reach of child.

**Standard precautions in child care settings vs. hospitals and clinics**

Child care facilities follow the same standard precautions as clinic and hospital settings with the following exceptions:
- Use of latex (or vinyl) gloves is optional except when blood or blood-containing body fluids may be involved.
- Gowns and masks are not required.
- Appropriate barriers include materials such as disposable diaper table paper, disposable towels and surfaces that can be sanitized in group care settings.

**What else am I required to do?**

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

1. Exposure determination. This is a list of the job title or duties that might put an individual in contact with blood or blood-containing fluids (such as first aid, nose blowing, diapering, etc.).
Methods of compliance. These are the ways you will assure your plan will work and which include written standard precautions and cleaning plans, training of staff in their use and the availability of gloves.

Hepatitis B vaccination.
This must be offered by the employer at no cost to staff. The vaccine series can begin either:
- Within 10 days of employment.
- Within 24 hours after a potential blood exposure (accidental contact with blood while administering first aid, diapering an infant with a bloody stool, etc.).


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

Exposure-reporting procedures. These are required and tell staff what to do if something happens that puts an employee in contact with blood on their broken skin (cuts, scratches, open rashes or chapped skin) or on their mucous membranes (in the eye, mouth or nose). There are also record-keeping requirements to document the exposure situation, whether the employee received a free medical exam and follow-up and the employee was offered the hepatitis B vaccination if she/he did not already have the series.

Training on OSHA regulations. This should be provided to all staff at the time that they start work and include:
- An explanation of how HIV (which causes AIDS) and hepatitis B are transmitted.
- An explanation of standard precautions and the exposure control plan for your program.

For more information contact:
Ohio Regional OSHA Offices:
Cincinnati Area Office
(513) 841-4132
Cleveland Area Office
(216) 522-3818
Columbus Area Office
(614) 469-5582
Toledo Area Office
(419) 259-7542
Child Care Health Consultants:
Ohio Department of Health
Bureau of Early Intervention Services
(614) 644-8389
BEIS@odh.ohio.gov

Adapted from:
California Childcare Health Program
Self-Learning Module (SLM) Keeping Safe When Touching Blood or Other Body Fluids, Early Childhood Education Linkage System - Healthy Child Care PA, American Academy of Pediatrics, PA Chapter
Prevention and Control of Diseases

Control and prevention of communicable diseases are important for the following reasons: communicable diseases can lead to serious health problems such as pneumonia, meningitis or kidney disease; are easily spread to other people; and cause absenteeism. Immunization is one of the most effective means to prevent the spread of diseases such as polio, measles and mumps. In addition to immunization, hand washing is also one of the most effective means to prevent the spread of disease on a daily basis.

All children admitted to the child care facility (including school-age child care programs) should be up to date on immunizations. Ohio law requires each child not yet attending school have an annual physical exam and written proof of their immunizations. Each child in your care should have a record of up-to-date immunizations on file. If the child is exempt from immunizations because of a medical condition or religious objection, this should be noted on the immunization record and supported in the child’s file with documentation from the physician (for a medical waiver) or a request from the parent (for a religious exemption).

Several diseases that can cause serious problems for children and adults can be prevented by immunizations. These diseases are chickenpox (varicella), diphtheria, Haemophilus influenzae type B, meningitis, hepatitis A, hepatitis B, influenza, pneumococcal disease, measles, mumps, polio, rubella (German measles or 3-day measles), tetanus and whooping cough (pertussis). Many of these diseases are less common in the United States because most people have been immunized against them, but cases still occur. Staff and children in a child care setting are at increased risk for many of these diseases because of the many hours they spend in close contact with other children.

The Ohio Department of Health (ODH) recommends children who are not up to date on their immunizations be excluded from child care until they have begun the series of shots needed. Because this schedule changes frequently, you should contact your local or state health department for updates at least annually or go to: http://www.odh.ohio.gov/odhPrograms/idc/imunize/cliloc.aspx.

Child Emergency Information

In addition to the immunization status, health and medical emergency information should be kept on every child in the setting. The OAC (ODJFS rules: 5101:2-12-37, and 5101:2-13-37) require emergency transportation authorization statements from the child’s parent be on file before the child begins attending the facility. Information that must be known is:

- Where parents can be reached, full names, work and home phone numbers, and addresses. Request numbers of pagers, cell phones and a person who can locate the parents during child care hours.
- At least two local people to contact if parents can’t be reached and their phone numbers. At least one person listed must be able to take responsibility for the child. These are people designated by parents who will be able to pick up and care for the child when the parent cannot be reached. Be sure to add this adult to the approved pick-up list if you maintain a separate list.
- The name of the child’s regular health care providers (physician, nurse practitioner), their addresses and phone numbers.
- Each child (except those children who are attending a grade of kindergarten or above) needs to have documentation on file of a physical exam within the previous 12 months. A copy of the medical form needs to be on file within 30 days of the child’s date of admission and be updated every 13 months thereafter, until the child is attending kindergarten.
- Any special health problems or medical conditions that a child may have and procedures to follow to deal with these conditions. Examples of conditions needing procedures are allergies,
asthma, diabetes, epilepsy and sickle cell anemia. These conditions can cause sudden attacks that may require immediate action. It is important to know: 1) what happens to the child during a crisis related to the condition; 2) how to prevent a crisis; 3) how to deal with a crisis; and 4) whether you need training in a particular emergency procedure. A Medical/Physical Care Plan (JFS 01236) or an equivalent form needs to be completed.

**Immunization and Health History for Child Care Staff**

Children, especially those in groups, are more likely to get certain communicable diseases than are adults. Child care staff are exposed to infectious diseases more frequently than someone who has fewer contacts with children. To protect yourself and children in your care, you need to know what immunizations you received as a child and if you had certain childhood diseases. If you are not sure, your health care provider can test your blood to determine if you are immune to some of these diseases and can vaccinate you against those to which you are not immune. **Staff should be immunized against measles-mumps-rubella [MMR], tetanus-diphtheria [Td] or tetanus-diphtheria-pertussis [Tdap], and varicella (if no history of disease).** All childcare workers are also recommended to receive the influenza vaccine. Some staff need the hepatitis B vaccine (See: Standard Precautions). Individuals should also consult with their primary health provider for further recommendations. The table on pages __- ___ list the immunizations the CDC and ODH believe are appropriate for child care staff, based on the official recommendations for immunizations of adults in other occupations and settings.

According to the Ohio child care rules (ODJFS Rule 5101:2-12-25 (centers); Rule 5101: 2-13-25 (Type A) each employee must have a medical statement signed by their health care provider verifying they are: free of communicable tuberculosis, physically fit for employment in a facility caring for children and immunized with the Measles-Mumps -Rubella (M-M-R) and the Tdap vaccines.

**Tuberculosis (TB) Screening**

Persons who have the following symptoms at any time should not attend, work or volunteer at a child care facility until they have been evaluated by a physician or the designated TB authority: persistent cough lasting longer than two or three weeks; coughing up blood; unexplained weight loss; night sweats; fatigue; fever. Persons who have active or suspected active infectious TB should be excluded from the child care setting until the local designated TB authority has determined they may return to the center.
<table>
<thead>
<tr>
<th>Immunization</th>
<th>How often</th>
<th>Why</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza (Flu)</td>
<td>All child care staff, especially those who have chronic health conditions or are over 50 years of age should be immunized against influenza. Immunizations are given yearly, starting in October, because a new influenza vaccine is developed each year to protect against the viruses expected that year.</td>
<td>Flu is a respiratory disease and causes fever, chills, headache, muscle ache, sore throat, cough and cold symptoms. Vomiting and diarrhea are usually not seen with the flu. Influenza may lead to pneumonia and other severe illness among the young (0-23 months), elderly and those with chronic illnesses or weak immune systems.</td>
</tr>
<tr>
<td>Measles</td>
<td>Child care staff should be immune to measles, mumps and rubella. Staff born before 1957 can be considered immune to measles and mumps. Others can be considered immune if they have a history of measles or mumps disease or have received at least one dose of vaccine on or after their 1st birthday. Because a history of rubella disease is often unreliable, only a blood test indicating immunity to rubella or documented receipt of at least one dose of rubella vaccine is adequate proof of immunity.</td>
<td>Measles, mumps and rubella vaccines are usually given together as MMR. Most experts recommend two doses of MMR for persons without other evidence of immunity. Measles: two to three people out of every 1,000 who contract measles die from complications such as pneumonia or encephalitis. Encephalitis is an inflammation of the brain, which can lead to convulsions, deafness or mental retardation. Measles during pregnancy increases the risk of premature labor, spontaneous abortion and low birth weight. Mumps: Fifteen percent of cases are in adolescents and adults. Mumps may cause inflammation of the pancreas or sexual organs and may cause permanent deafness or sterility. Rubella: Rubella may cause miscarriage, stillbirth and multiple birth defects (congenital disorders, mental retardation) if contracted in the first months of pregnancy.</td>
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<tr>
<td>Immunization</td>
<td>How often</td>
<td>Why</td>
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<tr>
<td><strong>Tetanus Diptheria (Td)</strong></td>
<td>Child care staff should have a record of receiving a series of three doses (usually DTP given in childhood) and a booster dose (Td or Tdap) given within the past 10 years.</td>
<td>Tetanus (lockjaw) causes painful muscular contractions. Forty to 50 percent of persons who contract tetanus die. Diptheria affects throat and nasal passages, interferes with breathing and produces a toxin that damages the heart, kidneys and nerves. Ten percent of cases are fatal.</td>
</tr>
<tr>
<td><strong>Polio</strong></td>
<td>Child care staff, especially those working with children who are not toilet-trained, should have a record of a primary series of three doses (usually given in childhood) and a supplementary dose given at least six months after the third dose in the primary series.</td>
<td>Polio attacks the nervous system and can cause paralysis in legs or other areas.</td>
</tr>
<tr>
<td><strong>Hepatitis A</strong></td>
<td>Hepatitis A vaccine is not routinely recommended for child care staff but may be indicated if the local health department determines the risk of hepatitis A in the community is high. Any person who travels out of the country frequently should consider getting hepatitis A vaccine.</td>
<td>Hepatitis A is a liver infection that causes fever, a loss of appetite, nausea, diarrhea and generally ill feeling that may persist for weeks. During an outbreak in a child care setting, hepatitis A spreads easily and quickly. However, in the absence of an outbreak, the risk to child care staff in general does not seem to be increased.</td>
</tr>
<tr>
<td><strong>Chickenpox</strong></td>
<td>Child care staff who know they have had chickenpox (varicella) can assume they are immune. All other staff should consider getting immunized against chickenpox. Persons who believe they have never had chickenpox or are unsure can be immunized. In some areas, blood tests may be available to determine if a person is susceptible and in need of immunizations.</td>
<td>Chickenpox can be a severe disease in adults. Child care staff are at high risk of being exposed to chickenpox in the child care setting.</td>
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<tr>
<td><strong>Hepatitis B</strong></td>
<td>Child care staff who may have contact with blood or blood-contaminated body fluids or who work with developmentally disabled or aggressive children should be immunized against hepatitis B with a series of three doses of vaccine.</td>
<td>Hepatitis B causes serious illness and one in 20 persons will develop chronic hepatitis, which can destroy the liver and raise the risk of getting liver cancer. Persons who develop chronic hepatitis B are communicable to others for the rest of their lives.</td>
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</tbody>
</table>
# CDC Immunization Chart

Below is the 2009 immunization chart from the Center for Disease Control (CDC). Because this chart is updated yearly at CDC, the following link will provide the child care provider with a link to the most current version of the chart: http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable

### Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2009

**For those who fall behind or start late, see the catch-up schedule**

<table>
<thead>
<tr>
<th>Vaccine ▼</th>
<th>Age ▼</th>
<th>Birth</th>
<th>1 month</th>
<th>2 months</th>
<th>4 months</th>
<th>6 months</th>
<th>12 months</th>
<th>15 months</th>
<th>18 months</th>
<th>19-23 months</th>
<th>2-3 years</th>
<th>4-6 years</th>
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<tbody>
<tr>
<td>HepB (b)</td>
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<td>HepB</td>
<td>HepB</td>
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<td>HepB</td>
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<td>Prevnar²</td>
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<td>PCV</td>
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<td>Inactivated Polio</td>
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<td>Influenza</td>
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<td>Inf (Yr)</td>
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<td>MMR</td>
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<td>Varicella</td>
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<tr>
<td>Hepatitis A</td>
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<td>HepA (2 doses)</td>
<td>HepA Series</td>
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This schedule indicates the recommended ages for routine administration of currently licensed vaccines, as of December 1, 2009, for children aged 0 through 6 years. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. Licensed combination vaccines may be used whenever any component of the combination is indicated and other components are not contraindicated and if approved by the Food and Drug Administration for that age.

- **HepB**: Hepatitis B vaccine (HepB), (Minimum age: Birth)
  - Administer monovalent HepB to all newborns before hospital discharge.
  - If mother is hepatitis B surface antigen (HBSAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HIG) within 12 hours of birth.
  - If mother’s HBSAg status is unknown, administer HepB within 12 hours of birth. Determine mother’s HBSAg status as soon as possible and, if HBSAg-positive, administer HIG no later than 1 week.

- **DTaP**: Diphtheria, tetanus, and acellular pertussis vaccine (DTaP), (Minimum age: 2 months)
  - Administer the first dose at age 6 through 14 weeks (maximum: 14 weeks, 6 days). Vaccination should not be initiated for infants aged 16 weeks or older (i.e., 15 weeks, 7 days or older).
  - Administer the final dose in the series by age 8 months (maximum: 8 months, 6 days).
  - If 3 doses of DTaP are administered before age 6 months, a dose at 6 months is not indicated.

- **Prevnar²**: Pneumococcal conjugate vaccine (PCV), (Minimum age: 2 months)
  - PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 months or older who are not completely vaccinated for their age.

Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations, including high-risk conditions. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at http://www.vaers.hhs.gov or by telephone: 1-800-822-7967.
Health Insurance for Ohio’s Children and Families

Please share information with child care personnel and families about these two valuable health insurance programs called Healthy Start (for children) and Healthy Families (for families). A summary of the Healthy Start program is provided below which was printed from the ODJFS Web site: http://jfs.ohio.gov/ohp/bcps/FactSheets/hshf.pdf. Check the Web site for information about the Healthy Families program and instructions for applying for both programs.

Healthy Start and Healthy Families are Ohio Medicaid programs that provide eligible Ohio children, pregnant women and families comprehensive health coverage. In 2008, Ohio Medicaid expanded Healthy Start eligibility guidelines to cover more of Ohio’s uninsured. Ohioans who qualify for Healthy Start and Healthy Families programs gain access to important services such as doctor visits, prescriptions, hospital care, immunizations, vision and dental care, substance abuse services, mental health services and more.

Healthy Start

Healthy Start covers children (up to age 19) in families with income at or below 200 percent of the federal poverty level (FPL).

The program also covers pregnant women (any age) in families with income at or below 200 percent of the FPL and certain children younger than age 21 aging out of the foster care system. Pregnant women are eligible for Healthy Start coverage during the entire pregnancy and up to 60 days after the baby is born. Babies born to mothers on Healthy Start are automatically eligible for free health coverage for one full year from the date of birth.

Can children have other health insurance and still qualify for Healthy Start?

Children in families whose income is between 150 percent and 200 percent of the FPL must be considered “uninsured” to be eligible for Healthy Start. Please note: Children in families with income below 150 percent FPL can have other health insurance and still qualify for Healthy Start.

<table>
<thead>
<tr>
<th>Healthy Start Monthly Income Guidelines for Children &amp; Pregnant Women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Size</strong></td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>

Based on 2009 federal poverty guidelines and change annually.

See the chart on the right to see if a child must be uninsured in order to qualify for Healthy Start.
Health Risks for Pregnant Child Care Staff

Introduction: Several common childhood diseases may be harmful to either the unborn child or the pregnant woman herself if she contracts the disease after a first time exposure. Specific details follow:

Cytomegalovirus (CMV)

Prevalence: Dependent on maternal age (older) and socio-economic status (lower). Within the United States, the primary CMV infection rate in pregnant women ranges from 0.7-4%; the rate of recurrent infection can be as high as 13.5%. About 50% of children attending child care have been found to actively shed CMV virus in their saliva and urine.

Maternal effects: Women may either have no symptoms or a combination of the following: fever, fatigue, muscle aches, chills and enlarged lymph nodes in the neck.
Fetal effects: Leading cause of hearing loss in children; other possible effects include blindness, mental retardation and long-term neurologic impairment.

Prevention: There is not an available CMV vaccine. Passive prophylaxis has not been well studied but may be appropriate in specific instances; exposed women should consult with their physicians. Prevention of congenital infection depends on good hygiene and hand washing technique to prevent maternal infection.

Treatment: None

NOTE: Prior infection does not provide permanent immunity; this is an infection that a woman could have more than once.

Influenza

Prevalence: In the United States, approximately 25 percent of the population has flu-associated illness annually, leading to an average of 20,000 to 40,000 deaths per year.

Maternal effects: Upper respiratory illness with fever; pneumonia occurs in 12% of pregnant women so infected.

Fetal effects: None identified

Prevention: Both the American College of Obstetricians and Gynecologists and the Centers for Disease Control and Prevention recommend that all pregnant women be vaccinated during influenza season (optimally October-November)

Treatment: Supportive care and antiviral medication for acute and/or severe infection.

Mumps

Prevalence: Because of childhood immunization, 80-90% of adults are immune

Maternal effects:
Fetal effects: Miscarriage risk may be increased but there is not increased risk for birth defects.
Prevention: A vaccine is available; since it contains attenuated live virus, it should not be given to pregnant women and pregnancy should be avoided for one month after receiving the vaccine.

Treatment: Treatment for symptoms

Parvovirus (Fifth disease or erythema infectiosum)

Prevalence: About 65% of pregnant women have evidence of prior infection and are immune. The maternal infection rate is highest in child care workers and women with school-aged children. Risk of infection is 5% for casual contact; 20% for intense, prolonged work exposure,
and 50% for close, frequent interaction such as household contacts. Child care workers need not avoid infected children, because infectivity is greatest before any sign of clinical illness.

**Maternal effects:** Fever, headache, flu-like symptoms followed by a bright red rash affecting the face. Adults often have milder rashes and symmetrical pain in multiple joints. About 20-30% of adults have no symptoms.

**Fetal effects:** Miscarriage, nonimmune hydrops, or fetal death.

**Prevention:** There is no vaccine for this virus nor is there any evidence that antiviral treatment

**Treatment:** Treatment for symptoms

**Rubella (German or 3-day measles)**

**Prevalence:** Up to 25% of women in the United States are not immune to infection from this virus and may become infected after exposure.

**Maternal effects:** Mild illness involving fever and a rash. May also have joint pain and enlarged lymph nodes.

**Fetal effects:** Miscarriage and congenital rubella syndrome. The syndrome includes growth retardation and sensori-neural hearing loss most commonly. Other features include birth defects of the heart, eye problems and mental retardation.

**Prevention:** A vaccine is available; since it contains attenuated live virus, it should not be given to pregnant women and pregnancy should be avoided for one month after receiving the vaccine.

**Treatment:** Treatment for symptoms

**Rubeola (Measles)**

**Prevalence:** Most adults are immune due to childhood vaccinations

**Maternal effects:** Fever, fatigue, muscle aches, headache, and rash. Rare complications include pneumonia, hepatitis and encephalitis (inflammation of the brain).

**Fetal effects:** Miscarriage and premature delivery

**Prevention:** A vaccine has been available since the 1960’s. Since it contains attenuated live virus, it should not be given to pregnant women and pregnancy should be avoided for one month after receiving the vaccine. If a non-immune woman is exposed to measles, she should receive immune serum globulin within six (6) days of exposure.

**Treatment:** Treatment for symptoms

**Varicella (Chickenpox or shingles)**

**Prevalence:** The majority of adults (> 90%) are immune, even if there is no clinical history of having chickenpox before.

**Maternal effects:** Adults have a higher mortality rate than children. In pregnancy, maternal varicella pneumonia has a 14% mortality rate.

**Fetal effects:** Miscarriage, fetal death, or birth defects are possible. There is a low risk of birth defects for exposures at < 13 weeks’ of pregnancy (0.4%). The highest risk occurs with maternal infection between 13 and 20 weeks’ (2%). No such birth defects have been reported with maternal infections beyond 20 weeks’.

**Prevention:** A vaccine (Varivax) is available to non-pregnant women who are not immune to varicella in a 2 shot course that will prevent 70-80% of natural infections. It should not be given during pregnancy and pregnancy should be avoided for 3 months after each shot.
If exposed to the infection, all pregnant women who are either known not to be immune or have no clinical history and do not know their immune status, should contact their obstetrician for administration of two therapies:

- **Varicella immune globulin (VZIG)** should be given as a shot within 96 hours of exposure; this preparation is 60-80% effective at preventing infection.
- **Acyclovir 800mg 5X daily for 5-7 days starting within 9 days of exposure.** This may reduce infection rates.

Given the time constraints involved in giving these medications, women with no history of having had chickenpox should consider having a blood test to check for immunity at the beginning of pregnancy.

**Treatment:** Supportive care including calamine lotion and medications to reduce fever and itching. Oral acyclovir (prescription medication) is safe in pregnancy and may decrease the duration of illness if given within 24 hours of rash development.

## Environmental Control Measures

In addition to the prevention of disease through immunizations, good child monitoring and environmental practices will reduce the spread of illness in the child care center.

In this edition of Handbook for Common Childhood Illnesses, the term sanitize is used throughout to describe the process of removing most germs from an object or a surface. The two terms, disinfect and sanitize, are used interchangeably in the child care field, however, OAC child care rules all require sanitizing. The language in the handbook now matches the language in Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care.

**Hand washing:** The single most effective practice that prevents the spread of germs in a child care setting is good hand washing by child care staff, children and others. Some activities in particular expose children and staff to germs or the opportunity to spread them. The spread of germs can be stopped by washing your hands and teaching the children in your care good hand washing practices.

**Children should wash their hands:**

- Immediately before eating — ODJFS Rule 5101:2-12-15
- Immediately after eating — Recommended
- After toileting — ODJFS Rule 5101:2-12-15
- After contact with bodily fluids — ODJFS Rule 5101:2-12-15
- Upon arrival at the child care setting — Recommended
- Before and after using sensory tables — Recommended
- After playing on the playground — ODJFS Rule 5101:2-12-15
- After handling pets, pet cages or other pet objects — ODJFS Rule 5101:2-12-15
- Whenever hands are visibly dirty — ODJFS Rule 5101:2-12-15
- Before going home. — Recommended

**Staff should wash their hands:**

- Upon arrival at work — ODJFS Rule 5101:2-12-15.1
- Immediately before handling food, preparing bottles or feeding children — ODJFS Rule 5101:2-12-15
After using the toilet, assisting a child in using the toilet or changing diapers — ODJFS Rule 5101:2-12-15.1

After contacting body fluids, including wet, soiled diapers, runny noses, spit, vomit — ODJFS Rule 5101:2-12-15.1

After handling pets, pet cages or other pet objects — ODJFS Rule 5101:2-12-15.1

After removing gloves used for any purpose — ODJFS Rule 5101:2-12-15.1

Before and after giving or applying medication or ointment to a child or self — ODJFS Rule 5101:2-12-15.1

When hands are visibly dirty or after cleaning up a child, the room, bathroom items or toys— Recommended

After sneezing and coughing — Recommended

Before applying make up or handling contact lenses — Recommended

Before going home — Recommended

If artificial fingernails are worn, extra attention should be given to performing proper hand washing techniques. Fingernails should be kept clean and trimmed with no rough edges. — Recommended

Use of gloves alone will not prevent contamination of hands or spread of germs and should not be considered a substitute for hand washing. When removing gloves be careful to avoid skin contact.

Rubbing hands together under warm, running water and soap is the most important part of washing away infectious germs. Disposable wipes* and alcohol-based hand rubs** should not be used as a substitute for washing hands with soap and running water. Disposable wipes should be used only to remove residue such as food off a baby's face or feces from a baby's bottom during diaper changing. When out of the child care setting and running water is unavailable such as during an outing, disposable wipes may be used as a temporary measure until hands can be washed under warm, running water. Child care staff may use a disposable wipe to clean hands while diapering a child who cannot be left alone on a changing table that is not within reach of running water. However, hands should be washed when diapering is completed and the child is removed from the changing table. Water basins should not be used as an alternative to running water. If forced to use a water basin as a temporary measure, clean and sanitize the basin between each use (refer to section on Cleaning and Sanitation Materials). When necessary use disposable products. Avoid the use of a community basin or shared washcloth. Outbreaks have been linked with sharing wash water and washbasins.

NOTE: Alcohol rubs must not be used on children because they contain an active ingredient. Alcohol rubs must be kept out of the reach of children because they are poisonous if ingested.

Remember, child care providers are role models for good health practices. Children learn by observation. If staff uses proper hand washing techniques, the children will follow their example.

*Disposable wipes- Premoistened towelettes or disposable towels which may be used to clean solid residue (eg., baby wipes, non alcohol-based hand rubs) on children or surfaces.

**Alcohol-based hand rubs- Premoistened, alcohol-based hand rubs are considered hand sanitizers but must be used according to Ohio Child Care Rules. These should not be used on children.

How to Wash Hands

Always use warm, running water and a mild, liquid, soap. Antibacterial soaps should not be used because their effectiveness has not been proven and may decrease the resistance of organisms in a individual to antibiotics. Disposable hand wipes do not effectively clean
hands and do not take the place of hand washing.

- Wet the hands and apply a small amount (dime to quarter size) of liquid soap to hands.
- Rub hands together vigorously until a soapy lather appears and continue for at least 15 seconds. Be sure to scrub between fingers, under fingernails and around the tops and palms of the hands.
- Rinse hands under warm, running water. Leave the water running while drying hands.
- Dry hands with a clean, disposable (or single use) towel, being careful to avoid touching the faucet handles or towel holder with clean hands.
- Turn the faucet off using the towel as a barrier between your hands and the faucet handle.
- Discard the used towel in a trash can lined with a fluid-resistant (plastic) bag. Trash cans with foot-pedal operated lids are preferable.
- When assisting a child in hand washing, either hold the child (if an infant) or have the child stand on a safety step at a height at which the child's hands can hang freely under the running water. Assist the child in performing all of the above steps and then wash your own hands.
Hand Washing Chart
The following chart explains the hand washing procedure and may be used as a poster.

Handwashing

Have the necessary supplies on hand
- soap
- towel
- lotion

Scrub hands with soap and water for at least 15 seconds. Include between fingers, under and around nail beds, backs of hands.

Rinse hands well under running water with fingers down so water flows from wrist to finger tips. Leave the water running.

Turn off the faucet with the paper towel, instead of bare hands. Discard the paper towel in the trash can.

Apply hand lotion, if needed.

Illustrations by Jack Hankinson.
Diapering

Two different diaper changing methods may be used to minimize the risk of transmitting infection from one child to another or to staff. One method involves the use of gloves and the other does not. The method selected should be used consistently by the staff. Whichever method is chosen, never wash or rinse diapers or clothes soiled with fecal material in the child care setting. Because of the risk of splashing and gross contamination of hands, sinks and bathroom surfaces, rinsing increases the risk that staff and children would be exposed to germs that cause infection. All soiled clothing should be bagged and sent home with the child without rinsing. (Solid feces may be dumped into a toilet.) Bagged, soiled clothing needs to be stored away from the rest of the child’s belongings and out of reach of children. Be sure to tell parents about this procedure and why it is important.

Procedure for Diapering a Child

The following chart explains the procedure for diapering.

   - Before you bring the child to the diaper changing area, gather what you need: non-absorbent paper, a fresh diaper, wipes, gloves if you use them, a plastic bag for any soiled clothes, and a dab of any diapering cream if the baby uses it. Take the supplies you will need out of the containers and put the containers away.
   - Put on the disposable gloves, if you use them.

2. Avoid contact with soiled items, and always keep a hand on the baby—anything that comes in contact with stool or urine is a source of germs, including safety straps.
   - Carry the baby to the changing table, keeping soiled clothing away from you.
   - Bag soiled clothes and, later, securely tie the plastic bag to send them home.

3. Clean the child's diaper area.
   - Unfasten the diaper, but leave the soiled diaper under the child.
   - Use disposable wipes to clean the diaper area. Remove stool and urine from front to back and use a fresh wipe each time. Put the wipes into the soiled diaper.
   - Note and report any skin problems as redness.
4. Remove the soiled diaper and clean soiled surfaces.
   - Fold the diaper over and secure it with the tabs.
   - Put it into a covered, lined step can.
   - Check for spills under the baby.
   - Remove the gloves and put them directly into the step can.
   - Wipe your hands with a disposable wipe.

5. Put on a clean diaper—slide the diaper under the baby, adjust and fasten it.

6. Clean the baby's hands
   Use soap and water at a sink if you can. If a baby is too heavy to hold for handwashing at the sink, use disposable wipes or follow this procedure:
   - Wipe the child's hands with a damp paper towel moistened with a drop of liquid soap.
   - Wipe the child's hands with a paper towel wet with clear water.
   - Dry the child's hands with a paper towel.

7. Clean and disinfect the diapering area.
   - Dispose of the table liner.
   - Clean any visible soil from the changing table.
   - Disinfect the table by spraying it, so you wet the entire surface with bleach solution (1 tablespoon household bleach to 1 quart of water; mix fresh daily).
   - Leave the bleach on the surface for 2 minutes. The surface can then be wiped or left to air dry.

8. Wash your hands and record in the child's daily log.
   - Use soap and running warm water.
   - Use a paper towel to turn off faucet.
   - Use hand lotion to keep your hands from becoming dry and chapped.
   - Record in daily log what was in the diaper and any problems.
Using Toilet-training Equipment

Potty chairs are difficult to keep clean and out of the reach of children. Small-size, flushable toilets or modified toilet seats and step aids are preferable. If potty chairs are used for toilet training, you should use potty chairs only in a bathroom area and out of reach of toilets or other potty chairs. After each use of a potty chair, you should:

- Immediately empty the contents into a toilet, being careful not to splash or touch the water in the toilet.
- Rinse the potty with water from a sink used only for custodial cleaning.
- DO NOT rinse the potty in a sink used for washing hands or food preparation.
- Dump the rinse water into a toilet.
- Wash and sanitize the potty chair. (See Cleaning and Sanitation Materials).
- Wash and sanitize the sink and all exposed surfaces.
- Wash your hands and the child’s hands thoroughly.

Cleaning and Sanitation Materials

(Note: See Definitions Section.)

Keeping the child care environment clean and orderly is very important for health, safety and the emotional well-being of both children and staff. Ohio child care licensing rules require child care facilities to provide safe and sanitary furniture, materials and equipment. One of the most important steps in reducing the number of germs and therefore the spread of disease is the thorough cleaning of surfaces. Surfaces considered most likely to be contaminated are those with which children have close contact. These include toys that children put in their mouths, food preparation areas and surfaces likely to become very contaminated with germs such as diaper changing areas.

Cleaning is the reduction of soil on surfaces, furniture, equipment, toys and utensils. Routine cleaning with detergent and water is the most useful method for removing germs from surfaces in the child care setting. Good mechanical cleaning (scrubbing with soap and water) physically reduces the number of germs on the surface, just as hand washing reduces the number of germs on the hands. Removing germs in the child care setting is especially important for soiled surfaces that cannot be treated with chemical sanitizers such as some upholstery fabrics.

Some items and surfaces should receive an additional step, sanitation, to kill germs after cleaning with detergent and rinsing with clear water. Items that can be washed in a dishwasher or hot cycle of a washing machine do not have to be sanitized because these machines use water that is hot enough for a long enough period of time to kill most germs. Sanitation is the reduction of germs by a chemical process. Sanitation usually requires soaking the item for several minutes to give the chemical time to kill the remaining germs. Commercial products that meet the Environmental Protection Agency’s (EPA) standards for “hospital-grade” germicides (solutions that kill germs) may be used for this purpose.

One of the most effective chemicals for sanitation in child care settings is a homemade solution of household bleach and water. Bleach is registered by the EPA as a sanitizer and it is inexpensive and easy to get. The solution of bleach and water is easy to mix, is nontoxic, is safe if handled properly and kills most infectious agents except parasites.

Research by health care organizations and manufacturers recommend the following exposure time and concentration:
1. Recipe for bleach solution for sanitizing diapering area, bathrooms, floors and frequently touched areas such as doors or a surface contaminated with bodily fluids. (Do not use on food surfaces.)
   - 1/4 cup of bleach + 1 gallon of cool water (or 1 tablespoon bleach + 1 quart of cool water)
   - Wipe dry after two minutes of contact time or allow to air dry.

2. Weaker bleach recipe for sanitizing food preparation surfaces, kitchen utensils and toys that may be mouthed by children. Before applying the bleach solution, surfaces must be cleaned with detergents and rinsed.
   - 1 tablespoon of bleach + 1 gallon (16 cups = 1 gallon) of cool water
   - Wipe after two minutes of contact time or allow to air dry.

Discard bleach solution at the end of the day. A solution of bleach and water loses its strength very quickly and easily. It is weakened by organic material, evaporation, heat and sunlight. Therefore, bleach solution must be mixed fresh each day to make sure it is effective. Any leftover solution should be discarded at the end of the day. NEVER mix bleach with anything but fresh tap water! Other chemicals may react with bleach and create and release a toxic chlorine gas. Keep the labeled bleach solution you mix each day in a cool place out of direct sunlight and out of the reach of children.

**Industrial Products**

There are a number of industrial products that are available. Industrial products that meet the EPA’s standards for disinfectants or sanitizers may be used for sanitizing. The EPA-approved product must be appropriate for the surface or item you are sanitizing.

Be cautious about industrial products that advertise themselves as “disinfectants” having “germicidal action” or that “kill germs.” While they may have some effect on germs, they may not have the same effectiveness as bleach and water or EPA-approved disinfectants or sanitizers. Questions about commercial products must be directed to the manufacturer of the product or the US EPA.

If you use an EPA-approved industrial product as sanitizer, read the label and always follow the manufacturer’s instructions exactly.

**Cleaning Tips When Using Bleach**

**Bathrooms:** Use the bleach solution (1/4 cup bleach + 1 gallon of cool water) to wipe down all hard non-aluminum surfaces including sinks, floors, tiles, handles on toilet; leave wet for two minutes, rinse and wipe dry. For the toilet, first flush, then pour three-quarters cup liquid bleach solution into the bowl and brush the surface. Let the solution sit for 10 minutes, then flush again. Bleach is not recommended for use on aluminum surfaces because the solution is corrosive.

**Infant/diapering area:** Wipe down painted cribs, changing tables, diaper pails, plastic mattress covers, crib bumpers and high chairs with the bleach solution (1/4 cup bleach + 1 gallon of cool water). Let stand for two minutes, rinse and dry.

**Toys:** Use a brush to clean toys with soap and water and rinse the toys in water. Then soak the toys in the sanitizing solutions for 10–20 minutes. After they have soaked, remove them, rinse with water and air dry. (A net bag works well for submerging the toys which can be used to hold the toys while they air dry).

Refer to the section on Food Sanitation on how to clean food surface areas.
Washing and Sanitizing Toys

Toys that children (particularly infants and toddlers) put in their mouths need to be washed, sanitized and rinsed with water between uses by individual children. If toys can’t be washed between uses, they should at least be washed at the end of the day. Toys for infants and toddlers should be chosen with this in mind. If a toy can’t be washed, it probably is not appropriate for an infant or toddler. Use the weaker bleach solution (1 tablespoon of bleach + 1 gallon of cool water) for toys mouthed by children.

When an infant or toddler finishes playing with a toy, you should retrieve it from the play area and put it in a bin reserved for dirty toys. This bin should be out of reach of the children. Toys can be washed at a later, more convenient time and then transferred to a bin for clean toys and safely reused by other children.

To wash and sanitize a hard plastic toy:
- Scrub the toy in warm, soapy water.
- Use a brush to reach into the crevices.
- Rinse the toy in clean water.
- Immerse the toy in a bleach solution and soak it in the solution for 10-20 minutes.
- Remove the toy from the bleach solution and rinse well in cool water and air dry.
- Use a net bag for submerging toys and hanging to air dry.

Hard plastic toys that are washed in a dishwasher or cloth toys washed in the hot water cycle of a washing machine do not need to be additionally sanitized.

Children in diapers should have only washable toys. Each group of children should have its own toys. Toys should not be shared with other groups. Stuffed toys used by only a single child should be cleaned in a washing machine every week or more frequently if heavily soiled.

Toys and equipment used by older children and not put into their mouths should be cleaned at least monthly and when obviously soiled. A soap and water wash followed by clear water rinsing and air drying should be adequate. See chart on page 22 and 23 for sanitation guidelines. (These types of toys and equipment include blocks, dolls, tricycles, trucks and other similar toys.) If wading pools are used, they need to be filtered or emptied daily. Portable wading pools should be sanitized daily or more often if needed. Parent permission is required for use by infants and toddlers.

Water play tables can spread germs. To prevent this it is recommended to:
- Sanitize the table with chlorine bleach solution before filling it with water.
- Sanitize all toys to be used in the table with chlorine bleach solution. Avoid using sponge toys. They can trap bacteria and are difficult to clean.
- Have all children wash their hands before and after playing in the table.
- Do not allow children with open sores or wounds to play in the table.
- Carefully supervise the children to make sure they don’t drink the water.
- Discard water after play is over.

Washing and Sanitizing Bathroom and Other Surfaces

Bathroom surfaces such as faucet handles and toilet seats should be washed and sanitized several times a day, if possible, but at least once a day and when soiled.

The stronger bleach and water solution can be used in these areas.
(See also: Standard Precautions.)
Surfaces that infants and young toddlers are likely to mouth such as crib rails and toys should be washed with soap and water and sanitized with a nontoxic sanitizer such as bleach solution at least once every day, more often if visibly soiled and before use by another child. The sanitizer should be applied to the entire surface for at least two minutes, then wipe dry or air dry. **Be sure not to use a toxic cleaner on these surfaces. If using the bleach solution, use the weaker dilution (1 tablespoon bleach + 1 gallon of cool water).**

**Diaper Changing Areas**

Diaper changing areas should:

- Be used only for changing diapers.
- Be smooth and nonporous such as formica (NOT wood).
- Have a raised edge or low fence around the area to prevent a child from falling off.
- Be next to a sink with running water.
- Not be used to prepare food, mix formula or rinse pacifiers.
- Be easily accessible to staff.
- Be out of reach of children.

**Washing and Sanitizing Diaper Changing Areas**

Diaper changing areas should be cleaned and sanitized after each diaper change as follows:

- Clean the surface with soap and water and rinse with clear water.
- Dry the surface with a paper towel.
- Thoroughly wet the surface with the recommended bleach solution.
- Let air dry or wipe dry after two minutes.

**Washing and Sanitizing Clothing, Linen and Furnishings**

Do not wash or rinse clothing soiled with fecal material in the child care setting. Solid feces may emptied into the toilet, but be careful not to splash or touch toilet water with your hands. Put the soiled clothes in a plastic bag and seal the bag to await pick up by the child's parent or guardian at the end of the day. Always wash your hands after handling soiled clothing.

Explain to parents that washing or rinsing soiled diapers and clothing increases the chances that you and the children may be exposed to germs that cause diseases. Although receiving soiled clothes isn’t pleasant, remind parents that this policy protects the health of all children and staff. According to ODJFS rule 5101:2-12-15, the center shall provide furniture, materials and equipment which are sanitary.

Each item of sleep equipment including cribs, cots, mattresses, blankets, sheets, etc., should be cleaned and sanitized before being assigned to a specific child.

The bedding items should be labeled with that child’s name and should be used only by that child. Children should not share bedding. Infants’ linens (sheets, blankets) should be changed weekly or more often as necessary and crib mattresses should be cleaned and sanitized monthly or when soiled or wet. Blankets and/or sheets belonging to the child care center and used by children should be laundered weekly or more often if soiled. If a child accidentally uses another child’s bedding, the linen and mattress cover should be changed before allowing the assigned child to use it again. If a child has his/her own blanket and/or sheets, they should be sent home weekly to be laundered by the parents.

Children’s bedding and sleep surfaces should be stored so that they do not come into contact with those of other children.
Cleaning Body Fluid Spills

Spills of body fluids including feces, nasal and eye discharges, saliva, urine and vomit should be cleaned up immediately. It is not necessary to wear gloves unless the fluid contains blood. Clean and sanitize any surfaces such as countertops and floors, on which body fluids have been spilled. Be sure to wash your hands after cleaning up any spill.

Spills containing blood or bodily fluids containing blood - The child care provider should always wear gloves to clean up blood or bodily fluids containing blood. Gloves are used mainly when people knowingly contact or suspect they may contact blood or bodily fluids containing blood including blood-containing tissue or injury discharge. These fluids may contain viruses that transmit HIV, hepatitis B or hepatitis C.

Be careful not to get any of the fluid you are cleaning in your eyes, nose, mouth or any open sores you may have. Clean and sanitize any surfaces such as countertops and floors, on which body fluids have been spilled. Use the stronger bleach solution whenever cleaning up blood or fluids containing blood (1/4 cup bleach + 1 gallon of cool water). Discard fluid-contaminated material in a plastic bag that has been securely sealed. Mops used to clean up body fluids containing blood should be:

1.) Cleaned.
2.) Rinsed with a sanitizing solution.
3.) Wrung as dry as possible.
4.) Hung to dry completely.

**Be sure to wash your hands after removing your gloves.**

(See also Standard Precautions)
<table>
<thead>
<tr>
<th>Area/Object</th>
<th>Clean</th>
<th>Sanitize</th>
<th>Frequency Requirements</th>
<th>Clean and Sanitizing Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any item soiled with blood or bodily fluid</td>
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<td>X</td>
<td>Immediately</td>
<td>Must use stronger bleach solution.*</td>
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<td>Weekly, when soiled and before another child uses.</td>
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<td>Carpets</td>
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<td>Vacuum daily. Clean when soiled.</td>
<td>Clean and dry only when children will not be present.</td>
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<td>Changing table</td>
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<td>X</td>
<td>Clean when visibly soiled and sanitize after each use</td>
<td>Must use stronger bleach solution *</td>
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<tr>
<td>Cots</td>
<td>X</td>
<td>X</td>
<td>Before assigning to a different child, when soiled, and at least every 3 months.</td>
<td>Must use stronger bleach solution.*</td>
</tr>
<tr>
<td>Cribs</td>
<td>X</td>
<td>X</td>
<td>Monthly, when soiled and before another child uses.</td>
<td>Must use stronger bleach solution.*</td>
</tr>
<tr>
<td>Diaper receptacles</td>
<td>X</td>
<td>X</td>
<td>Daily or more frequently as needed to eliminate odor</td>
<td>Must use stronger bleach solution *</td>
</tr>
<tr>
<td>Dishes/cups/silverware/water containers</td>
<td>X</td>
<td>X</td>
<td>Clean after each use. Water containers that are labeled with the child’s name can be used all day, but must be cleaned and sanitized before used again on another day.</td>
<td>Must use weaker bleach solution**</td>
</tr>
<tr>
<td>Dress up clothes and hats (used in dramatic play)</td>
<td>X</td>
<td></td>
<td>Monthly and when soiled.</td>
<td>Hats can harbor eggs from head lice, launder frequently. Use plastic hats and do not use wigs.</td>
</tr>
<tr>
<td>Floors</td>
<td>X</td>
<td></td>
<td>Daily and when soiled.</td>
<td></td>
</tr>
<tr>
<td>Food prep area, including sink</td>
<td>X</td>
<td>X</td>
<td>Before and after preparing food and between preparing raw and cooked food.</td>
<td>Must use weaker bleach solution.**</td>
</tr>
<tr>
<td>Area/Object</td>
<td>Clean</td>
<td>Sanitize</td>
<td>Frequency Requirements</td>
<td>Clean and Sanitizing Detail</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------</td>
<td>----------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Potty chairs</td>
<td>X</td>
<td>X</td>
<td>After each use, empty contents into toilet and rinse prior to cleaning and sanitizing.</td>
<td>Must use stronger bleach solution.*</td>
</tr>
<tr>
<td>Tabletops and highchair trays</td>
<td>X</td>
<td>X</td>
<td>Clean when visibly soiled. Sanitize before and after food is served.</td>
<td>Must use weaker bleach solution.**</td>
</tr>
<tr>
<td>Toilet bowls</td>
<td>X</td>
<td>X</td>
<td>Clean when visibly soiled. Sanitize daily.</td>
<td>Must use stronger bleach solution.*</td>
</tr>
<tr>
<td>Toilet seats, handles and hand washing sinks</td>
<td>X</td>
<td>X</td>
<td>Clean when visibly soiled. Sanitize daily.</td>
<td>Must use stronger bleach solution.*</td>
</tr>
<tr>
<td>Toys that go into the mouth</td>
<td>X</td>
<td>X</td>
<td>After each child's use.</td>
<td>Must use weaker bleach solution.**</td>
</tr>
<tr>
<td>Toys – other than those going into the mouth</td>
<td>X</td>
<td></td>
<td>Monthly and when visibly soiled.</td>
<td></td>
</tr>
<tr>
<td>Washable furniture</td>
<td></td>
<td></td>
<td>Weekly and when soiled. Upholstered furniture must be steam cleaned when soiled, if not covered by a washable slipcover. Slipcovers must be washed at least monthly and when soiled.</td>
<td></td>
</tr>
<tr>
<td>Wastebaskets, including lids</td>
<td>X</td>
<td>X</td>
<td>Empty daily and more frequently as needed. Clean and sanitize when visibly soiled.</td>
<td>Must use stronger bleach solution.*</td>
</tr>
</tbody>
</table>

To clean: wash the surface or item with a detergent solution or other appropriate commercial product used for cleaning purposes for the item you are cleaning and rinse the surface or item. Questions about products must be directed to the manufacturer of the product. Follow the manufacturer’s instructions exactly.

To sanitize: centers must use the following chlorine bleach solutions (household bleach with 5.25% hypochlorite) or a commercial product registered by the United States Environmental Protection Agency (US EPA) as a sanitizer that has directions for use that are appropriate for the surface or item you are sanitizing. Questions regarding commercial products must be directed to the manufacturer of the product or the US EPA. Follow manufacturer’s instructions exactly when using any product to sanitize.

Daily bleach and water solution:

* Stronger chlorine bleach solution = 1/4 cup bleach + 1 gallon cool water
** Weaker bleach solution = 1 tablespoon bleach + 1 gallon cool water

PREPARE BLEACH SOLUTIONS DAILY

All bottles of cleaners and sanitizers must be labeled with the contents and/or recipe.
**Toothbrush Use and Handling**

Tooth brushing is a lifelong preventive habit important to maintain oral health and prevent tooth decay. Tooth brushing in the child care setting helps children to develop this habit. The guidelines below are outlined in Rules 5101:2-12-15.4 and 5101:2-13-15.4. To brush teeth properly and to prevent infections from spreading from germs found in saliva and blood on toothbrushes:

- Always supervise children when they are brushing their teeth. It is easier to supervise if each child brushes separately.
- Make sure each child has his/her own toothbrush clearly labeled with his/her name. NEVER allow children to share or borrow toothbrushes.
- If a single tube of toothpaste is used for more than one child when brushing teeth, a pea sized amount shall be dispensed onto a clean piece of paper or paper product for each child. It shall not be placed directly on the toothbrush. (Children 24 months and younger should have their teeth brushed with water and not toothpaste.)
- Instruct each child to brush his/her teeth and then spit out the toothpaste.
- Use a paper cup for each child to rinse their mouth out with water. Dispose of the cup after each use.
- Store and rinse toothbrush so it cannot touch any other toothbrush and allow it to air dry. Never “sanitize” toothbrushes. If a child uses another child's toothbrush or if two toothbrushes come in contact, throw them away and give the children new toothbrushes.
- If a child uses the toothbrush of another child who is known to be ill or have a chronic blood-borne infection (such as hepatitis B or HIV), parents of the child who used the ill child’s brush should be notified.
- Toothbrushes must be replaced every three months or if the toothbrush comes in contract with the toilet or toileting area.
- Racks and devices used to hold toothbrushes for storage shall be labeled and shall be washed and sanitized or replaced on a monthly bases or whenever visibly soiled or after any contamination with bodily fluids.

**Food Sanitation**

(If you are a licensed food service operation, check with your local health department for food sanitation regulations. Below is general information.)

Food sanitation is essential to prevent the spread of disease. Improperly handled or prepared food can cause illness. Infants and young children are especially at risk. Food poisoning germs live everywhere and can carry disease through food and drink including water. Kitchen cleanliness is also very important. Bacteria are easily transferred to food.

To keep the kitchen area clean, follow these guidelines:

- To prevent cross contamination, do not use the same utensil or cutting board for both raw and cooked meat, poultry, fish or eggs unless they are sanitized between uses. A nonporous cutting board should be used.
- Clean, rinse and sanitize with bleach the counters and cutting boards after each use, with sanitizing bleach solution (one tablespoon of bleach + one gallon of cool water). Remember the area must be cleaned first of food or dirt. If this step is skipped, then the bleach solution will not be able to sanitize the surface.
- Use clean utensils and containers.
- A wet wiping cloth stored in sanitizing solution may be used to clean spill or use paper towels.
- Use a disposable hand towel or paper towel to wipe hands and spills.
- Rinse the top of cans before opening.
- Do not prepare or handle food if you are ill.
- Wash hand as often as necessary to remove soil and contamination.

Poor personal hygiene, contaminated equipment, poor protection from contamination and improper holding temperatures have been identified by the U.S. Food and Drug Administration as food-borne risk factors. Remember to keep hot foods hot and cold foods cold and never leave food at room temperature for more than two hours. Refer to food-borne disease information sheet. Poor food preparation, handling or storage can quickly result in food being contaminated with germs and may lead to illness if the contaminated food is eaten. Contact your local health department to obtain the local regulations and standards for food safety and sanitation and to ask about the availability of a food handler course in your area.

The most efficient way to wash, rinse and sanitize dishes and eating utensils is to use a dishwasher. The dishwasher must be of a commercial type to assure proper final rinse temperature is attained to sanitize dishes and eating utensils. If a dishwasher is not available, a three-compartment sink is needed to wash, rinse and sanitize dishes. If your facility does not include a licensed food service operation, a two-compartment or one-compartment sink may be used by adding one or two dishpans as needed. In addition to three compartments or dishpans, you will need a dish rack with a drain board to allow dishes and utensils to air dry. Be sure to sanitize dishpans after each use.

To wash, rinse and sanitize dishes by hand:

- Fill one sink compartment or dishpan with hot tap water (approximately 100°F) and a dishwashing detergent.
- Fill the second compartment or dishpan with hot tap water (approximately 100°F).
- Fill the third compartment or dishpan with lukewarm or cool (70-75°F) tap water and one tablespoon of liquid bleach for each gallon of water.
- Scrape dishes and utensils and dispose of excess food.
- Immerse scraped dish or utensil in first sink compartment or dishpan and wash thoroughly.
- Rinse dish or utensil in second dishpan of clear water.
- Immerse dish or utensil in third dishpan of chlorinated water for at least one minute.
- Place dish or utensil in rack to air dry.

Note: Food preparation and dishwashing (warewashing) sinks should be used only for these activities and should NEVER be used for routine hand washing or diaper changing activities.

Preparing and Handling Infant Formula and Foods

Babies are more susceptible to bacteria and other germs than older children. Unsanitary food conditions can cause serious infections. Extra care needs to be taken when handling babies’ food, bottles and utensils to make sure they are safe and clean.

Breast Milk

- Should be in the infant’s own bottle, bottle liner or plastic bag.
- The child’s name and date should be on each bottle, bottle liner or plastic bag.
- Do not store breast milk in the refrigerator for more than 24 hours. Frozen breast milk may be stored no more than two weeks.
- Do not refreeze thawed breast milk.
- Breast milk left in the bottle after feeding must be thrown away immediately.
• When using frozen breast milk stored in plastic bags, be sure the milk is placed in a sterile plastic bottle liner or a clean and sanitized bottle for feeding.

Infant Formula
ODJFS Rule 5101:2-12-41 and Rule 5101:2-13-41 state that if bottles are prepared by the center or Type A home, they be prepared in accordance with written instructions from the parents or physician in charge of the child. All powdered or concentrated formula shall be prepared according to manufacturer’s instructions. Use water from a source approved by the local health department if not on a public water system.

Before preparing formula, all equipment to be used (bottles, nipples, caps, spoons, can opener) needs to be cleaned and sanitized by washing in the dishwasher or by washing thoroughly with hot water and detergent, followed by a thorough rinsing in hot running water and then boiling for five minutes or more just prior to filling. Prepared formula not used immediately must be labeled, refrigerated and used within 24 hours. Open containers of ready-to-feed or concentrated formula must be covered, dated and refrigerated. Prepared formula and food need to be discarded if not used within 24 hours. Any formula or food to be stored at the center, whether prepared by the parent or guardian, shall be labeled with the child’s name and date of receipt or date of preparation. Formula left in the bottle after feeding is to be thrown away immediately after each feeding.

What to do if a child is mistakenly fed another child’s bottle of formula or breast milk:
1. Inform the parents of the child who was given the wrong bottle and exactly what the child was given.
2. Inform the parents who brought the formula or breast milk of the mistake.
3. Suggest that the parents contact their health care provider.
4. Document the incident.

Warming Bottles
• Warm bottles of milk immediately before serving. Never use a microwave oven to warm infant formula. The liquid may become very hot when microwaved and get hotter when removed from the microwave even though the bottle feels cool. The hot liquid could seriously burn babies and the plastic liner can explode.
• The best way to warm bottles is to set the bottle in a container of hot (not boiling) water. The container of water needs to be emptied and cleaned daily. The bottle can also be warmed by holding it under running warm tap water. NEVER warm bottles by setting them out on the counter.
• After warming the bottle, gently shake the bottle.
• Always test the temperature by squirting (shaking) a few drops of formula on to the back of your hand.
• Warm only as much infant formula as is needed for one feeding.
• Thaw frozen breast milk before warming by: holding under cool water, then warm water, gently shake the bottle to mix and set the bottle in a bowl of warm water or continue to run bottle under warm water.

Baby Foods
• Be sure the vacuum seal has not been broken before using. You should hear a “pop” when you open the jar.
• Spoon out only enough food for a serving.
• Do not use the jar as serving dish.
• Leftover food in serving dish is to be thrown away.
• Any unused baby food in the jar should be refrigerated and sent home or thrown away at the end of the day.
• Don’t heat baby food in jars in the microwave. The heat is uneven and can produce “hot spots” that can scald baby’s mouth and throat.
• Stir heated food before serving.
• Meals to be served may require written authorization from a health care provider.

**Group Separation of Children**

In the child care setting, the risk of illness and injury can be reduced by separating older children from children under 30 months of age. The presence of infants and toddlers who are still in diapers poses a higher risk for the spread of diarrheal diseases and hepatitis A. Separating groups of children can help to keep infectious diseases of one group from spreading to other groups. Please see Appendix for diagram.
Exclusion for Illness in a Child

Illness for children is not an unusual event. ODJFS rules 5101:2-12-33 and 5101:2-13-33 state that a staff member with valid communicable disease training must check each child daily upon arrival for any sign of illness. ODJFS rules 5101:2-12-30 and 5101:2-13-30 and ODE rules 3301-37-04 and 3301-37-11 require that the child care facility have written policies and procedures for management of a child with an illness that may be communicable. Refer to the section about staff and child exclusion/re-admittance chart. The chart below includes the symptoms for exclusion as stated in the child care regulations and the center’s responsibilities.

<table>
<thead>
<tr>
<th>Signs and Symptoms of Illness</th>
<th>Center’s Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature of at least 100 F (axillary), when in combination with any of the following signs or symptoms of illness</td>
<td>Per regulations: A child with any of these signs or symptoms shall be immediately isolated and discharged to his parent or guardian</td>
</tr>
<tr>
<td>When in combination with lethargy, vomiting, extreme tiredness, difficulty to wake, possibly life threatening</td>
<td>Sign of possible immediate life threatening situation. Call emergency squad and call parents</td>
</tr>
<tr>
<td>Difficult or rapid breathing</td>
<td></td>
</tr>
<tr>
<td>Severe coughing, causing the child to become red or blue in the face or to make a whooping sound</td>
<td></td>
</tr>
<tr>
<td>Vomiting more than one time or when accompanied by any other sign of symptom of illness</td>
<td></td>
</tr>
<tr>
<td>Diarrhea (three or more abnormally loose stools within a 24-hour period)</td>
<td></td>
</tr>
<tr>
<td>Yellowish skin or eyes</td>
<td></td>
</tr>
<tr>
<td>Purulent (pus) eye discharge or eye pain, or eye lid redness or fever</td>
<td></td>
</tr>
<tr>
<td>Untreated infected skin patches, unusual spots or rashes</td>
<td></td>
</tr>
<tr>
<td>Unusually dark urine and/or gray or white stool</td>
<td></td>
</tr>
<tr>
<td>Stiff neck with and elevated temperature</td>
<td></td>
</tr>
<tr>
<td>Evidence of untreated lice, scabies or other parasitic infestation</td>
<td></td>
</tr>
<tr>
<td>Sore throat or difficulty in swallowing</td>
<td></td>
</tr>
<tr>
<td>Earache</td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td></td>
</tr>
<tr>
<td>Fever less than 100 F (axillary)</td>
<td></td>
</tr>
<tr>
<td>Fussiness</td>
<td></td>
</tr>
<tr>
<td>Runny nose</td>
<td></td>
</tr>
<tr>
<td>Mild cough</td>
<td></td>
</tr>
<tr>
<td>Irritable, crying, unusual behavior</td>
<td></td>
</tr>
</tbody>
</table>

Note: Children with special health care needs may require quicker/different responses from the child care staff. These guidelines should be spelled out in the child’s Medical/Physical Care Plan.

For a life threatening and probable illness that might be communicable, according to ODJFS Rule 5101:2-12-33, the child needs to be isolated and discharged. It is important that the child care administrator call and discuss the child’s illness with the parents.
In deciding and developing a policy on caring for a sick child until the parent comes to pick the child up, consider:

1. Is there an area where the child can be isolated from others to prevent spreading germs;
2. Would I be able to take the child to a doctor or hospital if the child got worse and the parent was unavailable?

If the child is isolated for discharge, the following steps must be observed:

1. Place the child in a room or portion of a room not being used for other types of child care.
2. Do not leave child alone or unsupervised. Child must be within sight and hearing distance of an adult at all times.
3. Make child comfortable; all linens used by the ill child must be laundered before being used again.
4. Maintain continued observation by an adult for development of worsening condition or additional symptoms.
5. Record observation.

In observing the child, it is important to take the child’s temperature. You can not tell how high a fever is by just feeling the child’s skin. Fever is a symptom, not an illness. It means the child’s body temperature is above the child’s normal temperature for that time of day. Younger children have fevers more often than older children. Increase in fever can occur when the body heats up due to such things as infection, intense exercise or overdressing. High fevers don’t always mean serious illness; in fact, low fevers less than 102˚ F (axillary) help the child fight infection.

Some guidelines to follow if the child has a fever: dress the child in lightweight clothing to help prevent the temperature from rising further. Have the child drink cool, clear fluids because fevers cause the child to lose water from the body. Do not give aspirin to children to control a fever. Aspirin can cause Reye’s syndrome in children. Reye’s syndrome affects the liver and brain, causes the abrupt onset of seizures and in some cases, death. For this and other reasons, aspirin should not be given to any child.

**Ask parents to come soon and take the child to a doctor if the child is acting sick and if:**

- A child between ages of 4 and 24 months has axillary temperature of 101° or higher.
- A child over 24 months has an axillary temperature of 102° or higher.

**Get medical help immediately and tell parent to come right away if:**

- Infant under 4 months of age has an axillary temperature of 100° or higher.
- A child over 4 months of age has an axillary temperature of 105° or higher.

In the child care center, you are ONLY permitted to take an axillary (under the arm) temperature. A digital thermometer should be used.

**Taking A Temperature**

The axillary method (under the arm)

The normal axillary temperature is 97.6°.

1. Check to see that the child’s armpit is dry.
2. Place the digital thermometer under the child’s arm. Fold the child’s arm around his chest to keep the thermometer in place.
3. Follow the directions that come with the thermometer.
4. Do not leave the child alone while taking the temperature.
5. Record the temperature in degrees and that it was taken by the axillary method. Report temperature to the parents and doctor.
6. Sanitize the thermometer after each use. Use the manufacturer’s guideline for sanitizing the thermometer.

**Remember:** Do not add or subtract a degree when determining a child’s temperature. If the axillary temperature is 100°F, then indicate in the child’s record the temperature was 100° F axillary. When determining whether a child has a temperature, use the actual reading which is 100°F axillary.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Readmit to the Child Care Facility</th>
</tr>
</thead>
</table>
| Campylobacteriosis               | Staff may return after diarrhea has ceased for 24 hours provided no food handling is involved in their duties. If food handling is involved, they may return after diarrhea has ceased and after 48 hours of effective antimicrobial therapy. If not treated with antimicrobial therapy, they may return to work after diarrhea has ceased and after two consecutive follow-up stool specimens are negative for Campylobacter.  
A child may return to the child care facility after diarrhea has ceased for 24 hours. |
<p>| Chickenpox                       | Staff and children with chickenpox shall be excluded until the sixth day after onset of rash or until all lesions are dry, whichever comes first.                                                                                                               |
| Conjunctivitis                   | Staff and children with purulent (pus) conjunctivitis should be excluded until 24 hours after the start of antimicrobial therapy (if ordered by MD).                                                                                                      |
| Cryptosporidosis                 | Staff may return after diarrhea has ceased for 24-hours provided no food handling is involved in their duties. If food handling is involved, they may return after diarrhea has ceased and after three consecutive follow-up stool specimens are negative for Cryptosporidium. A child may return to the child care facility after diarrhea has ceased for 24 hours. |
| Diarrhea illness                 | Diarrhea is defined as three or more loose stools in a 24-hour period. Staff or children with diarrhea of unidentified, possibly infectious cause shall be excluded from the child care center. Staff and children may return after diarrhea has resolved for 24 hours. Exclusion of persons with diarrhea of known infectious cause shall be in accordance with regulations pertaining to the infectious disease. |
| Diphtheria                       | Staff and children may return after two cultures from both throat and nose (and skin lesions in cutaneous diphtheria ) taken not less than 24 hours apart, and not less than 24 hours after cessation of antimicrobial therapy, fail to show diphtheria bacilli. If culturing is unavailable or impractical, exclusion may be ended after 14 days of appropriate antimicrobial therapy. |
| E. coliO157:H7 or Hemolytic Uremic Syndrome (HUS) | Staff and children may return after diarrhea has ceased for 24 hours and after two consecutive follow-up stool specimens are syndrome (HUS) negative for E.coliO157:H7.                                                                                       |
| Giardiasis                       | Staff and children may return after diarrhea has ceased for 24 hours and after 72 hours of effective antimicrobial therapy. If not treated with antimicrobial therapy, they may return to work after diarrhea has ceased and after three consecutive follow-up stool specimens are negative for Giardia. |
| Hepatitis A                      | Symptomatic staff and children shall be excluded until 10 days after initial onset of symptoms.                                                                                                                                                     |</p>
<table>
<thead>
<tr>
<th>Condition</th>
<th>Readmit to the Child Care Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impetigo</td>
<td>Staff and children may return 24 hours after initiation of antimicrobial (a skin infection) therapy and all lesions (sores) are dry.</td>
</tr>
<tr>
<td>Measles</td>
<td>Staff and children shall be excluded for five days following the onset of rash.</td>
</tr>
<tr>
<td>Meningitis (Bacterial)</td>
<td>Excluded until at least 24 hours of effective treatment. Must be under physician’s care.</td>
</tr>
<tr>
<td>Mumps</td>
<td>Staff and children shall be excluded for nine days after the onset of parotid swelling and until swelling subsides.</td>
</tr>
<tr>
<td>Pediculosis (Lice)</td>
<td>Staff or children with body lice may return 24 hours after application of an effective pediculicide. Staff or children with head lice may return after the first treatment with appropriate pediculicide.</td>
</tr>
<tr>
<td>Pertussis (whooping cough)</td>
<td>Staff and children shall be excluded for five days after initiation of antimicrobial therapy. If the case is not treated with appropriate antimicrobial therapy, the staff member or child shall be excluded until three weeks after the onset of paroxysms (fit of abnormally severe coughing).</td>
</tr>
<tr>
<td>Rash with fever or joint pain</td>
<td>Staff and children shall be excluded until diagnosed not to be measles, rubella or other communicable disease.</td>
</tr>
<tr>
<td>Rubella</td>
<td>Staff and children shall be excluded for at least seven days after the onset of rash.</td>
</tr>
<tr>
<td>Salmonellosis</td>
<td>Staff may return after diarrhea has ceased for 24 hours provided no food handling is involved in their duties. If food handling is involved in their duties. If food handling is involved, they may return after diarrhea has ceased and after two consecutive follow-up stool specimens are negative for Salmonella. A child may return to the child care facility after diarrhea has ceased for 24 hours.</td>
</tr>
<tr>
<td>Scabies</td>
<td>Staff and children shall be excluded for 24 hours following the initial treatment with appropriate scabicide.</td>
</tr>
<tr>
<td>Shigellosis</td>
<td>Staff and children may return to work after diarrhea has ceased for 24 hours and after two consecutive stool specimens are negative for Shigella.</td>
</tr>
<tr>
<td>Shingles</td>
<td>If sores cannot be covered by clothing or a dressing, exclude until sores have crusted and are dry. A person with active shingles should not care for immune-suppressed children.</td>
</tr>
<tr>
<td>Strep throat or other streptococcal infection</td>
<td>Staff and children shall be excluded for 24 hours after the initiation of antimicrobial therapy.</td>
</tr>
<tr>
<td>Tuberculosis (TB)</td>
<td>Staff and children with confirmed or suspected TB shall be excluded from the child care center until the local designated TB authority approves the person’s return to the center.</td>
</tr>
<tr>
<td>Typhoid fever</td>
<td>Staff and children may return when asymptomatic and after three consecutive follow-up stool specimens are negative for Salmonella typhi.</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Staff and children may return when vomiting resolves or is determined to be due to a noninfectious condition such as pregnancy or a digestive disorder.</td>
</tr>
<tr>
<td>Yersiniosis</td>
<td>Staff and children may return after diarrhea has ceased for 24 hours provided no food handling is involved in their duties. If food handling is involved, they may return after diarrhea has ceased and after two consecutive follow-up stool specimens are negative for Yersinia.</td>
</tr>
</tbody>
</table>
Children with Special Needs

The Americans with Disabilities Act (ADA) requires that reasonable accommodation should be given to people with disabilities. The law covers children with disabilities seeking reasonable accommodation in a child care setting. In addition to making physical changes such as installing ramps, wide doors and restrooms that can accommodate children in wheelchairs, you may need to provide for a child’s special physical, emotional or psychological needs. Other special needs may include assistance in feeding, following special dietary requirements, giving medicines and/or performing medical procedures and ensuring that special equipment operates or is used properly.

If a child has been identified as a child with a health condition or a child requiring a medical procedure, ODJFS Rule 5101:2-12-38 requires that the child have a written plan of care called “Medical/Physical Care Plan” (JFS 01236). The plan should include written instructions for procedures, schedules for giving medicines and menus to meet any eating requirements. This plan needs to be updated and signed annually. It may be necessary to develop an individualized emergency plan for the child. It is important to meet with the child’s parents and child care provider to discuss the special health needs of the child. Information that is helpful to know is:

- Specific procedures that the child may need to have done.
- How much time will be needed to meet the child’s needs.
- Staff training needed to perform a special procedure.
- The child’s developmental level.
- The child’s health care providers who can provide ongoing consultation when needed and their phone numbers.
- A list of any special telephone numbers, for example medical equipment technical assistance services.

Children from birth to age 3 with a handicapping condition (or at risk) may have a written plan called an Individual Family Service Plan (IFSP). This is similar to an Individual Education Plan (IEP) for school-age children. These families will have an assigned service coordinator that is responsible for the IFSP. If a child care center or a family needs more information about the IFSP process, call the Help Me Grow Program at 1-800-755-GROW.

These two plans (IFSP and Medical/Physical Care Plan) should support each other.

Medication Administration

Some children may need to take medications during the hours they are in child care. Before agreeing to give any medication, whether prescription or over-the-counter, obtain written permission from the parent. In addition, refer to the child care center’s policy on administration of medications. Licensed child care programs must have a staff person designated to administer medication. Everyone administering medication in a child care facility should be trained in medication administration. A log of when a child received medications must be kept. ODJFS form JFS 01217 must be used when giving a child any medication. The staff member assigned to administer medication needs to sign the required form showing she or he gave the child the medicine. Entry on the log should be in ink and legible. If an error is made on the log, cross out the error entry and add your initials. Re-enter the correct information on the next line. Never erase or white out information placed in the log.
You should make sure any prescribed medication you give to a child:

- Has the first and last name of the child on the container.
- Has been prescribed by a licensed physician, certified nurse practitioner or licensed dentist.
- Has the name of the authorized health professional and credentials who ordered the medication on the container.
- Is in the original package or container.
- Has the date the prescription was filled.
- Has an expiration date and is still current
- Has the name of the medication and specific instructions for giving, storing and disposing of the medication.
- Is in a childproof container.

You may want to suggest to parents that they ask their pharmacist to divide medications into two bottles, one to be kept at home and one to be kept at the child care facility. Children will be less likely to miss a dose of their prescription due to parents forgetting to bring medications to the facility or to take them home at night. Parents may attach patient education and administration forms from the pharmacy.

A child’s parent may ask that you give a child an over-the-counter medication such as acetaminophen (Tylenol and other brand names). Refer to the ODJFS Rule 5101:2-12-31 for the specific kinds of over-the-counter drugs permitted. Over-the-counter medications for each child must be in their original container and labeled with:

- The child’s first and last names.
- The expiration date.
- The specific instructions for giving, storing and disposing of the medication.
- The appropriate dosage for the height, weight or age of the child (or written authorization from the child’s health care provider).

All medications should have childproof caps and be stored out of reach of children. Medications requiring refrigeration should be clearly marked and separated from food. You must keep all medications in a separate, covered container marked “Medications” within the refrigerator but away from food items and must be inaccessible to children.

Never use medications after the expiration date. Also, do not allow parents to add medications to bottles of formula or milk brought from home. This can lead to inadvertent overdoses or underdoses. You should keep a medication record in your child care facility (JFS 01217). The record must list:

- Child’s name.
- Name of the medication, dosage, how and when it is to be given.
- Parent’s signature of consent.
- Time the medication needs to be given while in the child care.
- Start and end date.
- Special instructions or storage information.

If you have a concern about a medication or dosage, contact the parent or physician. Do not make any decisions about medications without contacting the parent and/or physician. It is useful to have a current, commonly ordered pediatric drug reference/resource book in the child care setting. The reference book should provide information on trade/generic names; child-appropriate dosage based on weight/age; classification; actions; absorption; metabolism; distribution;
excretion; possible side effects; contraindications; storage procedures; and associated necessary precautions, i.e., reduced sun exposure, administration with food or empty stomach, etc. Use a child-appropriate dispenser when giving liquid medications.

**Five Rights of Medication Administration**

When giving a child medication, perform the five rights checks: Right child; right medication; right route (how is it to be given); right time; and right amount. If the five rights are followed, there will be less chance a child will receive the wrong medication.

Documentation and action are required when a medication error has occurred.

**Wrong child:**

**Action**

- Call Poison Control as soon as the error is discovered and follow the directions given.
- Call parent of the child to whom the medication was given as soon as the error is discovered and request parent to call the family physician.
- Contact the parent of the child who missed a dose.
- Administer medication to the correct child.

**Documentation**

- Document action taken including who was contacted.
- Fill out incident report form (JFS 01299).

**Wrong medication:**

**Action**

- Call Poison Control as soon as the error is discovered and follow the directions given.
- Check with Poison Control to determine if correct medication should be given.
- Call parent as soon as the error is found and encourage the parent to call the physician for advice.
- Give correct medication if advised to do so and document actions.

**Documentation**

- Document action taken, including who was contacted.
- Fill out incident report form (JFS 01299).

**Wrong Route/Wrong Amount:**

**Action**

- Call Poison Control as soon as the error is discovered and follow the directions given.
- Call parent as soon as the error is found.
- Encourage the parent to contact child’s physician to determine procedure to follow.

**Documentation**

- Document action taken, including who was contacted.
- Fill out incident report form (JFS 01299).

**Wrong Time (note: 1/2 hour either side of the administration time):**

**Action**

- Call parent as soon as the error is discovered.
• Encourage the parent to contact child’s physician and determine procedure to follow.

Documentation
• Document action taken, including who was contacted.
• Fill out incident report form (JFS 01299).

For more information on medication administration, please refer to the Medication Administration Course available through the Healthy Child Care Ohio program’s Child Care Health Consultants (614-644-8389).

Policies and Procedures

Local Health Departments
If a parent or physician notifies the child care facility that a child has a communicable disease, the other parents with children in the child care center and the local health department (LHD) need to be notified. The sooner a disease or outbreak is reported, the better the chance for preventing new cases. Some diseases require special efforts to control.

The LHD is concerned about the health of the public in general and provides help in control and prevention of communicable diseases including diseases in the child care setting. The LHD is responsible for any communicable disease investigations. The LHD can provide: information on how to control the spread or increased incidence of an illness such as diarrhea in the facility; answers to questions about sanitation and health issues; informative letters to send to parents and/or physicians about a disease; and in some situations, free stool-specimen testing in your community. The phone number of the LHD should be written in your policy and procedure manual on how to manage communicable disease.

Communicable Diseases that Need to be Reported
If someone in the child care facility has a medically confirmed case of communicable disease, you have the authority to contact your LHD with all the facts related to the case (Ohio Administrative Code 3701-3-04). Communicable diseases that must be reported to the LHD are listed in Ohio Administrative Code 3701-3-02. This list of diseases is called “Know the ABCs.” The ABCs list is found in the appendix of this manual or on the ODH Web site: http://www.odh.ohio.gov/pdf/lDCM/intro1.pdf and scroll to page 4.

Periodically, new diseases are added to the ABCs document. Closing a center is not usually recommended because parents may place their child in another day care setting which could facilitate the spread of disease.

Emergency/Disaster Preparedness in Child Care

ODJFS Rule 5101:2-12-34 addresses the general emergency, medical and dental plans that are minimum requirements. According to this rule, the center shall have a written plan for medical, dental and general emergencies written on the Medical, Dental and General Emergency Plan (JFS 01242). This medical, dental and general emergency plan shall be implemented, when necessary, and shall be posted, readily in view, by each telephone and in each classroom, and other spaces used by the children.
In addition, it is recommended that centers plan for broader community disasters or emergencies because children can be touched directly or indirectly by community disasters. Natural disasters such as floods, fire and tornadoes can strike a community with little or no warning. Community violence and terrorism unfortunately have moved into our neighborhoods. Children rely on adults who can protect them.

Definitions
Emergencies/disasters are typically unplanned and shocking. There is a definite difference between an emergency and a disaster. An emergency is “a sudden, urgent, usually unexpected occurrence requiring immediate action.” A disaster is “a calamitous (great misfortune) event, especially one occurring suddenly and causing great damage.” Both emergencies and disasters can begin suddenly, but disasters usually result in a larger impact to the community, when compared to emergencies.

The Plan
Having a plan can help staff be prepared before an emergency/disaster. Child care settings should have written plans that are updated, practiced and/or trained routinely. Disaster plans “define the policies, procedures, and resources put in place by a program to prepare for, respond to and recover from any type of disaster that may occur.” The above definition may be used to define an emergency plan by putting the word “emergency” in place of disaster.

Listed below are the steps to prepare a child care center for a disaster. This list, taken from the NACCRA Web site, will help outline a boarder emergency plan.

- Determine the types of disaster most likely to occur in your area
- Learn about the types of disasters
- Appoint a small group of people to serve on an emergency preparation committee
- Gather the information needed on each staff member
- Gather the information needed on children and families
- Set up a system for knowing who is in the facility at all times
- Set up emergency kits for staying in the facility and evacuating
- Develop an emergency contacts list
- Decide how vital records and resources will be protected
- Develop and practice an evacuation plan
- Develop a shelter-in-place strategy
- Develop a communications plan
- Complete a written Child Care Program Emergency Plan including the above listed steps

Above adapted from the California Childcare Health Program and NCCRRRA Web sites.

There are many resources to help child care centers plan for emergencies and disasters. It is important that child care staff contact their local emergency medical services (EMS) and LHD to develop relationships that could be crucial during an actual event. In addition, there are many emergency preparedness resources that may be useful as staff develops plans and trainings. These include:

American Red Cross
http://www.redcross.org/
First Aid Kit
A first aid kit is a requirement of an emergency plan. One first aid kit shall be available for every 75 children and one shall be on each floor if the center has multiple floors. The supplies for a complete kit are outlined in ODJFS Rule 5101:2-12-36. If the kit contains more than the items listed in the rule, then the additional items must be clearly labeled as to whom they can be administered to.

Ohio Child Care Rules Related to Child Health and Communicable Diseases

Every child care center is required to have written policies and procedures for the following items:

**Medical, dental and general emergency plans** are required to be written according to ODJFS Rule 5101:2-12-34 and ODE Rule 3301-37-04. The plan at a minimum must address the following points:

- General instructions to staff in general emergency situations and instructions for serious incidents, injuries or illnesses affecting a child. A list of staff trained in first aid, communicable disease and CPR.
- Location of car seats or the written policy to use an emergency squad for emergency transportation.

(Child restraint requirements must be followed. Please see ODJFS Rule 5101:2-12-34 Appendix A.)

- Process for notification of parents.
- Location of first aid kit, Dental First Aid Chart (JFS 01201) and children's records.
- Emergency phone numbers such as emergency response number, Poison Control Center, fire, police.
- The location of the first aid kit.

**Management of communicable diseases** and how the center will deal with an ill child. According to ODJFS Rule 5101:2-12-33 and ODE Rules 3301-37-04 and 3301-37-11, the following points at a minimum need to be addressed in the policy:

- A person trained to recognize the common signs of communicable disease and other illness do a daily health check on the child upon arrival to the center.
• The procedure to follow when the child becomes ill, is isolated or discharged (excluded) from the center and when the child can be readmitted to child care.

• Process for notification of parents and local health department.

• Where the Ohio Department of Health recommendations on communicable disease guidelines are located. At the present time, this is the “ODH Communicable Disease Chart” poster.

In addition, it is recommended by the APHA that the following be included in a policy on management of communicable disease and how to deal with a child who becomes ill:

• Post and monitor hand washing and sanitation procedures.

• Ask parents to notify the center within 24 hours after the child has developed a suspected communicable disease, or if any member of the immediate household has a communicable disease.

• Management of communicable disease among the employees. Refer to prevention and control of diseases section.

1. Procedure for staff exclusion/readmission criteria.

2. Process of educating female staff of the health risk if they are pregnant or should become pregnant while employed. Refer to section on prevention and control of disease.

Administration of medications, food supplements, modified diets or fluoride supplements. According to ODJFS Rule 5101:2-12-31 and ODE Rule 3301-37-04, if the child care center administer these items, the following points at a minimum need to be addressed in the policy:

• The following definitions.
  1. Medication is any substance or preparation containing active chemical ingredients for the purpose of prevention or treatment of a wound, injury, infection or disease.
  2. Modified diet is any diet eliminating the use of any one or more of the four food groups or altering the amount of food required to be served to meet one-third of the recommended daily dietary allowance.
  3. Food supplement means a vitamin, mineral or combination of one or more vitamins, minerals and/or energy-producing nutrients (carbohydrate, protein or fat) used in addition to meals or snacks.
  4. Fluoride supplement is any fluoride preparation prescribed to be taken internally for the purpose of preventing dental cavities.

• Written permission by the parents and instruction by a licensed physician, certified nurse practitioner or licensed dentist for the administration of the medication, food supplements, modified diets or fluoride supplements (refer to medication administration section).

• That each medication or food supplement must be labeled with the child’s name, current date (within the past 12 months), exact dose to be given, the number of dosages to be given daily and the route of administration.

• Procedure for storage of medication, fluoride and food supplements so they are out of the reach of children and free from contamination of food.

• Procedure for proper administration of medication (refer to medication administration section).

• Procedure for completing the medication log. All documentation related to administration of medications, food supplements, modified diets or fluoride supplements must be kept on file for one year.
• Procedure to contact the Poison Control Center.

• Procedure for administration of nonprescription topical ointments, creams or lotions. The procedure must include written permission and instructions from the parents and is valid for no longer than 12 months. If an ointment, cream or lotion is to be used for skin irritation, it can not be applied for more than 14 consecutive days.

**Procedure for administration of nonprescription, fever-reducing medication** that DOES NOT contain aspirin or cough medicine containing codeine. The following points should be included in the procedure:

• Permission and instructions from the parents to give the medication.

• Medication must be in the original container.

• The label should specify the dosage based on the child’s age or weight.

• Medication cannot be administered for longer than three consecutive days in a 14 day period.

In addition, it is recommended by the APHA that the following be included in a policy on medication, fluoride and food supplements:

• Training and education for personnel responsible for administering medications, food supplements, modified diets or fluoride supplements to children.

• No stock drugs should be kept in the center. All medications should be labeled with a child’s name.

• Emergency protocols for a child who may have a serious adverse or allergic reaction to a medication or food.

• Procedure for what to do when a child is given the wrong medication or food supplements.

• Significant health history to include child’s allergies, health status and/or special needs.

• Documented observations of child in relation to medication administration, side effects or any other notable health status concerns.

• Procedure to communicate with parents when a child has been given medication or food supplement.

• A reference file of pharmacy fact sheets on various medications being administered in the center.

• Procedure and storage of controlled substances, e.g., Ritalin.

• All medication containers have child-protective lids.

**Food:** ODJFS Rules 5101:2-12-39 and 5101:2-12-41 refer to the serving of nutritious meals in a child care center. Centers that prepare their own food or serve food supplied by an outside vendor are required to have a food service license from the LHD. Contact your LHD for additional information regarding serving of food in the center. The following point at a minimum needs to be addressed in the policy:

• Plan for storage of food provided by the parents that meets the requirements of the food service operations laws and rules.

For centers that do not require a food service license because the outside vendor also serves the food or parents supply the food, APHA recommends that the following be included in a policy related to food safety:

• Potentially hazardous and perishable foods brought from home need to be refrigerated properly and all foods shall be protected against contamination.

• No one who has signs or symptoms of illness including vomiting, diarrhea or infectious skin sores that cannot be covered shall be responsible for assisting children with their lunches or in the preparation of any foods served by the center.
All centers are recommended by APHA to develop policies on the following:

- Staff members who help with food service shall not change diapers. Staff members who work with diapered children shall not prepare or serve food for older groups of children. When it is not possible to follow these restrictions, staff can prepare or serve food to the infants and toddlers in their groups only after thoroughly washing their hands.
- All staff members with food handling responsibilities shall be trained in proper food handling techniques.
- Food preparation in the classroom:
  1. Teachers who conduct food preparation activities in the classroom shall be trained in proper food handling.

Maintenance of Health Records: ODJFS Rule 5102:1-12-37 states that a center shall have a policy that addresses the confidentiality, periodic updating and storage of health records. At a minimum the policy needs to include the following points:

- Child health records, which should include the following:
  2. Enrollment information that includes the emergency transportation authorization.
  3. Disease history.
  4. Allergies.
  5. Chronic physical problems and hospitalization history.
- Employee Health Records:
  1. ODJFS Rule 5101:2-12-25 requires that a child care employee be physically fit to provide child care.

Pets: According to ODJFS Rule 5101:2-12-15, the following points at a minimum must be included in a policy on pets:

- Must not be a threat to the safety or health of the children.
- Must be properly housed, vaccinated and cared for.
- Procedure to maintain verification of vaccination of pet against diseases.
- Children will not be directly exposed to animal urine or feces.

In addition, it is recommended by the APHA that the following be included in a policy related to pets in a child care center:

- Any pet present at the center should be in good health and show no evidence of disease.
- Dogs or cats should be kept on flea-, tick- and worm-control programs.
- Staff member shall always be present when a child plays with a pet.
- Living quarters of animals shall be enclosed and kept clean of waste.
- Some pets, particularly of the reptile and parrot family are not appropriate for child care facilities. All reptiles carry Salmonella. Reptiles (lizards, turtles, iguanas) that might be handled by child can easily transmit Salmonella.

Child Abuse and Neglect: According to ODJFS Rules 5101:2-12-26 and 5101:2-12-30, the following points at a minimum need to be included in a policy on child abuse:

- Procedure to ensure that no person who has been convicted of or pleaded guilty to child abuse or other crimes of violence owns or operates a child care center or is an employee of child care center.
- Procedure to notify the child protective service if child abuse or neglect is suspected.
In addition, it is recommended by the APHA that the following be included in a policy related to child abuse:

- Establishment of links with health professionals who can provide consultation about suspicious injuries or other circumstances that may indicate abuse or neglect.
- Education programs for staff on the common behavior shown by abused children.

**Federal Occupational Safety and Health Administration Rule 29 CFR 1910.1030(a)**, requires that a child care worker who is designated as a responsible for rendering first aid or medical assistance as part of their job duties should be offered the hepatitis B vaccine. The vaccine should be offered pre-exposure to an event. Please refer to the Employee Safety-Use Standard Precautions chapter for more details on this Rule.

**References**


**Appendix**

**Definitions**

**Clean:** To remove dirt and debris (such as blood, urine and feces) by scrubbing and washing with a detergent solution and rinsing with water.

**Disinfect:** To eliminate virtually all germs from inanimate surfaces through the use of chemicals (e.g., products registered with the U.S. Environmental Protection Agency as “disinfectants”) or physical agents (e.g., heat).

In the child care environment, a 1:64 dilution of domestic bleach made by mixing a solution of 1/4 cup household liquid chlorine bleach with one gallon of tap water and prepared fresh daily is an effective method to remove germs from environmental surfaces and other inanimate objects that have been contaminated with body fluids (see Body fluids), provided that the surfaces have first been cleaned (see Clean) of organic material before applying bleach and at least two minutes of contact time with the surface occurs. (Because complete elimination of all germs may not be achieved using the 1:64 dilution of domestic bleach solution, technically, the process is called sanitizing, not disinfecting.) The term **sanitize** is used in these standards most often, but disinfect may appear in other or earlier publications when addressing sanitation in child care.

To achieve maximum germ reduction with bleach, the precleaned surfaces should be left moderately or glistening wet with the bleach solution and allowed to air dry or be dried only after at least two minutes of contact time. A slight chlorine odor should emanate from this solution. If there is no chlorine smell, a new solution needs to be made, even if the solution was prepared fresh that day. The 1:64 diluted solution will contain 500:800 parts per million (ppm) chlorine.

Two minutes of contact with a coating of a sprayed 1:64 diluted solution of 1/4 cup household liquid chlorine bleach in one gallon of tap water prepared fresh daily is an effective method of surface-sanitizing of environmental surfaces and other inanimate objects that have first been thoroughly cleaned of organic soil.
By itself, bleach is not a good cleaning agent. Household bleach is sold in the conventional strength of 5.25 percent hypochlorite and a more recently marketed “ultra” bleach that contains 6 percent hypochlorite solution. In child care, either may be used in a 1:64 dilution.

Bleach solutions much less-concentrated than the recommended dilution have been shown in laboratory tests to kill high numbers of bloodborne viruses including HIV and hepatitis B virus. This solution is not toxic if accidentally ingested by a child. However, because this solution is moderately corrosive, caution should be exercised in handling it and when wetting or using it on items containing metals, especially aluminum.

**DO NOT MIX UNDILUTED BLEACH OR THE DILUTED BLEACH SOLUTION WITH OTHER FLUIDS, ESPECIALLY ACIDS (E.G., VINEGAR), AS THIS WILL RESULT IN THE RAPID EVOLUTION OF HIGHLY POISONOUS CHLORINE GAS.**

Commercially prepared detergent - sanitizer solutions or detergent cleaning, rinsing and application of a non-bleach sanitizer that is at least as effective as the chlorine bleach solution is acceptable as long as these products are nontoxic for children, are used according to the manufacturer’s instructions and are approved by the state or local health department for use as a disinfectant in place of the bleach solution.

These methods are used for toys, children’s table tops, diaper changing tables, food utensils and any other object or surface that is significantly contaminated with body fluids. Sanitizing food utensils can be accomplished by using a dishwasher or equivalent process, usually involving more dilute chemicals than are required for other surfaces.

**Sanitize:** To remove filth or soil and small amounts of certain bacteria. For an inanimate surface to be considered sanitary, the surface must be clean (see Clean) and the number of germs must be reduced to such a level that disease transmission by that surface is unlikely. This procedure is less rigorous than disinfection (see Disinfect) and is applicable to a wide variety of routine housekeeping procedures involving, for example, bedding, bathrooms, kitchen countertops, floors and walls. To clean, detergent or abrasive cleaners may be used but an additional sanitizer solution must be applied to sanitize. A number of EPA-registered “detergent/disinfectant” products are also appropriate for sanitizing. Directions on product labels should be followed closely.

**Standard precautions:** Apply to contact with non-intact skin, mucous membranes, blood, all body fluids and excretions except sweat, whether or not they contain visible blood. The general methods of infection prevention are indicated for all people in the child care setting and are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection. Although standard precautions were designed to apply to hospital settings, with the exceptions detailed in this definition, they also apply in child care settings. Standard precautions involve use of barriers as in universal precautions (see separate definition) as well as cleaning and sanitizing contaminated surfaces.

Child Care Adaptation of Standard Precautions (exceptions from the use in hospital settings):

a) In child care settings, use of nonporous gloves is optional except when blood or blood containing body fluids may be involved.

b) In child care settings, gowns and masks are not required.

**Universal Precautions:** apply to blood, other body fluids containing blood, semen and vaginal secretions, but not to feces, nasal secretions, sputum, sweat, tears, urine, saliva and vomitus unless they contain visible blood or are likely to contain blood. Universal precautions include avoiding injuries caused by sharp instruments or devices and the use
of protective barriers such as gloves, gowns, aprons, masks or protective eyewear, which can reduce the risk of exposure of the worker’s skin or mucous membranes that could come in contact with materials that may contain blood-borne pathogens while the worker is providing first aid or care.

Classrooms by age in a child care center

A group is designated as a 2½ and under group (blue boxes) when children 2½ years of age and under are permanently assigned to that specific group. A group is designated as 2½ and older (yellow boxes) when children 2½ years of age and older are permanently assigned to that specific group. Groups in the blue and yellow boxes should not be combined.

**Infant Room**
- Babies age 0-18 months

**Toddler Room**
- Toddlers age 18-36 months

**Mixed Age Room**
- Children age 2½ to 3½ years

**Preschool Room**
- Children age 3 years to 5 years, not yet in Kindergarten

**Mixed Age Room**
- Children age 4 and 5 and 5 year olds eligible to attend Kindergarten, but still in preschool

**School age Room**
- Children age 5 and attending Kindergarten and above

Blue rooms can combine with blue rooms and yellow rooms can combine with yellow rooms, but blue rooms and yellow rooms can not combine with each other.