HEALTH CARE PLAN

1104 W. HEROY,

SPOKANE, WA

99205

MAIN CENTER PHONE:

509-327-3111

PORTABLE PHONE:

509-473-9726

OWNER/DIRECTOR

MELISSA WELLS

EMERGENCY TELEPHONE NUMBERS

FIRE/POLICE/AMBULANCE	911
CHILD PROTECTIVE SERVICES	509-363-3333 1-866-ENDHARM (363-4376)
POISON CONTROL	1-800-222-1222
ANIMAL CONTROL	509-477-2532

IN CASE OF EMERGENCY, CHILDREN WILL BE TRANSPORTED TO:

HOLY FAMILY HOSPITAL

5633 N. LIDGERWOOD

SPOKANE, WA, 99207

509-482-2640

NON-THREATENING INJURIES AND EMERGENCIES, WE WILL DEFER TO THE PARENT LISTED EMERGENCY CONTACTS

DEL LICENSOR	JUDY DAVIS 509-789-3832
CHILDCARE HEALTH CONSULTANT HEALTH SYSTEMS ANALYST	JENNIFER HELSETH 360-522-6256
PUBLIC HEALTH NUTRITIONALIST	TERRI ADOLFSON 509-789-3542
COMMUNICABLE DISEASE & IMMUNIZATION HOTLINE/REPORT	RECORDED LINE 1-877-539-4344

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PURPOSE AND USE OF HEALTH POLICY

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

Staff will be oriented to our health policy by the Director/Supervisor upon hiring and whenever there are changes to policies and procedures.

Our policy is accessible to staff and parents and is located outside for each classroom, as well as in the front office bulletin board.

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

→ Pesticide Policy
→ Blood borne Pathogen Policy
→ Behavior Policy
→ Disaster Policy

CLEANING, SANITIZING, DISINFECTING AND LAUNDERING

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

Definitions:

→ Sanitizers are used to reduce germs from surfaces, but not totally get rid of them. Sanitizers reduce the germs from surfaces to levels that are considered safe.
→ Disinfectants are chemical products that destroy or inactivate germs and prevent them from growing. Disinfectants are regulated by the U.S. Environmental Protection Agency (EPA).

Rationale:

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

3-Step Method

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

Bleach Preparation

Bleach solutions are prepared using the correct proportions on the "Method for Mixing Bleach" table (see table on NEXT page). To avoid cross-contamination, two sets of spray bottles are used: one set for disinfecting and one set for sanitizing. Bleach solutions are prepared in the storage closet next to the kitchen, daily by the opener.

Cleaning Supply Storage

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

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

Method for Mixing Bleach

Sanitizing using bleach concentrations of sodium hypochlorite 2.75 — 8.3%

Solution for sanitizing on Food Surfaces, in Kitchen and Classrooms	Amount of Bleach	Amount of Water	Contact time
8.25-8.3%	$\frac{1}{4}$ teaspoon	1 quart	2 minutes
	1 teaspoon	1 gallon	2 minutes
5.25-6.25%	$\frac{1}{2}$ teaspoon	1 quart	2 minutes
	2 teaspoons	1 gallon	2 minutes
2.75%	1 teaspoon	1 quart	2 minutes
	1 tablespoon	1 gallon	2 minutes

Disinfecting using bleach concentrations of sodium hypochlorite 2.75 — 8.3%

Solution for disinfecting for Body Fluids, Bathrooms and Diapering	Amount of Bleach	Amount of Water	Contact time
8.25-8.3%	$1\frac{1}{2}$ teaspoons	1 quart	2 minutes
	2 tablespoons	1 gallon	2 minutes
5.25-6.25%	$2\frac{1}{4}$ teaspoons	1 quart	2 minutes
	3 tablespoons	1 gallon	2 minutes
2.75%	$1\frac{1}{2}$ tablespoons	1 quart	2 minutes
	$1\frac{1}{2}$ cup plus 1 tablespoon	1 gallon	2 minutes

Cleaning, Sanitizing & Disinfecting Specific Areas, and Items

General cleaning of the entire facility is done throughout the day as needed.

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

Bathrooms

→ Sinks, counters, and floors are cleaned, rinsed, and disinfected daily or more often if necessary.

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

Cots and mats

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

Door handles

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

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

Floors

→ Solid-surface floors are swept, washed, rinsed, and sanitized daily.

→ Carpets and rugs in all areas are vacuumed daily and cleaned using a carpet shampoo machine or steam cleaner every six months or as necessary. Carpets are not vacuumed when children are present (due to noise and dust).

→ Carpets or area rugs soiled with bodily fluids must be cleaned and disinfected at least twice per year.

Furniture

→ Upholstered furniture is vacuumed daily and cleaned using a carpet shampoo machine or steam cleaner twice a year or as necessary.

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

→ Painted furniture is kept free of paint chips. No bare wood is exposed; paint is touched up as necessary. (Bare wood cannot be adequate/y cleaned and sanitized.)

Mops

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

Garbage

→ Garbage cans are lined with disposable bags and are emptied daily or when full.

→ Outside surfaces of garbage cans are cleaned, rinsed, and disinfected daily. Inside surfaces of garbage cans are cleaned, rinsed, and disinfected as needed.

→ Garbage cans for paper towels must be hands-free.

Kitchen

→ Kitchen counters and sinks are cleaned, rinsed, and sanitized daily.

→ Food preparation surfaces are cleaned, rinsed, and sanitized before and after each use.

→ Equipment (such as blenders, can openers, and cutting boards) is washed, rinsed, and sanitized after each use. No wooden cutting boards are used.

→ Refrigerators and freezers are cleaned, rinsed, and sanitized monthly or as needed. ● Kitchen floors are swept, washed, rinsed, and sanitized daily.

Laundry

→ Cloths used for cleaning or rinsing are laundered after each use.

→ Child care laundry is done on site or by a commercial service (it is not washed in a private home).

→ Laundry is washed above 1400F due to heat needed to sanitize items. If the hot water tank is set to 1 200F, then you must use bleach to sanitize laundry according to equipment manufacturer's instructions.

Toys

→ Only washable toys are used.

→ Cloth toys and dress-up clothes are laundered weekly and as necessary.

→ Pre-school and school-aged toys are washed, rinsed, and sanitized weekly and as necessary.

→ Infant and toddler toys are washed, rinsed, and sanitized daily and as necessary.

Water Tables

→ Water tables are emptied, cleaned, rinsed, and sanitized after each use and as necessary.

→ Children wash hands before and after water table play.

HAND HYGEINE

Liquid soap, warm running water (1 20^{0}F or below), and paper towels or single-use cloth towels are available for staff and children at sinks, at all times.

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

- → Upon arrival at the site
- → Before and after handling foods, cooking activities, eating, or serving food
- → Before preparing bottles
- → After toileting self or children
- → Before, during (with wet wipe - this step only), and after diaper changing
- → After handling or coming in contact with body fluids such as mucus, blood, saliva, or urine
- → After giving first aid
- → Before and after giving medication, or applying topical ointments or creams
- → After attending to an ill child
- → After smoking or vaping
- → After being outdoors and/or gardening activities
- → After handling garbage and garbage receptacles
- → As needed or required by circumstances

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

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

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

Handwashing Procedure

The following handwashing procedure is followed:

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

Handwashing procedures are posted at each sink used for handwashing.

HEALTH RECORDS

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

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

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

- → Consent for services provided by any health professionals who work with the program
- → Allergy information and food intolerances
- → Individualized care plan for child with special health care needs (medical, physical, developmental or behavioral). *In order to provide consistent, appropriate, and safe care, a copy of the plan is also be available in child's classroom.*
- → List of current medications
- → Injury report
- → Any assistive devices used (e.g., glasses, hearing aids, braces)
- → Documentation of any food or health related illness reports made by provider to appropriate agency/body
- → The above information will be as needed for any changes.

IMMUNIZATIONS

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

- → Diphtheria, Tetanus, Pertussis (DTaP/D1)
- → Polio (IPV)
- → Measles, Mumps, Rubella (MMR)
- → Hepatitis B
- → Haemophiles influenzas type b (Hib) until age 5
- → Varicella (Chicken Pox)
- → Pneumococcal bacteria (PCV) until age 5

Immunization records are reviewed and updated quarterly to ensure all children and staff are up to date on all eligible immunizations.

Documentation and Reporting

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

- → A Certificate of Immunization Status (CIS) printed from the Immunization Information System
- → A physical copy of the CIS form with a healthcare provider signature
- → A physical copy of the CIS filled out and signed by the parent and verified and signed by childcare or early learning program administrator. For this option, the CIS needs to have medical immunization records from a healthcare provider attached

A CIS printed from MyIR (families can create an account on MyIR and print this form themselves)
A copy of immunization records is available upon request. We cannot withhold this documentation for any reason.

All employees and volunteers at the program are required to provide an immunization record indicating that they have received the MMR vaccine or proof of immunity. (See STAFF HEALTH section for more information on staff requirements.)

We submit an immunization status report to DOH by November 1st of each year (or 30 days after the first day of school if a program starts after October 1st).

Requirements for Attending Early Learning and Child Care Programs

A child may begin childcare only when:

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

We accept children into care who may have an exemption from immunization. If a parent/guardian chooses to exempt their child from immunization requirements, they must complete and sign the COE form, which accompanies the CIS form. The child's health care provider must also sign the COE form for a medical, religious belief, or personal/philosophical exemption.

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

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

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

POLICY AND PROCEDURE FOR EXCLUDING ILL CHILDREN

All children are observed for signs of illness when they arrive at the early learning program and throughout the day. Children with any of the following symptoms are not permitted to remain in care:

- → Fever: for children older than 2 months, a fever of 101 0 F or above, as read using a digital forehead scan thermometer (temporal scan) or digital thermometer placed under the arm (axillary method)
- → diarrhea or vomiting
- → Earache
- → Headache o Signs of irritability or confusion o Sore throat o Rash
- → Fatigue, crankiness, or illness that limits participation in daily activities
- → Vomiting: 2 or more occasions within the past 24 hours
- → Diarrhea: 2 or more loose or watery stools more than normal for the child in a 24-hour period; or any blood or mucus in stool
- → Rash: Body rash (not related to allergic reaction, diapering, or heat)
- → Open or oozing sores (unless properly covered with a waterproof dressing and 24 hours has passed since starting antibiotic treatment, if antibiotic treatment is necessary) or mouth sores with drooling
- → Lice: Children will be sent home immediately upon finding nits or adult lice. Your child must be checked by a staff member again before returning to care. The life cycle of a louse is about 25 to 30 days, so sometimes treatments need to be repeated 7 to 12 days after the first treatment to kill newly hatching lice.
- → Scabies or ringworm: Children will be sent home immediately. Children should see their health care provider to be assessed and get an appropriate prescription for treatment and instructions on its proper use.
- → Sick appearance, not feeling well, and/or not able to keep up with program activities.

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

We notify parents and guardians when their children may have been exposed to a communicable disease or condition (other than the common cold) and provide them with information about that disease or condition. We notify parents and guardians of possible exposure via the Procare Sign-In system, and notices/flyers on the door. When a child has illness symptoms or a condition, individual confidentiality is maintained, as not to single out children and/or families.

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

Staff members follow the same exclusion criteria as children.

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

STAFF HEALTH

Tuberculosis (TB) testing requirements:

There are two types of FDA-approved tuberculosis 0B) tests available in Washington State; the tuberculin skin test and a type of blood test known as an Interferon Gamma Release Assay (IGRA).

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

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

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

Measles, Mumps, and Rubella (MMR) requirements:

All licensed childcare center staff and volunteers must provide either:

- → An immunization record showing they have received at least one dose of MMR vaccination.
- → Proof of immunity to measles disease (also known as a blood test or titer).
- → Documentation from a health care provider that the person has had measles disease sufficient to provide immunity against measles; or
- → Written certification signed by a licensed health care practitioner that the MMR vaccine is, in the practitioner's judgment, not advisable for the person.

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

Our early learning program complies with all recommendations from the local health jurisdiction. Staff members who have a communicable disease are expected to remain at home until no longer contagious. Staff are required to follow the same guidelines outlined in EXCLUSION OF ILL CHILDREN in this policy. Staff members are encouraged to consult with their health care provider regarding their susceptibility to vaccine-preventable diseases.

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

NOTIFIABLE CONDITIONS and COMMUNICABLE DISEASE REPORTING

Licensed child care providers in Washington are required to notify Public Health Communicable Disease/Epidemiology (CD/EPI), within 24 hours, when they learn that a child, staff member, volunteer, or household member has been diagnosed with one of the communicable diseases listed below. Immediately notifiable conditions in bold should be reported when suspected or confirmed

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

To report COVID-19 (MERS-CoV, SARS, Other Novel Coronavirus), call the COVID-19 Call Center at 1800-525-0127. Identify yourself as a child care provider.

To report any of the other above conditions, call CD/EPI at 1-877-539-4344.

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

MEDICATION POLICY

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

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

Prescription medications:

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

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

Over-the-counter (non-prescription) medications:

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

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

If an over-the-counter medication's label instruction doesn't include age, expiration date, dosage amount, and/or length of time to give the medication/product, as is often the case for vitamins herbal supplements, fluoride supplements, homeopathic or naturopathic medication, and teething gel or tablets, it must be accompanied with a completed Medication Authorization Form that is signed by the health care provider with prescriptive authority. An over the counter-medication is given only to the child named on the label provided by the parent/guardian.

Non-medical products:

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

- → Diaper ointment (used according to manufacturer's instructions)
- → Pease note: As with all medications, label directions must be followed. Most diaper ointment labels indicate that rashes that are not resolved, or reoccur, within 5-7 days should be evaluated by a health care provider.
- → Sunscreen for children over 6 months of age
- → Lip balm or lotion

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

Medication and non-medical products are not accepted if they are expired. Written consent for medications covers only the course of illness or specific time-limited episode. Medication is added to a child's food or liquid only with the written consent of health care provider. Homemade medication, such as diaper cream or sunscreen, cannot be accepted by an early learning provider or given to a child in care.

Medication Storage

Medication for children is stored out of children's reach in the child's classroom, controlled substances (Ritalin, Methylphenidate, etc.) are kept in a lock box in the office.

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

Rescue medication (e.g., EpiPen@ or inhaler) is stored in the "Grab and Go" bag or in Mindi's room Controlled substances (e.g., ADHD medication) are stored in a locked container in the office or Mindi's cabinet which is inaccessible to children. Controlled substances are counted and tracked with a controlled substance form.

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

Staff medication is stored in the office, out of reach of children. Staff medication is clearly labeled as such.

Emergency supply of critical medications

For children's critical medications, including those taken at home, we will always have a three-day supply in case of emergency. Staff are also encouraged to supply the same. Critical medications — to be used only in an emergency when a child has not been picked up by a parent, guardian, or emergency contact — are stored in the office.

Medication is kept current (not expired).

Staff Administration and Documentation

Before administering medication to children, staff members must first be oriented to the early learning program's medication procedure and policy; and

The parent/guardian of each child requiring medication involving special procedures (e.g., nebulizer, inhaler, EpiPen@) trains staff on those procedures.

Documentation of the training must be signed by the early learning care provider and the child's parent/guardian. A record of trained staff is maintained on/with the Medication Authorization Form.

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

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

Current WACs do not require documentation when administering non-medical items, such as diaper creams/ointments and sunscreen.

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

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

Outdated Medication Authorization Forms are promptly removed from the classroom and placed in a file in the office. All of these files will be boxed at the end of the year and kept in the storage room with the year dated. All information related to medication authorization and documentation is considered confidential and is stored out of general view.

Medication Administration Procedure

The following procedure is followed each time a medication is administered:

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

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

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

Self-Administration by Child

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

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

FIRST AID

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

First Aid and CPR Training must:

- → Be delivered in person.
- → Include a hands-on component for first aid and CPR that is demonstrated in front of an instructor who is certified by a nationally recognized certification program (i.e. American Red Cross, American Heart Association, etc.).
- → Include child and adult CPR. o Include infant CPR, if applicable.
- → Documentation of staff training is kept in personnel files.

First Aid Kits

Our first aid kits are inaccessible to children and located in each "Grab and Go" bag, in each classroom, as well as in the Director's office. First aid kits are labeled and identified by a First Aid Sign.

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

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

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

A fully stocked first aid kit is taken on all field trips and playground trips and is kept in each vehicle used to transport children. This travel first aid kits also contain:

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

INJURY PREVENTION

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

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

Hazards include, but are not limited to

- → Security issues (unsecured doors, inadequate supervision, etc.)
- → Genera/ safety hazards (broken toys & equipment, standing water, chokeable & sharp objects, etc.)
- → Strangulation hazards
- → Trip/fall hazards (rugs, cords, etc.)
- → Poisoning hazards (plants, chemicals, etc.)
- → Burn hazards (hot coffee in child-accessible areas, unanchored crock pots, etc.)
- → Windows within the reach of children

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

→ The playground is inspected daily to ensure to remain compliant with Consumer Product Safety Commission (CPSC) guidelines and/or American Society for Testing and Materials (ASTM) standards and is free of broken equipment, environmental hazards, garbage, and animal contamination.

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

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

→ Ensure firearms, guns, weapons, and ammunition are not on premises of childcare program

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

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

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

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

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

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

PROCEDURES FOR INJURIES AND MEDICAL EMERGENCIES

1. Assess the injured child and obtain appropriate supplies.
2. Staff trained in first aid will refer to the First Aid Guide, located in every first aid kit, for more information if needed.
3. Administer first aid. Non-porous, non-latex gloves (i.e. nitrile or vinyl*) are used if blood is present. If the injury/medical emergency is life threatening, one staff person stays with the injured/ill child, administers appropriate first aid, and starts CPR, while another staff person calls 911 and brings the AED. If only one staff member is present, that person assesses the child for breathing and circulation.
   - → If collapse is un-witnessed: First perform 2 minutes of CPR, then call 911 and bring an AED to the child.
   - → If collapse is witnessed: First call 911 and bring an AED, then start CPR.
4. Staff calls parent/guardian or designated emergency contact if necessary. For major injuries/medical emergencies, a staff person stays with the injured/ill child until a parent/guardian or emergency contact arrives, including during transport to a hospital.
5. Staff record the injury/medical emergency on an accident/injury report form. The report includes:
   - → Date, time, place and cause of the injury/medical emergency (if known),
   - → Treatment provided,
   - → Name(s) of staff providing treatment, and
   - → Persons contacted.

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

6. The designated staff person immediately calls the childcare licensor when serious injuries/incidents that require medical attention occur.
7. Record any injury on the site "Incident/Injury Log." Every entry will include the child's name, name(s) of staff involved, and a brief description of the incident. The site injury log is confidential.

*Pease note: Always wash hands after glove removal.

BLOOD/BODY FLUID CONTACT OR EXPOSURE

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

- → Non-porous, non-latex gloves are always used when blood or wound drainage is present.
- → Any open cuts or sores on children or staff are kept covered.
- → Whenever a child or staff comes in contact with a body fluid, the exposed area is washed immediately with soap and water, rinsed, and dried with paper towels.
- → Surfaces that come in contact with blood/body fluids are cleaned immediately with detergent and water, rinsed, and disinfected with an appropriate EPA approved disinfectant, such as bleach in the concentration used for disinfecting body fluids (refer to "Methods for Mixing Bleach"). The site's "Bloodborne Pathogen Exposure Control Plan" (BBP ECP) includes details on how to clean and disinfect specific surfaces (carpets, smooth surfaces, etc).
- → A child's clothing soiled with body fluids is removed as soon as possible, put into a plastic bag, securely tied or sealed, then put into another plastic bag that is securely tied or sealed and sent home with the child's parent/guardian. A change of clothing is available for children in care, as well as for staff.
- → Any equipment (mops, brooms, dustpans, etc.) used to clean-up body fluids is cleaned with a disinfectant according to manufacturer's instructions and air-dried.
- → Gloves, paper towels, and other first aid materials used to wipe up body fluids are put in a plastic bag, tied closed, and placed in a plastic-lined waste container with lid.
- → Hands are always washed after handling soiled laundry or equipment, and after removing gloves.

Blood Contact or Exposure

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

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

DISASTER PREPAREDNESS

Plan and Training

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

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

Staff receive fire extinguisher training. John Wells (owner) has received utility control training (how to turn off gas, electric, water):

Documentation of disaster and earthquake preparation and training filed on site.

Supplies

Our early learning program maintains a supply of food and water on site for children and staff sufficient for at least 72 hours, in case parents/guardians are unable to pick up children at the usual time. The Director is responsible for stocking supplies.

We check food, water, and supply expiration dates at least annually and rotate supplies accordingly.

We maintain essential prescribed medications and medical supplies on hand for individuals who need them.

Hazard Mitigation

We have taken action to make our space earthquake/disaster-safe. We have safely secured bookshelves, tall furniture, refrigerators, crockpots, and other potential hazards to wall studs as appropriate.

We continuously monitor all rooms and offices for anything that could fall and hurt someone or block an exit, and take corrective action as needed.

John Wells (owner) is the primary person responsible for hazard mitigation. It is the program's expectation that all staff members be aware of the environment and make changes as necessary to increase safety.

Drills

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

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

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

According to WAC110-300-0300, we are required to notify our licensor when a child with special health care needs is enrolled or identified in our program. We maintain confidentiality when reporting this by not revealing names or diagnoses. All families will be treated with dignity and with respect for their individual needs and/or differences. Children with special needs will be accepted into our program under the guidelines of the Americans with Disabilities Act (ADA).

Children with special needs will be given the opportunity to participate in the program to the fullest extent possible. To accomplish this, we may consult with our public health nurse consultant and other agencies/organizations, as needed.

An individual plan of care is developed for each child with a special health care need. The plan of care is kept in the child's file and includes information and instructions for: Daily care, potential emergency situations, evacuation and care during and after a disaster Completed plans are requested from health care provider annually or more often if there is a change in the child's special needs. Teachers, cooks, and other staff will be oriented to any special needs or diet restrictions by the Director.

Children with special needs are not present without an individual plan of care on site. All staff receives general training on working with children with special needs. Any staff that is involved in the care of a child with special needs receives updated training, as needed, around implementing the child's care plan. Verification that staff has been trained is kept in the child's file.

DIAPERING

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

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

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

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

Stand-Up Diapering for Older Children

We do stand-up diapering as appropriate.

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

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

TOILET TRAINING

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

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

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

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

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

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

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

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

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

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

TODDLER AND PRESCHOOL SLEEP

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

FOOD SERVICE

We prepare meals and snacks at our early learning program. A permanent copy of the menu (including any changes made or food returned) is kept for at least 6 months.

Food handler permits are required ALL STAFF. An "in charge" person with a food handler permit is onsite during all hours of operation, to assure that all food safety steps are followed. Orientation and training in safe food handling is given to all staff and documented. lll staff or children do not prepare or handle food.

Food workers may not work with food if they have:

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

Child care cooks do not change diapers or clean toilets.

All food safe handling policies and procedures are followed.

NUTRITION

Lil Hawks serves meals and snacks which meet the daily nutritional requirements of the USDA Nutrition Standards for the Child and Adult Care Food Program (CACFP) We provide breakfast, morning snack, lunch, afternoon snack, and dinner.

Menus are posted in advance, dated, and list specific types of fruits, vegetables, crackers, etc. that are served, per CACFP requirement.

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

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

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

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

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

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

Mealtime Environment and Socialization

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

Staff sit with children (and preferably eat the same food that is served to the children in care) and have casual conversations with children during mealtimes.

Children are not coerced or forced to eat any food.

Children decide how much and which foods to choose to eat of the foods available.

Food is not used as a reward or punishment.

Foods are served family style to promote self-regulation.

Staff provide healthy nutritional role modeling (serving sizes of foods, appropriate mealtime behavior and socialization during mealtime).

Sweet Treat Policy

Special "treats" for celebrations should be limited to no more than twice a month; this should be coordinated and monitored by the classroom teacher. Items that are health promoting should always be encouraged; information is available for parents with ideas for birthday, holiday or special occasions "treat".

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

Examples of more nutrition sweet treats include:

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

Cultural and ethnic food items that are considered dessert or special "treat" may be served to honor cultures represented in the program. Examples may include sticky rice and sweet rice such as banh bo, noodle-based dessert, lefse, flan, sweet potato pie (modified for fat and sugar), bean dessert items, sambusa or "mush-mush". Recipes or directions from parents could be shared with food service staff who prepares the item.

Use of non-food items to celebrate special occasions is encouraged. Examples of these types of items include: stickers, pencils, birthday "hats" or crowns, bubble solution, or piñatas filled with these items.

Toddler Mealtimes

- → Gloves are worn or utensils are used for direct contact with food. (No bare hand contact with ready-to-eat food is allowed.) Gloves used for food preparation are kept in food preparation area. Hands are washed prior to and after using gloves.
- → Children eat from plates and utensils. Food is not placed directly on table unless a high chair is used. High chair tray functions as a plate for seated children. The tray is washed and sanitized before and after use.
- → Children are not allowed to walk around with food or cups.
- → Teachers sit with infants and young children when eating, engage in positive social interaction, and observe each child eating. Teachers are encouraged to eat the same foods the toddlers are served from the menu to model eating a variety of foods and demonstrate safe usage of eating utensils and eating behaviors.
- → Toddlers are prevented from sharing the same dish or utensil.
- → If there is uneaten food in a serving container that's been on, or passed around the table, it cannot be served after the intended meal.

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

PHYSICAL ACTIVITY AND SCREEN TIME LIMITATIONS

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

Outdoor play

A variety of age-appropriate activities and play equipment for climbing, pulling, pushing, riding and balancing are available outdoors. All children go outside in all weather (rain, snow etc…) unless it is dangerous or unhealthful. Our early learning program provides shaded areas in outdoor play space provided by trees, umbrellas, and building structures.

- → Toddlers spend 20 minutes per every 3 hours of programming outdoors. If they are in care for a full day, they are allowed 60 to 90 minutes of moderate to vigorous activity, of which 30 minutes may be indoor activities.
- → Preschool-age and older spend 30 minutes per every 3 hours of programming outdoors. If they are in care for a full day, they are allowed 90-120 minutes per day of moderate to vigorous activities, of which 30 minutes may be indoor activities.

Screen Time

Children under 2 years do not get any screen time.

Children over 2 years are limited to 30 minutes of educational viewing per week, if at all. Computer use is limited to 15 minute increments of play time, except when children are completing homework or school lessons.

There is no screen time during scheduled meals or snacks.

SOCIAL-EMOTIONAL CARE

Establishing positive relationships with children and their families is extremely important. Children need a consistent and supportive connection with their teachers to grow and learn. Childcare professionals must role model the social-emotional behavior they want to see develop in their students, such as empathy, appropriate interactions with others, and self-regulation.

Children come from many different kinds of families and with many different experiences. Some children will come to you affected by a variety of stressors, while some children may have even been deprived of the relationships they needed to thrive. Other children may have the benefit of adequate resources. Regardless of what experiences children may bring to your class, they all require your warmth and attention.

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

Program and Environment

Teachers work to establish a respectful, warm, and nurturing relationship with each child in the classroom, including with parents and colleagues.

Teachers provide children with the comforts of routine and structure that are flexible so as to meet the needs of a wide range of children.

Teachers spend time at floor/eye level with the children.

A responsive problem solving approach is used with children. Guidance techniques such as coaching, modeling, offering choices, and/or redirection may be used to lead developmentally appropriate conflict resolution.

Children's feelings are named and acknowledged to help a child learn and feel validated.

Transitions are treated as learning opportunities for children within a developmentally appropriate time frame, and expectations are clearly communicated.

Teachers can comfort children through conversation, sitting with children, and/or holding infants or toddlers when they are unhappy.

Discipline is seen as an opportunity to teach children self-control and skill building.

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

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

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

DEVELOPMENTAL CARE

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

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

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

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

Providers must discuss with parents or guardians the importance of developmental screenings for each child and offer available resources when necessary

CHILD ABUSE AND NEGLECT

Child care providers are state mandated reporters of child abuse and neglect; we immediately report suspected or witnessed child abuse or neglect to Child Protective Services (CPS).

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

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

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

"NO SMOKING, NO VAPING" POLICY

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

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

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

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

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