Minding Miracles Learning Center
Annual Policy Orientation
Effective August 2023

Our Program Philosophy

MINDING MIRACLES Learning Center, Inc.

We believe that quality childcare depends upon consistent caregiving in a language-rich environment. Children grow and learn best in a safe atmosphere that provides opportunities to explore, create and communicate with other children and adults. Our program is designed to be inclusive of all children, including those with identified disabilities and special learning/developmental needs.

Our program is designed to include both planned and spontaneous activities in response to children's interests. Our daily schedule has a mix of student-led, play based and teacher-directed lessons and activities. We infuse movement throughout the day & take the attention span of each child into consideration when planning activities. Experiences with music, movement, art, language and building are incorporated into daily plans. Regularly scheduled snacks and meals, rest time, indoor and outdoor play, and routines for primary care promote the child's health, comfort and ability to care for him/herself.

Flexibility, choice-making and self-advocacy are promoted for the children as a group and as individuals. Children are encouraged to develop a positive self-image, learn self-regulation skills and to cooperate with peers and caregivers. Clearly defined limits help them recognize and accept their emotions and express their feelings as they grow and feel secure in the world around them.

Staff Roles

- **Director:** The director is accountable for the overall licensing, compliance and program quality. The director's accountability includes all logistical and programmatic decisions including staff supervision, maintaining appropriate policies/procedures and the overall integrity of all Minding Miracles programs. The director is charged with upholding all center policies and amending policies as needed to comply with Office of Licensing regulations.

- **Supervisors (Consulting Head Teacher /Curriculum Coordinator/BCBA):** Supervisors are accountable for the training, development, and performance of all staff within the margins of their individual certification & talents. Supervisors are accountable for maintenance of student records and programming updates. Supervisors must serve as liaison for parents and paraprofessionals for conflict resolution and decision-making disputes. Furthermore, supervisors are accountable for the overall implementation of treatment plans, behavior modification plans, developmental assessments and reporting to designated agencies.

- **Center Manager:** The center manager is responsible for maintaining the quality of each Minding Miracles Program in accordance with the vision and objectives set forth by the director; maintaining student & staff records; maintaining all DCF/DDD licensing requirements; supervision of all teaching and assisting staff; hiring of staff & maintaining staff schedules; management of building maintenance; maintaining adequate office, teaching, janitorial and first aid supplies; staff training and assistance, filing of accident reports; support of staff grievances; scheduling of students; completing new client calls and tours; processing of all new client & employee paperwork.

Staff Roles

- **Supervisors:** Supervisors are accountable for the training, development, and performance of all staff within the margins of their individual certification & talents. Supervisors are accountable for maintenance of student records and programming updates. Supervisors must serve as liaison for parents and paraprofessionals for conflict resolution and decision-making disputes. Minding Miracles supervisory roles include the following:
  - BCBA: (Board Certified Behavior Analyst) are accountable for the overall implementation of treatment plans, behavior modification plans, developmental assessments and reporting to designated agencies for MM clients with autism. The BCBA monitors the effectiveness/implementation of behavior strategies, client goals, programming strategies and treatment fidelity.
  - Consulting Head Teacher: The consulting head teacher is accountable for creating a cohesive, student-centered level of quality amongst all MM classrooms. Implementation of curriculum, maintaining assessment strategies, monitoring lesson plans, staff training and strategic planning are among the accountabilities of the consulting head teacher. Additionally, the consulting head teacher performs classroom assessments (ECERS/ITERS), creates improvement plans and supports head-teachers in effective classroom management.

- **Registered Behavior Technician:** RBTs work under the direct supervision of the BCBA and are accountable for following through on behavior strategies, implementation of ITT programming, data collection and reporting. An RBT at MM may double as a paraprofessional in the natural environment of the classroom.

Staff Roles

- **Head Classroom Teacher:** The head classroom teacher is responsible for the health and safety of all students; development and assessment of student goals; maintaining classroom equipment and supplies; organization of classroom materials and student belongings; implementing behavior plans as necessary; maintain portfolio information for each student; annual parent meetings; daily parent communication; reporting incidents or concerns to supervisor on duty; lesson plans for group teaching; supervision of subsequent staff; implementation of Minding Miracles curriculum and individual program goals.

- **Classroom Paraprofessional:** Paraprofessionals are experienced in child development & center operations first handedly responsible for the safety of all children in their care; required to report any hazardous or inappropriate situations to supervising staff; take specific instruction from their supervising teacher; maintain a clean, sanitary environment for all staff and clientele; support the classroom teacher in implementing curriculum activities; implement prompting techniques to support students within the classroom; take behavior data when necessary.

- **Classroom Assistant:** Classroom assistants are support workers that are supervised by the classroom teacher. Classroom assistants require direct supervision as minors or lack of experience. They may be accountable for student engagement, classroom cleaning/organization, assisting with primary care routines or implementing lesson plans as designed by the teacher.

Supervision

Supervising and tracking children:

Every staff member is obligated to…

- Maintain a running tally for the number of children in your care at each moment. This number should be maintained as children come and go- and should be 'at the tip of your tongue.'
- Know the exact age range within which the children in your care fall.
- Perform a head count as children are brought to/from the playground or a different area of the building.
- Communicate with other staff members whenever bringing one or more children away from their group. (i.e.- notify other staff if you are bringing a child into another room or the bathroom).
- At no time may any child be left unsupervised for ANY reason.
- Position yourself in the classroom or on the playground as to allow visible supervision of all children without obstruction.
- Accompany any child who leaves the classroom for ANY reason (i.e. to go to the bathroom, dismissal, etc.)

Student:Staff Ratios

Staff/Child Ratios

Under 18 months 1:4
18 months – 2 ½ years 1:6
2 ½ - 4 years 1:10
4 years 1:12
5 years and older 1:15

Staff/Child Ratios-Rest and Sleep

Under *18 months* 1:10
18 months to Under 2 ½ years 1:12
Over 2 ½ years 1:20

These staff/child ratios apply during rest/sleep when all three of the following criteria are met:

1.At least one staff member shall be physically present in the room or area in which children are napping and shall be able to summon other staff members without leaving the room or area.
2.A sufficient number of staff members shall be in the facility and readily accessible to ensure compliance with the awake staff/child ratios
3. Naptime preparations shall have been completed and all *children18 months of age or above* are resting or sleeping, while all children *under18 months of age* are sleeping.

ACTIVE SUPERVISION AT-A-GLANCE

SIX STRATEGIES TO KEEP CHILDREN SAFE

The following strategies allow children to explore their environments safely. Infants, toddlers, and preschoolers must be directly supervised at all times. Programs that use active supervision take advantage of all available learning opportunities and never leave children unattended.

Set Up the Environment

Staff set up the environment so that they can supervise children and be accessible at all times. When activities are grouped together and furniture is at waist height or shorter, adults are always able to see and hear children. Small spaces are kept clutter free and big spaces are set up so that children have clear play spaces that staff can observe.

Position Staff

Staff carefully plan where they will position themselves in the environment to prevent children from harm. They place themselves so that they can see and hear all of the children in their care. They make sure there are always clear paths to where children are playing, sleeping, and eating so they can react quickly when necessary. Staff stay close to children who may need additional support. Their location helps them provide support, if necessary.

Scan and Count

Staff are always able to account for the children in their care. They continually scan the entire environment to know where everyone is and what they are doing. They count the children frequently. This is especially important during transitions, when children are moving from one location to another.

Listen

Specific sounds or the absence of them may signify reason for concern. Staff who are listening closely to children immediately identify signs of potential danger. Programs that think systemically implement additional strategies to safeguard children. For example, bells added to doors help alert staff when a child leaves or enters the room.

Anticipate Children's Behavior

Staff use what they know about each child's individual interests and skills to predict what he/she will do. They create challenges that children are ready for and support them in succeeding. But they also recognize when children might wander, get upset, or take a dangerous risk. Information from the daily health check (e.g., illness, allergies, lack of sleep or food, etc.) informs staff's observations and helps them anticipate children's behavior. Staff who know what to expect are better able to protect children from harm.

Engage and Redirect

Staff use what they know about each child's individual needs and development to offer support. Staff wait until children are unable to solve problems on their own to get involved. They may offer different levels of assistance or redirection depending on each individual child's needs.

http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/health/safety-injury-prevention/safe-healthy-environments/active-supervision.html

Early Childhood

Daily Safety Checklist for Working with Young Children

Activity

- [ ] Check the floor and on surfaces; remove small objects which could be choking hazards for young children.
- [ ] Remove any items or adjust any areas that may cause tripping or invite a fall.
- [ ] Remove, repair, or throw away toys and materials with tears, cracks, breaks, and sharp edges.
- [ ] All electrical outlets are securely covered.
- [ ] Electrical cords, window blind cords, and telephone cords (or any string- or rope-like materials) are securely fastened and kept out of the reach of children.
- [ ] There are no toxic or hazardous materials in the room.
- [ ] Medicines, cleaning supplies, plastic bags, sharp scissors and other harmful materials are in locked cabinets.
- [ ] Check the safety locks on cabinets to make sure they are secure.
- [ ] Heavy furniture and equipment is securely fastened to the wall.
- [ ] All purses, backpacks, and adult personal belongings are kept in a locked cabinet or locked storage area.
- [ ] Identify any new or unique safety concerns and talk about them with your team.
- [ ] Make sure any/all food or eating surfaces are completely clean and sanitized before and between uses.
- [ ] Doors in all interior rooms designated for use by children are unlocked.
- [ ] Heating equipment and units should be made inaccessible to children by barriers such as guards, protective screens, or other devices.
- [ ] Garbage should be removed from rooms occupied by children, staff, parents/guardians, or volunteers on a daily basis and removed from the premises.

Information derived from: http://bkc-od-media.vmhost.psu.edu/documents/HO_CCDBG_DailyChecklist.pdf, https://www.nj.gov/dcf/providers/licensing/laws/CCCmanual.pdf and https://nrckids.org/CFOC/Database/5, https://www.ersi.info/PDF/Table%20washing%20handout%20revised%202-11.pdf, and https://nrckids.org/CFOC/Database/5

Playground Supervision

Playground Supervision

Each year more than 200,000 injuries occur on playgrounds. Our students have a developmental need to run, jump and climb and it is our job to ensure that they do-so in a safe and carefree way. The attached guidelines have been adopted by Minding Miracles in order to minimize risk while our students play on our playgrounds.

- Staff must position themselves in a way that allows visual monitoring of the entire play space.
- Monitor the playground for tripping hazards, broken objects or other potential physical obstacles. Any potential problems should be remediated or reported to the center manager immediately.
- Students who are exhibiting unsafe behavior (aggression, climbing on the fence, throwing inappropriate objects, etc.) should be redirected immediately.
- Staff are permitted to sit, but should be positioned in a way that is conducive to supervision….playground time is not a staff break- you must be diligent and attentive. If you are going to sit, be ready to jump up to assist or intervene.
- Groups of children should be changed or brought to the bathroom before going outside in order to minimize the number of times a staff member must leave the playground.
- As children are released onto the playground, a staff member must perform a head-count and each member of the supervision staff must maintain a head-count while the children are outside. A subsequent head-count and final visual 'sweep' must be performed to ensure that no child has been left outside as the group re-enters the building.

Playground Supervision (cont)

- In the event of an injury where a child is injured and cannot be moved indoors, the other children should be brought inside by a secondary caregiver in order to minimize distraction to the injured child and minimize upset to the uninjured children. ALL INJURIES MUST BE REPORTED! *(See below for more details)*
- Any child who has outdoor-related allergies (pollen, grass, bees) must have a allergy action plan implemented in case of an allergic reaction. Ask the center manager for more information.
- Most outdoor play should be 'free-play' based; however, when on exceptionally nice days, structured activities can be used to maximize the amount of time children spend outside. Whenever spending more than 30 consecutive minutes outdoors, incorporate additional structured activities. Obstacle courses, gross motor games, nature hunts, etc. are great ways to make the most of the outdoors.
- Beware of dehydration. Children become easily dehydrated and must have access to water while outdoors during the hot summer months. Their personal water cups/bottles can be brought outside or a pitcher of water with paper cups can be brought out- either way, they must have access to water.
- Stay on heightened alert for danger. When our students are outside, we are vulnerable to a myriad of potential dangers that are benign while our students are securely behind the locked doors of our center. Any situation which seems strange or potentially dangerous should be a catalyst to bring the children indoors. Such catalysts may include lurking strangers, unknown vehicles or potentially hazardous conditions.
- Sun safety is important. Parents have been asked to provide sunscreen for their children. Please be sure to apply sunscreen to any exposed skin and watch for potential sunburn. Do not use another child's sunscreen to others. Many children have sensitive skin and using unapproved sunscreen without permission could cause an allergic reaction.
- Before re-entering the building, children should be engaged in the act of cleaning up the playground. All debris should be placed in the garbage and loose toys should be arranged in an organized manner. Additionally, any equipment or materials that belongs inside should be brought in and cleaned off…..even if you are planning on going back out later in the day.

Playground Supervision (cont)

Minimizing risk in the physical space:

Look for the following potential hazards as you escort students outside:

- Tree branches/natural debris
- Evidence of animal presence or feces
- Broken playground equipment
- Tripping hazards
- Lack of safety surfacing (mulch) under fall zones
- Problems with the fence, gate or building

Indoor gross motor group:

Children need adequate gross motor activity even when weather doesn't permit outdoor play. Indoor gross motor activities can be used to supplement playground time. Try the following activities whenever conditions do not permit outside play:

- Dance activities (Listen & move, Freeze Dance, etc)
- Obstacle courses
- Simon Says
- Children's Yoga
- Go Noodle Video Movement
- Follow the Leader Exercises
- Parachute play

Important take-aways:

- Staff must supervise children diligently and proactively; reinforcing safe behavior and promoting positive play skills.
- Outdoor play lasting more than 30 minutes must incorporate short periods of staff-led structured gross motor games.
- When weather does not permit outdoor gross motor play, other outlets for physical activity must be incorporated to the daily schedule.
- Keeping students safe must incorporate considerations of environmental hazards, hydration and play space hazards.
- There is no 'set'

Child Care Weather Watch

Watching the weather is part of a child care provider's job. Planning for playtime, field trips, or weather safety is part of the daily routine. The changes in weather require the child care provider to monitor the health and safety of children. What clothing, beverages, and protections are appropriate? **Clothe** children to maintain a comfortable body temperature (warmer months - lightweight cotton, colder months - wear layers of clothing). **Beverages** help the body maintain a comfortable temperature. Water or fruit juices are best. Avoid high-sugar content beverages and soda pop. **Sunscreen** may be used year around. Use a sunscreen labeled as SPF-15 or higher. Read and follow all label instructions for the sunscreen product. Look for sunscreen with UVB and UVA ray protection. **Shaded** play areas protect children from the sun.

Condition **GREEN** - Children may play outdoors and be comfortable. Watch for signs of children becoming uncomfortable while playing. Use precautions regarding clothing, sunscreen, and beverages for all child age groups.
INFANTS AND TODDLERS are unable to tell the child care provider if they are too hot or cold. Children become fussy when uncomfortable. Infants/toddlers will tolerate shorter periods of outdoor play. Dress infants/toddlers in lightweight cotton or cotton-like fabrics during the warmer months. In cooler or cold months dress infants in layers to keep them warm. Protect infants from the sun by limiting the amount of time outdoors and playing in shaded areas. Give beverages when playing outdoors.
YOUNG CHILDREN remind children to stop playing, drink a beverage, and apply more sunscreen.
OLDER CHILDREN need a firm approach to wearing proper clothing for the weather (they may want to play without coats, hats or mittens). They may resist applying sunscreen and drinking beverages while outdoors.

Condition **YELLOW** - use caution and closely observe the children for signs of being too hot or cold while outdoors. Clothing, sunscreen, and beverages are important. Shorten the length of outdoor time.
INFANTS AND TODDLERS use precautions outlined in Condition Green. Clothing, sunscreen, and beverages are important. Shorten the length of time for outdoor play.
YOUNG CHILDREN may insist they are not too hot or cold because they are enjoying playtime. Child care providers need to structure the length of time for outdoor play for the young child.
OLDER CHILDREN need a firm approach to wearing proper clothing for the weather (they may want to play without coats, hats or mittens), applying sunscreen and drinking liquids while playing outdoors.

Condition **RED** - most children should not play outdoors due to the health risk.
INFANTS/TODDLERS should play indoors and have ample space for large motor play.
YOUNG CHILDREN may ask to play outside and do not understand the potential danger of weather conditions.
OLDER CHILDREN may play outdoors for very short periods of time if they are properly dressed, have plenty of fluids. Child care providers must be vigilant about maximum protection of children.

Child Care Weather Watch, Iowa Department Public Health, Healthy Child Care Iowa, Produced through federal grant (MCJ19T029 & MC
Services, Health Resources & Services Administration, Maternal & Child Health Bureau. Wind-Chill and Heat Index information is from the

Child Care Weather Watch

Understand the Weather

Wind-Chill

- 30°is *chilly* and generally uncomfortable
- 15°to 30° is *cold*
- 0° to 15° is *very cold*
- -20° to 0° is *bitter cold* with significant risk of *frostbite*
- -20° to -60° is *extreme cold* and *frostbite* is likely
- -60° is *frigid* and exposed *skin will freeze* in 1 minute

Heat Index

- 80° or below is considered *comfortable*
- 90° beginning to feel *uncomfortable*
- 100° *uncomfortable* and may be *hazardous*
- 110° considered *dangerous*

All temperatures are in degrees Fahrenheit

Wind-Chill Factor Chart (in Fahrenheit)

Air Temperature \ Wind Speed in mph	Calm	5	10	15	20	25	30	35	40
40	40	36	34	32	30	29	28	28	27
30	30	25	21	19	17	16	15	14	13
20	20	13	9	6	4	3	1	0	-1
10	10	1	-4	-7	-9	-11	-12	-14	-15
0	0	-11	-16	-19	-22	-24	-26	-27	-29
-10	-10	-22	-28	-32	-35	-37	-39	-41	-43

Comfortable for out door play

Caution

Danger

Heat Index Chart (in Fahrenheit %)

Air Temperature (F) \ Relative Humidity (Percent)	40	45	50	55	60	65	70	75	80	85	90	95	100
80	80	80	81	81	82	82	83	84	84	85	86	86	87
84	83	84	85	86	88	89	90	92	94	96	98	100	103
90	91	93	95	97	100	103	105	109	113	117	122	127	132
94	97	100	103	106	110	114	119	124	129	135			
100	109	114	118	124	129	130							
104	119	124	131	137									

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VERY IMPORTANT

Supervision Key Points:

** Staff must be spread around the playground to ensure that all children are visually supervised

**If a child needs to go inside to use the bathroom, first aid, etc; a staff member must accompany them or pass the child off to an indoor staff member.

**When the child returns to the playground, there should be clear communication of their return, "Michael is back from the bathroom." Even if their return seems obvious, verbal communication helps everyone be conscious of the hand-off and change in numbers.

Weather watch Key Points:

** Use the weather watch chart to help with decision making.

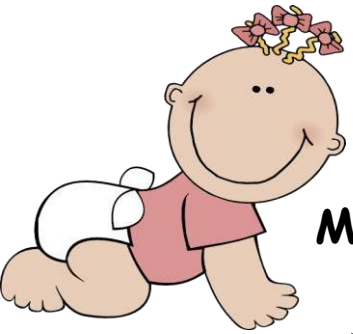
**We should be striving for maximum outside time.

**Promote hydration while children are outdoors.... ESPECIALLY on very hot days.

**Create opportunities for outdoor activities even when weather isn't optimal- ex- coloring at the table after it has rained if the playground is too wet, small groups in shaded areas when it is extremely sunny, et.

**Even when it is very hot or cold, short outdoor breaks can be accommodated if we are conscious of safety.

Care Routines



Minding Miracles Learning Center

Diaper Changing Procedure

For sanitation purposes, please follow this procedure every time you change a child's diaper:

1. Put on gloves before changing.
2. Remove soiled diaper.
3. Use baby wipes to sanitize the child's bottom (unless otherwise specified).
4. Remove gloves by wrapping them around the soiled diaper.
5. Place soiled diaper in the covered trash receptacle.
6. If the child's clothes are soiled, place them in a plastic bag to be sent home (DO NOT rinse).
7. When needed, or as specified by the parent, apply Vaseline or changing lotion.
8. Put clean diaper on the child, and replace clothing if necessary.
9. Sanitize the changing table and wash the child's hands and your own hands as per hand washing procedure.

****Failure to comply with this procedure is a violation of both the health code and NJ State standards.****

Safe Sleep Tips for Parents and Caregivers

•Place baby to sleep on his or her back…if a mobile infant rolls to his/her side or belly *on their own*; they may be left to rest comfortably, but may not be placed that way.
•The safest place for baby to sleep is in a crib near your bed.
•Research shows that bed sharing (falling asleep with your baby) can be unsafe as adults (or children) can accidentally roll onto baby while sleeping.
•Bed sharing is especially dangerous if an adult has taken drugs, alcohol or medication that makes them sleepy.
•Adult beds are not safe as baby can get trapped between the mattress and wall, headboard or footboard.
•It is not safe for baby to sleep on a couch, with you or alone.
•Breastfeeding and bonding are very important to baby's health. It's okay to nurse baby in bed, but remember to place baby in the crib when it's time to go to sleep.

Safe Sleep Tips for Parents and Caregivers (cont.)

•Baby can be placed on his or her stomach when awake. Supervised "tummy time" during awake hours allows for normal development.
•Provide a smoke-free environment for baby.
•Never lay baby to sleep on a pillow. Babies under one year old should never be given a pillow for the head.
•Soft materials can interfere with baby's breathing. Baby should not sleep with pillows, quilts, comforters, heavy blankets, or stuffed toys.
•Use a wearable blanket or other type sleeper. Use safe sleepwear without strings or ties.
•Never lay baby to sleep near any appliances, toys or household items that dangle, such as window treatment cords, telephone wires, computer extensions, etc.
•Babies should never sleep with a hot-water bottle or electric blanket, next to a radiator, heater, or fireplace, or in direct sunlight.
•Room temperature should not be too warm. Babies should not be overbundled.

During nap time, absolutely NO…..

*Pacifier clips/add-ons
*Blankets (other than 'wearable sleepers' with sleeves)
*Stuffed animals or other toys in crib
*Bibs

Children who fall asleep in a chair or on the floor must be transferred to a crib or cot within 5 minutes

COTS MUST NOW BE LABELED W/ CHILD'S NAME

Infant Safe Sleep Checklist

Purpose: The goal of creating a safe sleep environment for infants is to reduce the risk of Sudden Infant Death Syndrome and other sleep-related deaths such as accidental suffocation and strangulation in bed. The purpose of this checklist is to provide the home visitor with a method for reviewing the infant's sleep environment. This checklist can serve as a basis for providing safe sleep education. This material was prepared by the SIDS Center of New Jersey based on the most recently issued guidelines and technical report, to date, of the American Academy of Pediatrics (AAP) Task Force on Sudden Infant Death Syndrome. The articles (Moon, RY, Pediatrics, 2011) can be accessed through a link on the SIDS Center of New Jersey website: www.rwjms.rutgers.edu/sids. Safety guidelines for infant mattresses, cribs, cradles, bassinets and other sleep products can be accessed at the US Consumer Product Safety website, www.cpsc.gov. This information in this checklist addresses infants from birth through 12 months of age and is intended for discharged premature as well as term infants. Rarely, the infant's physicians may recommend alternative guidance based on a health condition. In these instances, the physician's advice should be the family's guideline.

The SIDS Center of New Jersey (SCNJ) is based at Robert Wood Johnson Medical School, a part of Rutgers, The State University of New Jersey, New Brunswick, NJ, and The Joseph M. Sanzari Children's Hospital at Hackensack University Medical Center, Hackensack, NJ. The program is funded in part by a grant from the New Jersey Department of Health to Robert Wood Johnson Medical School and a grant from the CJ Foundation for SIDS to Hackensack University Medical Center. For further information please contact the SCNJ at 1-800-545-7437. (This version prepared 7/13)

Directions: For each, place a plus sign where the description accurately conveys the infant care practice being used. Place a minus sign where the checklist description differs from what is done in the home. In reviewing all safe sleep guidelines with the family, point out where the practice in the home is consistent with the recommendations and where the practice differs from the description. Help families understand the purpose of each guideline, and address any concerns they may have about following a particular guideline. Use the SCNJ Safe Sleep flyer and the NICHD safe to sleep materials to illustrate your discussion.

1. Assess where the baby sleeps and what is in the sleep setting.

___ The Infant is always placed to sleep on a firm sleep surface, such as safety-approved crib mattress.

___ The infant is never placed to sleep on a sofa, chair or adult bed.

___ The infant is never put to sleep on the same sleep surface as another adult, child, infant or twin.

___ The mattress fits snugly in the crib with no gaps between end of mattress and the sides or edges of crib.

___ The fitted crib sheet fits tightly around the mattress

___ No soft or loose bedding, such as quilts or pillows, is placed underneath the infant.

___ Pillows, quilts, blankets, other loose bedding and bumpers are kept out of the infant's sleep area.

___ Instead of a blanket, the infant is placed to sleep in sleep clothing such as a one-piece sleeper. (The one-piece sleeper fits appropriately).

____ Nothing covers the infant's face.

___ Stuffed animals and stuffed toys are kept out of the sleep area.

___ If parents bring the infant to bed with them for comforting or feeding, they always return the infant to his or her separate sleep area such as a crib or bassinet or cradle when the parent is ready to sleep.

___It is recommended that the infant's crib, bassinet or cradle be placed in the parents' bedroom.

SAFETY ITEMS ARE CONTINUED ON BACK OF PAGE...

Infant Safe Sleep Checklist

2. Assess the infant's sleep position (Parents should indicate if they have discussed sleep positioning with the infant's healthcare provider.)

___ Infants under one year of age are always **placed on their backs to sleep**, for naps and at night. (Opportunities for discussion: (1) there is no increased risk of choking; (2) Infants should continue to be placed supine for the first 12 months; however, once an infant can roll over from supine to prone and prone to supine, he or she can be allowed to remain in the sleep position that he or she may roll into following supine placement; (3) In rare instances; a health condition may have been identified that leads the infant's healthcare provider to indicate an alternative placement. Parents should be able to describe the exception.

___ When the infant is awake and **being watched by a caregiver**, it is desirable to place him or her on the stomach for "tummy time." Tummy time helps infants achieve developmental milestones and reduces the risk of flat spots developing on the head. Avoiding excessive time in carriers and bouncers can also help. Another method for helping to prevent flat spots is to alternate the direction in which the baby is placed to sleep in the crib (see below). By changing the direction of the baby's placement, the activity in the room is more likely to be on his left for some nights and on the right on others, leading the baby to turn his head in different directions and thus not always sleep on the same side of his head.

___ Parents avoid products that are intended to control the position of the infant in sleep as these have not been sufficiently tested for effectiveness or safety and have been found by the Consumer Product Safety Commission to have unintended adverse consequences.).

3. Assess the infant's environment

___ There is no smoking in the home or alternative care environment.

___ The infant is kept away from any area where smoking has occurred.

___ The sleeping infant is not overheated by a room temperature that is too high or by too many layers of clothing.

4. Pacifier use:

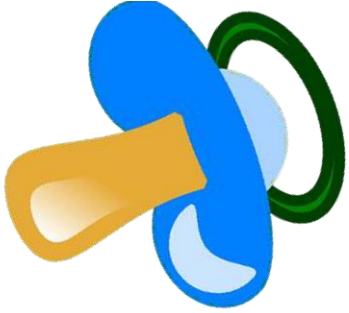
___ A clean dry pacifier is offered when placing the infant down to sleep for naps or at night. (The pacifier does not need to be re-inserted if it falls out. If infant refuses the pacifier, he or she should not be forced to take it. For breastfed infants pacifier use should be delayed until 1 month of age to ensure good onset of breastfeeding. The pacifier should not be coated in any sweet solution. Pacifier should be cleaned often and replaced regularly.)

5. Educational material (check off what has been provided)

___ Safe Sleep educational material was distributed and guidelines were discussed

___ SIDS Center of New Jersey phone number (1-800-545-7437) was given as a resource for further questions about sudden infant death syndrome, accidental suffocation or strangulation in bed or about safe sleep.

Pacifiers:



- Pacifiers must be disinfected daily….or anytime they fall from the child's mouth onto a unsanitary surface.
- Under NO circumstances may pacifiers be shared.
- Mobile infants (crawlers/walkers) may not have their pacifier unless being laid to sleep or soothed; they may not move about the classroom with it.
- Pacifier clips must be removed at nap time.
- When a child falls asleep with their pacifier, and it falls out, do not put it back in their mouth.
- Pacifiers are meant to help children self-soothe- overusing can create language delays and physically deform the child's mouth.

Keep in mind: We are a program aimed at creating premium developmental opportunities. Children using pacifiers during the day inhibits their language development and should be faded by the time they reach the age of 12 months.

Toilet Training Policy:

The initiation of toilet training should always be based on the child's developmental level rather than on the child's age. Initiating toilet training before the child is developmentally ready can create stress and anxiety for the child and the family, and increase the length of time it takes to train the child.

It is important for the child to begin toilet training when he/she exhibits signs of interest and readiness. Failure to recognize and act on these signs may cause the child's interest to wane and can delay the toilet training process. Therefore, readiness should be viewed as a valuable window of opportunity that day care providers can help parents to identify and respond to.

Day care providers can recognize the signs of readiness by understanding certain cues. Readiness cues include the following:

- The child can imitate his/her parents' behavior.
- The child begins to put things where they belong.
- The child can demonstrate independence by saying “no.”
- The child can express interest in toilet training.
- The child can walk and is ready to sit down.
- The child can communicate his/her need to eliminate (urinate/defecate).
- The child is able to pull clothes up and down (on and off).
- The temperament of the child, which includes motor activity, intensity of reactions, mood, regularity (especially behavioral), initial approach/withdrawal response, adaptability to new situations, attention span/persistence, distractibility, and sensory threshold/frustration level, needs to be considered when determining the child's readiness and the caregivers' strategy for toilet training.

Day care providers must advise parents that toilet training is a multi-stepped process and that ***setbacks are common***, should be anticipated, and need not be seen as a failure, but rather as a temporary step back to a more comfortable place and, indeed, another natural step toward progress.

Toilet Training Policy:

- Any child who is being potty trained should be brought to the bathroom immediately upon arrival to school and right before leaving.
- If the child arrives to school in a pull-up or diaper, he/she should be immediately changed into underpants.
- Check with the parent to confirm whether the child should be sent home in underwear or a pull-up (our recommendation is that the child be sent home in underwear). If the parent requests that the child be sent home in a diaper, place the diaper OVER the underwear.
- Shoes can be left off of children who are being potty trained in order to prevent ruining them in the event of an accident. For children who normally have issues with keeping their shoes on, check with the parent about rubber sandals or water shoes.
- For children who are being schedule trained, be sure to take the child as soon as the time interval is up. Do not ignore the timer!
- One pant lag should be completely removed and the child should be placed toward the back of the toilet to assure that he is comfortable and stable. For boys, this will also help with aim!
- The child should remain on the toilet for at least 2-3 minutes. Remember, this is new to the child; it may take several minutes for him to get comfortable enough to coordinate his muscles for success. Every toilet trial should be recorded in order to track progress.
- If you are having trouble keeping the child on the toilet for more than a few seconds, try singing, reading, massaging his feet, etc.
- In the event of a success, reward and praise the child IMMEDIATELY. A reward system should be decided before hand.
- Use toileting time to teach independence: the child should be practicing pulling up and down his own pants, washing hands, flushing, etc.
- The child must wash hands after EVERY bathroom visit, whether he has a success or not.
- Any child who has an accident should still be sat on the toilet…chances are he still has to go. Wet clothes should be placed in a plastic bag inside the child's back pack. Also, wherever the child was sitting at the time of the accident should be checked for urine and immediately sanitized.
- In the event of a bowel accident, the child's underpants should be shaken out into the toilet and placed into a ziplock type bag. Check with the parent to see if they would prefer you to discard the underwear.
- Because of a high risk of bacterial infection, under no circumstances should dirty underwear be rinsed out in the sink.
- For boys who have trouble aiming, prompt the child to sit on the very back of the toilet and lean forward. If all else fails, prompt the child by the elbow and have him push 'it' downward.
- Boys can be taught to stand for urination once they have demonstrated control during urination.

Mealtime Considerations

Minding Miracles does not provide meals, but we are responsible for properly storing and preparing student meals in a way that is mindful of sanitary, health and cultural considerations.

Please consider the following when preparing and interacting with students during mealtimes:

- Minding Miracles is a 'nut-free' school. In the event nut products (including peanut butter, almond butter, etc) are sent into school an alternate item must be provided to the child and the product in question must be sent home with the child with a reminder note to the parents.
- Allergy considerations. Be aware of all student allergies. Allergy action plans are available in student files. Students with food allergies should be seated away from children with lunches containing the allergens.
- Sharing snacks/lunch items is prohibited.
- All uneaten food must be sent home/disposed of at the end of each day.
- Students must all wash hands before eating.
- Offer students the most healthy snack/lunch item to be consumed before any 'treat' items.
  Help parents make healthy choices for their children by pointing them to the USDA recommendations (information is features on our website)
- <u>No child may be denied food/water as punishment for behavior.</u>

MMLC Child Feeding Policies

Breast Feeding:

- Minding Miracles' Breast-Feeding Policy has been established in alignment with information from the USDA, the CDA, Grow NJ Kids and DCF OOL regulations. It is a separate document and can be found on the parent information page of our website as well as featured in our staff orientation.
- Staff members must follow posted regulations for storing, heating and administering breast milk.
- Caregivers/teachers should feed infants on cue. Watch for common cues of hunger: crying, suckling, thumb sucking, agitation, etc.
- Infants must always be held for bottle feeding—no prop feeding. Infants who are able to hold their own bottle must still be carefully monitored to prevent spilling, aspiration & excess air intake.

Formula:

- Parents should be encouraged to leave a canister (or several extra portions) of formula at the center to accommodate changing appetites, account for spillage/spoiling, or other mishaps.
- The choice between feeding an infant formula versus breast feeding is a very personal decision that is usually guided by the family's physician. No parent should be pressured to stick to one method or the other. Concerns regarding this issue should be brought to the attention of the manager who can address with the parents.
- Directions for storage and preparation of formula must be followed EXACTLY as indicated on the package.

Transitioning to solids:

- When a child is first transitioning to solids, new foods should first be provided at home in order to allow parents to monitor for reactions, sensitivities and allergies.
- Each staff member must be advised of any allergies, sensitivities, food preferences and cultural food restrictions.
- Ensure foods are provided in safe sizes. Children must be monitored for choking at all times. Items such as grapes, meats, cheeses and blueberries pose a high risk of choking. Ensure such items are cut appropriately.
- Ensure that other children cannot access a child's food. Be mindful of reaching at the table, items dropped on the floor, etc. No food sharing without appropriate permission (for instance, in the case of siblings).
- All unused food should be sent home in order for the parent to monitor portions.
- Infants/toddlers are notorious for indecisive eating behaviors (Love bananas one day, hate them the next// great appetite one day, no appetite the next). Encourage parents to send extra healthy foods (and a variety of foods) to accommodate changing food temperaments.
- Responsive feeding is the only acceptable means of feeding for Minding Miracles staff. Children shouldn't be required to take "five more bites" or finish their food so that there aren't leftovers. Similarly, children who are exhibiting signs of hunger must be offered healthy foods for consumption.

MMLC Child Feeding Policies (cont)

Transitioning to Solids (cont)

- Children who request food (or show gestures of being hungry) between meals should be offered a small healthy snack.
- NJ DCF Office of Licensing requires that MM keep extra snacks on-site in the event that a child shows signs of hunger and does not have enough food sent from home. However, ensure that the foods given are in the child's food repertoire and that consumption is reported to the child's parents.

Quality over quantity:

- Instead of focusing on how much food is being consumed, focus on the quality of the food being offered.
- Children should be provided with their healthiest foods first. Less healthy snacks should be kept to a minimum and should only be provided after healthier options are consumed.
- If the foods being sent into school are questionable in terms of nutrition, it is our job to educate parents. Feel free to share our USDA handouts, the links on our website and our 'Picky Eater' handout as reminders. Extra help can be elicited on this topic from your center manager, Beth or Jessica.

Allergies/Sensitivities:

- Parents often forget that Minding Miracles is a nut-free school. In the event that a child brings in foods that contain nuts, they may not be made accessible while at the center. Give the food to the center manager, so that it can be safely sent home. Send a 'Nut-free reminder' home in the child's lunch box and message the parents on Brightwheel. If the parent is unable to provide an alternative, extra foods can be provided from the center's reserve.
- In the unlikely event that a child consumes a known allergen, follow the allergy action plan and immediately contact parents.

Water consumption:

- Water bottles/cups must be accessible at all times. Because younger children have a tendency to grab cups/bottles other than their own, teaching staff must diligently offer water while also ensuring that beverages to not accidently get shared or mixed-up.
- Parents are asked to send in a full water bottle/cup each day; however, our water cooler can be used at any time to refill a child's cup.
- 'Available' isn't always enough. Even with their beverage available to them, children may not recognize the feelings of thirst or dehydration. Water consumption should be encouraged throughout the day--- <u>especially</u> while playing outside and on hotter days.
- Juice is not a suitable beverage for infants or toddlers. Follow our USDA memo regarding restrictions for juice and consumption of milk (by age).

Other requirements:

- All classroom staff must be CPR/First Aid Certified and be well versed in the Heimlich maneuver for infants/toddlers.
- Any changes in appetite, observed food sensitivities, mealtime behaviors or food refusals must be reported to parents.
- According to State regulations, no child may go more than three hours without a meal.

USDA Food and Nutrition Service
U.S. DEPARTMENT OF AGRICULTURE

Healthy Eating for Infants

Healthy eating is important at every age. When it's time for solid foods, offer babies a variety of fruits, vegetables, grains, protein foods, and dairy or fortified soy alternatives. When deciding on foods and beverages, choose options that are full of nutrients and lower in sodium and avoid added sugars. Start with these tips:

Feeding your young baby

If possible, feed your baby only breast milk from birth to about 6 months of age, and continue through at least the first year of life—longer if desired. If breast milk is unavailable, feed your baby iron-fortified infant formula. Talk to your healthcare provider about vitamin D supplements for your baby.

Look for cues

When babies are hungry, they usually let you know. But fullness cues are not as obvious. Babies may be full if they close their mouth, turn their head away from breast or bottle, or relax their hands. Recognizing and responding to these cues helps children learn how to self-regulate their intake.

Starting solid foods

At about 6 months, infants may show signs that they're ready for solid foods, such as bringing objects to the mouth or swallowing food rather than pushing it out. Do not put infant cereal or other solid foods in an infant's bottle, but small amounts of water may also be introduced when your baby starts solid foods.

Serving first foods

Introduce a variety of foods, flavors, and textures from all food groups. Include foods rich in iron and zinc, particularly for breastfed infants. Examples include lean meats, fortified infant cereals, and beans.

Prevent choking

Make sure your baby is sitting in a highchair or other safe, supervised place for meals and snacks. Offer foods that are the appropriate size, consistency, and shape for your child's age and eating skills.

Serving safe foods

Avoid feeding your baby any foods that contain raw or cooked honey. Honey can contain bacteria that could cause serious illness or death among infants. Also avoid unpasteurized foods or beverages, such as juices, milk, yogurt, or cheeses, as they could contain harmful bacteria.

DGA Dietary Guidelines for Americans

Go to **MyPlate**.gov for more information.
USDA is an equal opportunity provider, employer, and lender.

The benefits of healthy eating add up over time, bite by bite.

FNS-905-14
March 2022

Healthy Eating for Kids

Healthy eating is important at every age. Offer kids a variety of fruits, vegetables, grains, protein foods, and dairy or fortified soy alternatives. When deciding on foods and beverages, choose options that are full of nutrients and limited in added sugars, saturated fat, and sodium. Start with these tips:

Offer variety

Include choices from each food group—fruits, vegetables, grains, protein foods, and dairy or fortified soy alternatives—in meals and snacks during each day.

Connect at mealtime

Eat meals together whenever possible. Turn off the TV and put away phones and tablets, so you can "unplug" and focus on healthy foods and each other.

Make good nutrition easy

Designate a shelf or a drawer in your fridge for your kids. Stock it with cut-up fruits and vegetables, yogurt, nut butters, and whole-wheat mini bagels and crackers.

Think about their drinks

Make water and low-fat or fat-free dairy milk or fortified soy alternatives easy options to grab in your home. Have ready-to-go containers filled and in the fridge to take on outings.

Get kids involved

Depending on their age, kids can peel fruits, assemble salads, measure, scoop, and slice. Let them create and name their own side dish.

Have a shopping buddy

Let kids participate in grocery shopping online or in the store. Reward them by letting them choose their favorite fruit or maybe a new one.

DGA Dietary Guidelines for Americans

Go to **MyPlate**.gov for more information.
USDA is an equal opportunity provider, employer, and lender.

The benefits of healthy eating add up over time, bite by bite.

FNS-905-17
March 2022

Minding Miracles Learning Center Breastfeeding Policy

Minding Miracles is committed to providing ongoing support to breastfeeding mothers. Well-defined research has documented a multitude of health benefits to both the mother and infant. Minding Miracles subscribes to the following policy:

Breastfeeding mothers shall be provided a place to breastfeed or express their milk.

Breastfeeding mothers, including employees, shall be provided a private and sanitary place to breastfeed their babies or express milk. This area has an electric outlet, comfortable chair, and nearby access to running water. Mothers are also welcome to breastfeed in front of others if they wish.

A refrigerator will be made available for storage of expressed breast milk.

Breastfeeding mothers and employees may store their expressed breast milk in the center refrigerator. Mothers should provide their own containers, clearly labeled with name and date.

Sensitivity will be shown to breastfeeding mothers and their babies.

The center is committed to providing ongoing support to breastfeeding mothers, including providing an opportunity to breastfeed their baby in the morning and evening, and holding off giving a bottle, if possible, when mom is due to arrive. Infant formula and solid foods will not be provided unless requested by the mother. All babies, regardless of what they are fed (breast milk or formula), will be held closely when feeding. Bottles will never be "propped" in an infant's mouth.

Staff shall be trained in handling breast milk.

All center staff will be trained in the proper storage and handling of breast milk, as well as ways to support breastfeeding mothers. The center will follow human milk storage guidelines from the American Academy of Pediatrics and Centers for Disease Control and Prevention to avoid waste and prevent food borne illness.

Breastfeeding employees shall be provided flexible breaks to accommodate breastfeeding or milk expression.

Breastfeeding employees shall be provided a flexible schedule for breastfeeding or pumping to provide breast milk for their children. The time allowed would not exceed the normal time allowed to other employees for lunch and breaks. For time above and beyond normal lunch and breaks, sick/annual leave may be used, or the employee can come in earlier or leave later to make up the time.

Breastfeeding promotion information will be displayed.

The center will provide information on breastfeeding, including the names of area resources should questions or problems arise. In addition, positive promotion of breastfeeding will be on display in the center.

BREAST FEEDING POLICY

Minding Miracles subscribes to the CDC recommendations for breast feeding infants. Therefore, we have embraced the following recommendations for promotion and encouragement of breastfeeding and infant feeding practices:

Staff Behaviors:

- Staff members will encourage and support breastfeeding mothers to continue breastfeeding.
- Caregivers/teachers should feed infants on cue unless the parent/guardian or the child's primary care provider give written instructions otherwise.
- Infants will always be held for bottle feeding.

Center Policies

- Breastfeeding mothers will have a clean, welcoming place to breastfeed or express their milk.
- A refrigerator will be made available for the storage of expressed milk. All stored breast milk must be labeled with the child's full name and the date it was expressed.
- No infant is fed the expressed human milk of another infant's mother. A mother's milk is for her child only.
- Breastfeeding promotional materials will be displayed to encourage and support breastfeeding mothers.
- Cow's milk is not fed to children under 1 year of age.
- Formula fed infants, under 1 year of age, drink the formula recommended for them by their health care professionals.
- Formula mixed with cereal, fruit juice, or any other foods will not be served unless written instructions are provided by the child's primary care provider.
- Infants are not permitted to have bottles in the crib and will not be allowed to carry a bottle while standing, walking, or running around.
- A plan to introduce age-appropriate solid foods (complementary foods) to infants will be made in consultation with the child's parent/guardian and primary care provider

Safe Storage Times for Breast Milk

At room temperature (77° F or cooler).....4 hours

Thawed in the refrigerator (from freezer) .....24 hours

In a refrigerator (39° F or colder) .....4 days

In the back of the freezer (0° F or colder).....9 months

In a deep freezer (-4° F or colder)..... .....12 months

NOTE: Chart is based on American Academy of Pediatrics guidelines. Hospitals may have their own rules. If you have specific questions, discuss these guidelines with your baby's pediatrician and/or hospital.

ACCESSIBLE VERSION: https://bit.ly/2dxVYLU

STORAGE AND PREPARATION OF BREAST MILK

BEFORE EXPRESSING/PUMPING MILK

Wash your hands well with soap and water.

Inspect the pump kit and tubing to make sure it is clean.

Replace moldy tubing immediately.

Clean pump dials and countertop.

STORING EXPRESSED MILK

Use breast milk storage bags or clean food-grade containers with tight fitting lids.

Avoid plastics containing bisphenol A (BPA) (recycle symbol #7).

HUMAN MILK STORAGE GUIDELINES

TYPE OF BREAST MILK	STORAGE LOCATIONS AND TEMPERATURES		
	Countertop **77°F (25°C) or colder** *(room temperature)*	**Refrigerator** **40 °F (4°C)**	**Freezer** **0 °F (-18°C) or colder**
Freshly Expressed or Pumped	Up to **4 Hours**	Up to **4 Days**	Within **6 months** is best Up to **12 months** is acceptable
Thawed, Previously Frozen	**1–2 Hours**	Up to **1 Day** *(24 hours)*	**NEVER** refreeze human milk after it has been thawed
Leftover from a Feeding (baby did not finish the bottle)	Use within **2 hours** after the baby is finished feeding		

STORE

Label milk with the date it was expressed and the child's name if delivering to childcare.

Store milk in the back of the freezer or refrigerator, not the door.

Freeze milk in **small amounts of 2 to 4 ounces** to avoid wasting any.

When freezing leave an inch of space at the top of the container; breast milk expands as it freezes.

Milk can be stored in an insulated cooler bag with frozen ice packs for **up to 24 hours** when you are traveling.

If you don't plan to use freshly expressed milk **within 4 days**, freeze it right away.

THAW

Always thaw the oldest milk first.

Thaw milk under lukewarm running water, in a container of lukewarm water, or overnight in the refrigerator.

Never thaw or heat milk in a microwave. Microwaving destroys nutrients and creates hot spots, which can burn a baby's mouth.

Use milk **within 24 hours** of thawing in the refrigerator *(from the time it is completely thawed, not from the time when you took it out of the freezer).*

Use thawed milk **within 2 hours** of bringing to room temperature or warming.

Never refreeze thawed milk.

FEED

Milk can be **served cold, room temperature, or warm.**

To heat milk, place the sealed container into a bowl of warm water or hold under warm running water.

Do not heat milk directly on the stove or in the microwave.

Test the temperature before feeding it to your baby by putting a few drops on your wrist. It should feel warm, **not hot.**

Swirl the milk to mix the fat, which may have separated.

If your baby did not finish the bottle, leftover milk should be used **within 2 hours.**

CLEAN

Wash disassembled pump and feeding parts in a clean basin with soap and water. **Do not wash directly** in the sink because the germs in the sink could contaminate items.

Rinse thoroughly under running water. Air-dry items on a clean dishtowel or paper towel.

Using clean hands, store dry items in a clean, protected area.

For extra germ removal, sanitize feeding items daily using one of these methods:

- clean in the dishwasher using hot water and heated drying cycle *(or sanitize setting).*
- boil in water for 5 minutes *(after cleaning).*
- steam in a microwave or plug-in steam system according to the manufacturer's directions *(after cleaning).*

June 2019

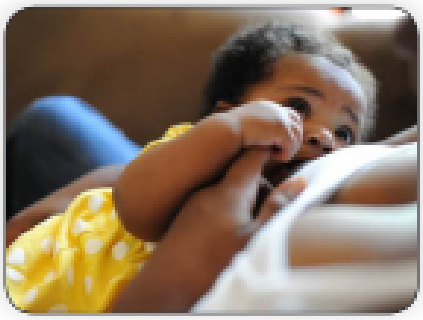
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and

FOR MORE INFORMATION, VISIT: 36
https://bit.ly/2dxVYLU

Breastfeeding and Early Care and Education (ECE)

Help ECE centers and homes make an impact by supporting breastfeeding moms

The American Academy of Pediatrics (AAP) recommends that infants be exclusively breastfed for the first 6 months but, only about 25% of infants are. 60% of mothers stop breastfeeding earlier than they want to. Several factors affect breastfeeding duration including support women receive from family members, health care providers, their workplace, and ECE facilities.



To meet national standards for supporting breastfeeding, ECE centers and family homes alike can:

- Provide a private space for mothers to breastfeed or express milk
- Allow and encourage mothers to breastfeed at the facility
- Train all staff to prepare, feed, and store breast milk properly
- Develop a breastfeeding-friendly feeding plan with each family
- Make sure breastfed infants are fed expressed breast milk at appropriate intervals
- Teach families to properly store and label their breast milk for use in an ECE facility

Did you know?
The more breastfeeding support a mother receives from her ECE provider the more likely she will continue to breastfeed her child.

For a comprehensive list of national standards to support breastfeeding in ECE refer to: Caring for Our Children: National Health and Safety Performance Standards (CFOC). 3rd ed. http://nrckids.org/CFOC

The Centers for Disease Control and Prevention's (CDC) Spectrum of Opportunities framework lists several ways that states and communities can embed and support these standards in their ECE systems. Examples include licensing regulations, the Child and Adult Care Food Program (CACFP), Quality Rating and Improvement Systems (QRIS)*, and pre-service and professional development opportunities. For a full description of CDC's Spectrum of Opportunities visit: https://www.cdc.gov/obesity/strategies/early-care-education/pdf/TheSpectrumofOpportunitiesFramework_May2018_508.pdf.

What Have States and Communities Done?

The **Nevada** legislature passed a bill (A.B. 152) (2015) that directs the State Board of Health to adopt regulations for licensed child care facilities that, among other things, requires the provision of an appropriate, private space where mothers may breastfeed. http://www.leg.state.nv.us/Session/75th2009/Bills/AB/AB152_EN.pdf

The **city of Boise (Idaho)** adopted an ordinance (2014) by which the city will monitor and disclose to the public each child care facility's compliance with a set of standards, two of which are related to breastfeeding: 1) whether the facility has a private, designated location other than a restroom for breastfeeding, and 2) whether the location for breastfeeding is maintained in a sanitary condition, with access to an outlet, chair, and nearby running water.
http://cityclerk.cityofboise.org/media/223551/0533.pdf

*QRIS is one opportunity in the Spectrum of Opportunities and is a systematic approach to assess, communicate, and improve the level of quality in ECE programs. Through QRIS, states define what constitutes a higher quality of care based on designated criteria and use a rating system with a recognizable and understandable symbol to communicate to the public how well participating ECE facilities meet these criteria.

Sanitation

NJ Department of Education, Division of Early Childhood Education

The Importance of Hand Washing

The Division of Early Childhood Education wants to reinforce the importance of hand washing as a significant preventive measure for reducing the spread of germs. Properly washed hands are key to the health of children and caregivers in child care centers and preschool classrooms.

Both children and adults should wash their hands several times throughout the day as recommended by the National Health and Safety Performance Standards: Guidelines for Early Care and education Programs, Third Edition Standard-3.2.2.1;http://cfoc.nrckids.org/WebFiles/CFOC3_Book_6-10-14Update_.pdf as follows:

- Upon arrival to the classroom.
- Re-entering the classroom after being outside.
- Before and after: eating, handling food, feeding a child, or giving medication.
- After using the toilet or helping a child use a toilet.
- After diaper changing or changing soiled underwear.
- After dealing with bodily fluids.
- After handling pets and other animals.
- Before and after playing in sandboxes (or water table).
- Before and after sharing wet materials.
- After emptying or handling the garbage.

Thorough hand washing with soap for at least 20 seconds, using warm, running water (no less than 60 degrees F and no more than 120 degrees F) removes germs and allows them to be rinsed away. Clean, disposable paper towels should be available for drying hands and turning off faucet handle. Since many children do not have the dexterity to handle a bar of soap which might also be contaminated with bacteria if not properly drained, liquid soap is recommended.

Health practices including hand washing are also measured by the Early Childhood Environmental Ratings Scale Third Edition (ECERS-3) as part of a standard classroom observation. Preschool classrooms are generally lacking in this area and should look to the ECERS as one way to measure their effectiveness in ensuring that health and hygiene standards are maintained.

The Environmental Rating Scales Institute (ERSI) allows the use of hand sanitizers, even if running water/soap are available, if the hands are not visibly soiled. The New Jersey Department of Education recommends the best practice of using soap and water, whenever possible. However, during an outing such as a field trip or on the playground, these methods can be used as a temporary measure until hands can be washed under running water. Finally, pre-moistened cleansing towelettes should not be used as a substitute for washing hands with soap and running water when running water is available. Please consult with your district nurses for any additional training or questions you may have about child illness and the development of program policies to ensure the health and safety of our children.

Table Cleaning and Disinfecting Guidance

Keep it Clean

One of the most important steps in reducing the spread of viruses in early childhood settings is cleaning and disinfecting surfaces that could possibly pose a risk to children and staff. Programs should be diligent in maintaining a healthy environment. Proper washing and disinfecting procedures should be followed for cleaning tables and food preparation surfaces. Staff should always wash their hands after wiping tables and before serving food. Before meals, children should wash their hands with soap and water, dry their hands with a paper towel, and go directly to a table.

To clean tables, follow the steps recommended in the Early Childhood Environmental Rating Scale Revised (ECERS-R), as follows:

1. *First, use a soapy water solution to clean tables using a clean disposable paper towel, and*
2. *Second, after cleaning the table surface with soap or detergent and rinsing with water, disinfect tables by using a diluted bleach water solution – according to directions listed below.*

*****DISPOSABLE PAPER TOWELS ONLY*****

NO WIPES!

NO TOWELS!

NO SPONGES!

When to Disinfect?

- After messy play (Play Dough, sand, paste, etc.)
- Before **and** after snack
- Before **and** after lunch
- Before going home

Selecting, Preparing, and Using a Bleach-Water Solution

Caring for Our Children (National Health and Safety Performance Standards) has issued a new recommendation for use of a diluted bleach solution for disinfecting because many brand name companies have changed their bleach solution and there is no longer a consistent solution across different brands. The new recommendation (in sync with ECERS-R) advises us to use only EPA registered products for disinfecting and follow the manufacturer's instructions for diluting the bleach solution and for the required contact time. When purchasing chlorine bleach products, make sure that the bleach concentration is for household use, and not for industrial applications.

When Using Standard Household Bleach

1. Make a bleach-water solution consisting of one-quarter to three quarter cups (1/4-3/4) of standard household bleach to each gallon of cool water or one to three (1-3) tablespoons of standard household bleach to each quart of cool water when children are not present in the area (make fresh bleach dilution daily).
2. It is recommended that you use a "pump" or "pour" bottle instead of a spray bottle to avoid aerosolizing the bleach solution.
3. Allow the solution to sit at least 10 seconds before wiping dry, using a clean disposable towel. Allowing the solution to sit for at least two minutes before wiping dry is preferable
4. Store out of reach of children in a way that prevents tipping and spilling. Always follow the manufacturer's instructions for safe handling.

Keep Schools Clean with Proper Cleaning & Disinfecting

Alternative Solutions to Bleach

An alternative EPA approved "disinfectant" (not sanitizer) may be used in place of the usual bleach and water solution **IF**:

- ⇒ It is registered with the EPA; Check the label of the original container and look for the designation as an EPA disinfectant
- ⇒ It is described as a disinfectant
- ⇒ It is used according to the manufacturer's instructions

References:

California Childcare Health program, 2009. Sanitize safely and effectively: Bleach and alternatives in child care programs. Health and Safety Notes (July).

Caring For Our Children: National Health and Safety Performance Standards.

California Childcare Health Program, 2013. Safe and Effective cleaning, sanitizing and disinfecting. Health and Safety notes (March).

U.S. Environmental Protection Agency. 2012. Selected EPA-registered disinfectants.

VERY IMPORTANT

Hand washing key-points:

** Children must wash hands
- -Before eating
- -After sensory play
- -When arriving to school
- -When coming indoors from the playground
- -When their hands are soiled (blowing nose, etc)
- -After using the bathroom/diaper changes

**Hand washing must last at least 20 seconds--- sing a song, hand-washing poem, count....whatever it takes.

**Focus on the process & promote independence

Table-disinfecting key points

** Tables must be disinfected
- -Before AND after children eat
- -After sensory/messy play
- -After a sick child has used the table
- -When noticeably soiled or infected with bodily fluids (i.e. when a child sneezes on the table or drools)

** 2-Step process: Bleach & water
- -Step 1- clean then wipe
- -Step 2- disinfect then wipe

**Bleach/water must be made fresh & tested daily

**Bleach/water solution MUST be left on the table for 2-minutes before wiped

VERY IMPORTANT

Changing Station Sanitation:

**Use table paper for each child and change Between children

**After disposing of the paper, Disinfect the table

**Teachers must wash hands between changings (soap & water not hand sanitizer)

**2-step, 2 min sanitation after all changes are complete

Toy disinfecting key points

** Toys should be disinfected daily

**Use a 'Yuck-Bucket' to compile toys that Have been mouthed, used by a sick child, Sneezed on, etc. The toys must be disinfected before recirculating into the classroom.

**Stuffed animals/pillows/toys with fabric must be washed weekly

Cots/cribs disinfecting key points

** Cots must be labeled with child's name & sanitized daily

** Cot sheets and blankets must be kept SEPARATELY

**Cribs must be disinfected weekly OR anytime the child who uses the crib changes.

**Label cribs with dry-erase marker on the plexiglass

Cleaning vs. Disinfecting: What's the Difference?

It's important to understand the difference among cleaning, disinfecting, and sanitizing.

The US CDC explains how these practices work together to help stop germs from spreading:

- **Cleaning physically removes germs** by using soap (or perhaps detergent) and water to wash away surface dirt and grime.

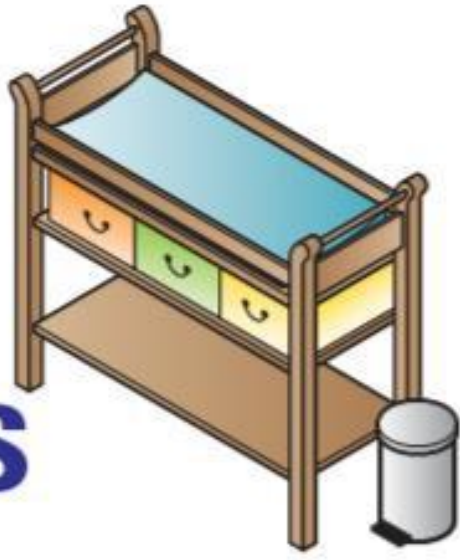
- **Disinfecting kills most germs** on objects like baby toys, or stops germs from reproducing.

Remember that cleaning should always come before disinfection. Start by cleaning baby toys to remove any visible dirt and grime, then rinse with water and apply disinfectant (see directions below).

Diluted bleach is a safe and inexpensive way to disinfect baby toys.

1. Clean non-absorbent toys with soapy water, rinse with clear water, and wipe dry with disposable paper towels.
2. Disinfect with a chlorine bleach solution of **one tablespoon of bleach** to **one gallon of water**.
3. Lay out toys to air dry.

Clean Daycares for Healthy Kids



Clean Diaper Changing Area

- Clean diaper changing area with soapy water, then rinse with clear water
- Wipe dry with disposable paper towels
- Sanitize by applying a chlorine bleach solution
- Air dry

1/4 CUP BLEACH

+

1 GALLON CLEAR WATER

Clean Hands

Wash hands carefully and frequently with soapy water, especially:

- After going to the bathroom
- After changing diapers or cleaning body fluids
- Before preparing foods or beverages

Wash hands for as long as it takes to hum the "Happy Birthday" song twice.
Dry hands thoroughly using disposable paper towels.

***Make bleach solutions fresh daily; keep out of reach of children; never mix bleach solution with other cleaners.**

www.co.somerset.nj.us/health

www.waterandhealth.org

American Chemistry Council
www.americanchemistry.com

www.disinfect-for-health.org

Detecting & Reporting Abuse

How Can I Recognize if a Child is Abused?

Sometimes children don't tell us they have a problem, they show us. A change in a child's behavior could be the result of abuse. Some of the following changes in behavior can alert adults to the possible problems.

Abused Children Are Often	-fearful of interpersonal relationships or overly compliant -withdrawn or aggressive, hyperactive -constantly irritable or listless, detached -affectionless or overly affectionate (misconstrued as seduction)
Physical Symptoms	-bruises, burns, scars, welts, broken bones, continuing or unexplainable injuries -urinary infections (particularly in young children) -sexually transmitted diseases -chronic ailments, stomach aches, vomiting, eating disorders, -vaginal or anal soreness, bleeding, or itching
Activity and Habit Clues	-recurring nightmares -inappropriate masturbation -a child afraid to go home or to some other location, running away -delinquency -fear of being with a particular person -lying -fire setting
Age Inappropriate Behavior	-regression in behavior (an onset of thumb sucking or toileting accidents after being toilet trained) -sexually active or aware -promiscuity -bed wetting -alcohol/substance abuse -older child assaulting younger children -child takes on adult responsibilities
Educational Concerns	-extreme curiosity, imagination -academic failure -sleeping in class -inability to concentrate -sudden change in school performance
Emotional Indicators	-depression -phobias, fear of darkness, public restrooms, etc. -chronic ailments -self-inflicted injuries -injuring/killing animals -excessively fearful -lack of spontaneity, creativity

Reporting Child Abuse in New Jersey

The Division of Child Protection and Permanency (DCP&P) is New Jersey's child protection and child welfare agency within the Department of Children and Families. (DCF)

DCP&P is responsible for investigating allegations of child abuse and neglect and, if necessary, arranging for the child's protection and providing support to the family.

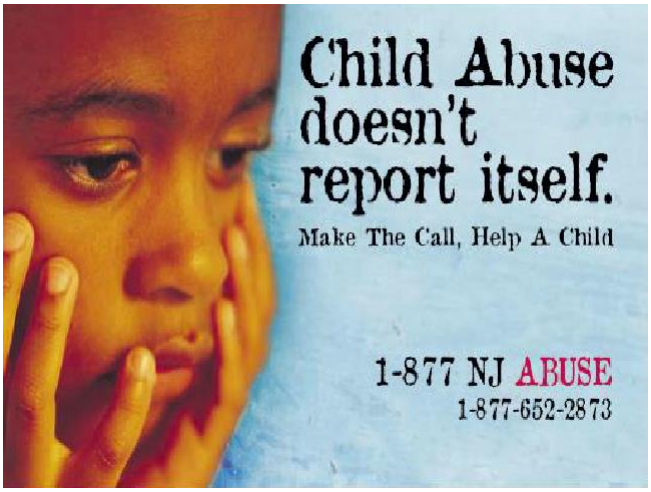
The Child Abuse Hotline (State Central Registry) receives all reports of child abuse and neglect 24-hours a day, 7-days a week. Reports requiring a field response are forwarded to a DCP&P Local Office for investigation. After normal business hours, the hotline is linked with a statewide network of Special Response Units charged with the responsibility of responding to reports.

If You Suspect Child Abuse

Call the NJ Child Abuse Hotline:
1-877-NJ ABUSE (24 HRS -7 DAYS A WEEK)
(1-877-652-2873)

The following information would be helpful:

- Name and address of child
- Name and address of parents or caretaker
- Age and sex of child
- Nature and extent of injuries or description of



Minding Miracles policies regarding reporting abuse are developed in accordance with State laws and DCP&P regulations.
They include the following:

- As employees of a child care center, we are ALL legally required to report suspicions of child abuse. You do not need administrative permission to file a report; however, you may want to confer with your supervisor for support in reporting and documentation.
- No employee will face retaliation or dismissal for filing a CREDIBLE suspicion of abuse.
- It is important to understand the difference between 'discipline' and abuse. Parents may choose to discipline their child with a light smack on the hand or mild spanking, but it's important to recognize the difference between a parent's attempt to instill positive behavior and actions that are harmful to the physical or emotional health of a child (abuse).
- All employees must complete the online training about abuse/neglect training offered by NJCCIS under the tab labeled 'Registry' within thirty days of the commencement of employment.

Aggressive, abusive & inappropriate actions displayed by staff:

•Guidelines for reporting potential abuse/neglect/inappropriate interactions:

- Childcare staff must be held to a much higher standard when it comes to daily interactions, supervision and disciplinary tactics than parents or other caregivers. All interactions must uphold a level of TLC and respect for each child.
- Keep in mind that the parameters of what is appropriate for parents are much different than the parameters that are appropriate for childcare staff. Childcare staff MUST abide by the center's discipline policy and MAY not use physical discipline methods, deprivation or emotionally damaging actions
- If an employee witnesses actions that are considered aggressive or harmful to a child in our care, even if they are unsure if the qualify as 'abuse,' the actions should be reported to the center manager/director immediately.
- If a fellow employee is engaging in behavior that can be considered abusive, or even aggressive, the observer may choose to intervene. Whether a staff member intervenes or not, the incident must be reported to a supervisor immediately. Failure to report such actions toward a student within 24 hours are grounds for suspension and possibly termination.
- How to report:
  - If your immediate supervisor is not available, a report of inappropriate staff actions can be made to *any* supervisor in person, by phone or through email.
  - If you would like to make the report anonymously, a note can be placed in the payment lock box at the entrance of any of the centers.
  - An actual incident of abuse does not need to occur for a report to be made to supervisors....at risk or escalating behavior on the part of a staff member should also be reported.

- Shaken Baby Syndrome is the shaking of a child that can cause severe brain damage or even death.
- Between 1,000 and 1,500 children are victims of Shaken Baby Syndrome a year.
- Infants between 3 and 8 months are the most susceptible to Shaken Baby Syndrome, but newborns and up to five year olds have been reported.
- 25% of all Shaken Baby Syndrome babies die of their injuries.

What Are the Signs of Head Trauma?

In any abusive head trauma case, the duration and force of the shaking, the number of episodes, and whether impact is involved all affect the severity of the child's injuries.

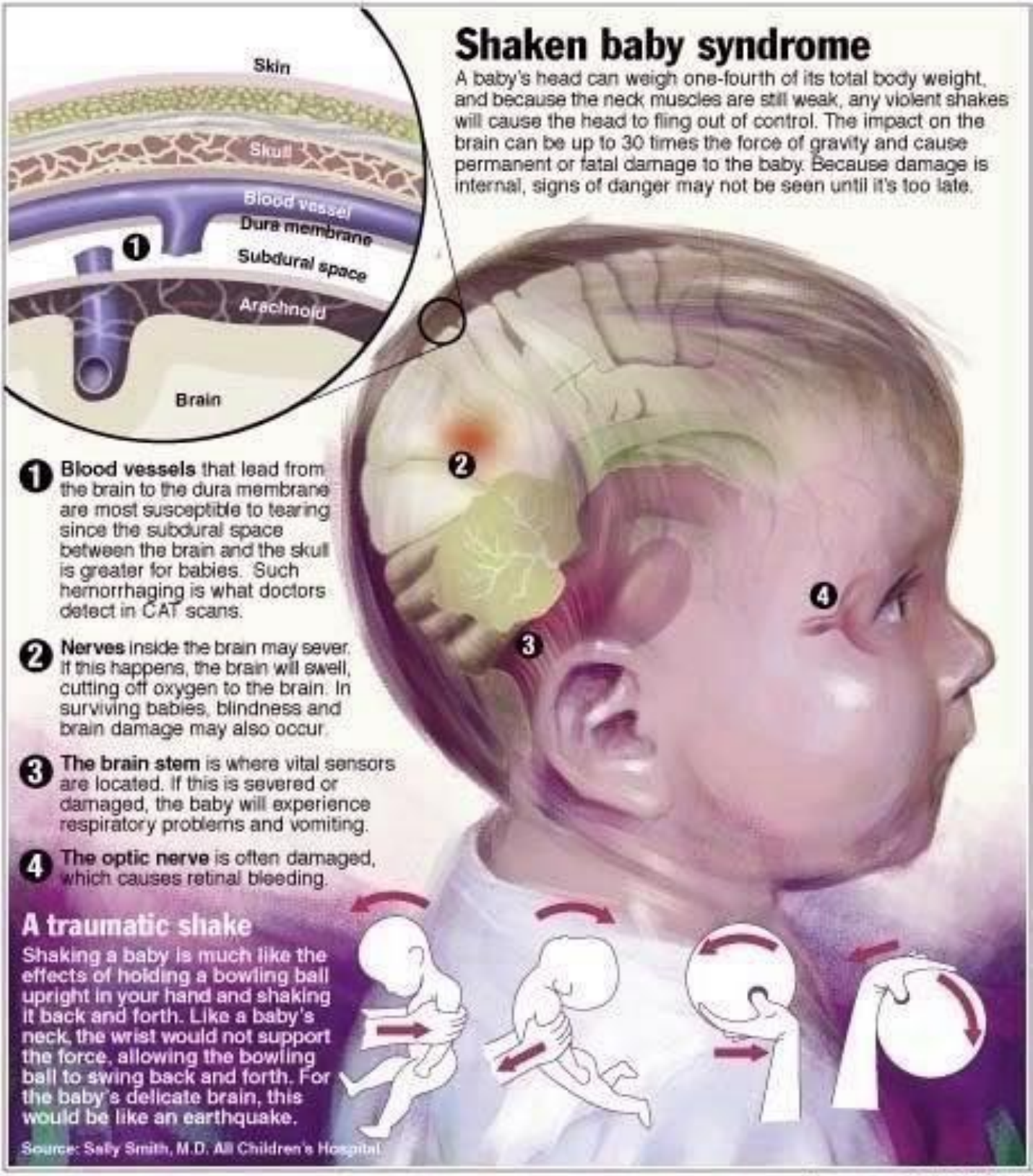
In the most violent cases, children may arrive at the emergency room unconscious, suffering seizures, or in shock. But in many cases, infants may *never* be brought to medical attention if they don't show such severe signs of injury.

In less severe cases, a child who has been shaken may have:

*Lethargy *Irritability *Vomiting
*Poor sucking or swallowing *Decreased appetite
*Lack of smiling or vocalizing *Rigidity
*Seizures *Difficulty breathing
*Blue color b/c lack of oxygen *Altered consciousness
*Unequal pupil size *Inability to lift the head
*An inability to focus the eyes or track movement

Shaken baby syndrome

A baby's head can weigh one-fourth of its total body weight, and because the neck muscles are still weak, any violent shakes will cause the head to fling out of control. The impact on the brain can be up to 30 times the force of gravity and cause permanent or fatal damage to the baby. Because damage is internal, signs of danger may not be seen until it's too late.



1. **Blood vessels** that lead from the brain to the dura membrane are most susceptible to tearing since the subdural space between the brain and the skull is greater for babies. Such hemorrhaging is what doctors detect in CAT scans.
2. **Nerves** inside the brain may sever. If this happens, the brain will swell, cutting off oxygen to the brain. In surviving babies, blindness and brain damage may also occur.
3. **The brain stem** is where vital sensors are located. If this is severed or damaged, the baby will experience respiratory problems and vomiting.
4. **The optic nerve** is often damaged, which causes retinal bleeding.

A traumatic shake

Shaking a baby is much like the effects of holding a bowling ball upright in your hand and shaking it back and forth. Like a baby's neck, the wrist would not support the force, allowing the bowling ball to swing back and forth. For the baby's delicate brain, this would be like an earthquake.

Source: Sally Smith, M.D. All Children's Hospital

Times art — JEFF GOERTZEN

Babies are Fragile

It's normal for babies to cry, even when you are trying to comfort them. Some babies cry more than others or for longer periods of time. This is normal too. It is also normal for a caregiver to become frustrated.

No matter how stressed, tired, angry or frustrated you feel, you must never, ever shake a baby. Shaking a baby can kill or cause serious injuries.

The message is simple:

Never Shake a Baby

And remember, some play activities also can be dangerous, such as:

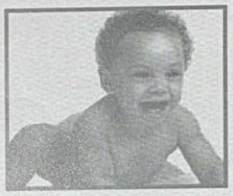
- Vigorous, repeated tossing of a baby into the air
- Jogging while carrying an infant on the back or shoulders
- Bouncing an infant on an adult's knee or swinging the baby on an adult's leg
- Swinging the baby around by the ankles
- Spinning an infant around

Never Shake a Baby...
we're fragile

If you are feeling stressed
Call the Family Helpline:

1-800-THE KIDS

24 hours a day, 7 days a week



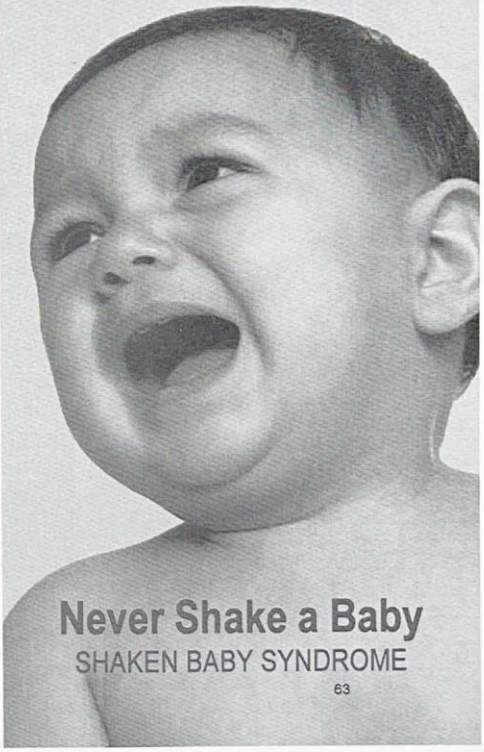
NJ Department of Children and Families
www.nj.gov/dcf

NJ Task Force on Child Abuse and Neglect

American Academy of Pediatrics, NJ Chapter

DEPARTMENT OF CHILDREN AND FAMILIES

When a Baby Cries



Never Shake a Baby

SHAKEN BABY SYNDROME

63

How to Cope with a Crying Baby

- Make sure the baby's basic needs (food, diapering, appropriate clothing, etc.) are met.
- Try swaddling, tightly wrapping your baby in a blanket for warmth and security.
- Offer the baby a pacifier.
- Lower the lights and noise to help calm the baby.
- Walk the baby around holding him or her close to you.
- Take the baby for a ride in a stroller or a car.
- Call a friend, relative, neighbor or medical provider for help.
- Take a break - sit down and count to 10 or 20.
- If all else fails, put the baby in the crib on his or her back. Close the door and check back every five minutes or so.

Don't pick up the baby until you feel calm.

If you are a child care provider and cannot handle a crying baby, please let the parent know.

Remember, a baby will outgrow crying, but shaking a baby may cause permanent damage.

Shaking a Baby is Dangerous

Shaken Baby Syndrome is a serious brain injury that occurs when a frustrated caregiver "shakes" an infant, usually to stop him/her from crying. It is considered a form of child abuse.

Some parents, siblings, or caregivers who would not consider hitting a baby, think that shaking a baby is okay. **This is Dangerous!**

Shaking a baby can cause bleeding inside the brain which may lead to:

- Death
- Brain Damage
- Retardation
- Blindness
- Paralysis
- Seizures
- Developmental delays

Protect our future by handling infants with the loving care they deserve!

Symptoms of Shaken Baby Syndrome

- Constant Crying
- Stiffness
- Sleeping more than usual
- Unable to wake up
- Seizures
- Dilated pupils
- Decreased appetite
- Vomiting
- Difficulty breathing
- Blood spots in eyes

If for any reason the baby has an injury, take him/her to the nearest hospital emergency room or call 911. The baby will not get better without receiving medical treatment.

Getting Help

If you feel that you can't cope, help is only a telephone call away.

Parents Anonymous Family Helpline

1-800-THE KIDS

24 hours a day, 7 days a week

64

Unusual Incident Report:

*This is **NOT** to be used as an accident report.*

Incident reports can include a wide variety of occurrences that warrant documentation; however, when the incident causes reasonable concern that the child may be experiencing abuse, the report **MUST** be accompanied by a formal report to the State Abuse Registry Hotline as indicated on the form.

UNUSUAL INCIDENT REPORT

Name of Child:	Date of Incident:	Time of Incident:
Name of Staff Writing Report:	**Name of Staff That Notified the Parent:**	
Name of Parent:	**Date Parent Notified:**	

Other Individuals Involved: (i.e. Other Staff/Adults, Witnesses, Children (Described as Child #1, Child #2, etc.)

Name:	Relationship to Child:	Age:	Other Important Information:

Please Indicate, in as Much Detail as Possible, the Incident That Occurred: (Who, What, When, Where, Why, How)

The sponsor, sponsor representative, director, or any staff member shall verbally notify the ***State Central Registry Hotline (1-877 NJ ABUSE/1-877-652-2873)*** immediately whenever there is reasonable cause to believe that a child has been subjected to abuse or neglect by a staff member, or any other adult. Additionally, the parent(s) shall be notified on the same day of the occurrence of any unusual incident(s) that occurred at the center. Such incidents may include, but are not limited to, unusual sexual activity; violent or destructive behavior; withdrawal or passivity; or significant change(s) in the child's personality, behavior or habits. The center shall maintain on file a record of such incidents and documentation that parents have been informed of them.

Does the nature of this incident indicate abuse or neglect?

☐ NO

☐ YES, the incident was immediately reported to the Child Abuse Hotline at 1-877-NJABUSE (1-877-652-2873)

Name/ID of NJ Abuse Hotline Screener:	Date of Call:	Comments:

Follow-Up Comments and/or Actions (if Needed):

Illness & Injury

Communicable Illness Policy

The following symptoms are considered a risk of communicable illness:

- Severe pain or discomfort
- Diarrhea
- Vomiting
- Elevated temperature of 101.5 degrees Fahrenheit
- Yellow eyes or jaundice skin
- Red eyes with or without discharge
- Infected or irritated skin patches
- Difficult or rapid breathing
- Skin lesions
- Swollen glands or red irritated throat/strep throat
- Visibly enlarged lymph nodes
- Stiff Neck
- Blood in urine
- Cloudy or colored nasal discharge
- Excessive cough

Once the child is symptom free for at least **twenty-four hours**, he/she may return to the center. However, a doctor's note may be required for return to school if the child has any of the following illnesses:

- Whooping Cough
- Mumps
- Hepatitis A
- German Measles
- Chicken Pox
- Influenza
- Measles
- Meningococcus
- Tuberculosis
- Giardia Lamblia
- Salmonella
- Shigella
- Impetigo
- Lice
- Scabies

Caring for Sick Children

A child who demonstrates any of the symptoms from the above list must be immediately separated from the group and a parent must be contacted for pick-up. Do your best to keep the child separate and comfortable while waiting for his/her parent.

ONLY the center manager may make the determination and contact the parent to send a child home sick—unless otherwise instructed by the center manager or director.

Disinfect all items that may have been contaminated by the sick child.

Upon pick-up, remind parents that the child must be symptom-free for 24 hours before returning to school.

Record the child's name and symptoms in the illness log at the front desk.

Quick Reference

Reporting Requirements for Communicable Diseases and Work-Related Conditions

(see New Jersey Administrative Code Title 8, Chapters 57 and 58)

Communicable Disease Service Disease Reporting Requirements and Regulations can be viewed at: http://nj.gov/health/cd/reporting.shtml

Health care providers required to report: physicians, advanced practice nurses, physician assistants, and certified nurse midwives.

Administrators required to report: persons having control or supervision over a health care facility, correctional facility, school, youth camp, child care center, preschool, or institution of higher education.

Laboratory directors: For specific reporting guidelines, see NJAC 8:57-1.7.

CONFIRMED or SUSPECT CASES TELEPHONE IMMEDIATELY to the LOCAL HEALTH DEPARTMENT

- Anthrax
- Botulism
- Brucellosis
- Diphtheria
- Foodborne intoxications (including, but not limited to, ciguatera, paralytic shellfish poisoning, scombroid, or mushroom poisoning)
- *Haemophilus influenzae*, invasive disease
- Hantavirus pulmonary syndrome
- Hepatitis A, acute
- Influenza, novel strains only
- Measles
- Meningococcal invasive disease
- Outbreak or suspected outbreak of illness, including, but not limited to, foodborne, waterborne or nosocomial disease or a suspected act of bioterrorism
- Pertussis
- Plague
- Poliomyelitis
- Rabies (human illness)
- Rubella
- SARS-CoV disease (SARS)
- Smallpox
- Tularemia
- Viral hemorrhagic fevers (including, but not limited to, Ebola, Lassa, and Marburg viruses)

Cases should be reported to the local health department where the patient resides. If patient residence is unknown, report to your own local health department. Contact information is available at: localhealth.nj.gov.

If the individual does not live in New Jersey, report the case to the New Jersey Department of Health at: 609-826-5964.

In cases of immediately reportable diseases and other emergencies - if the local health department cannot be reached - the New Jersey Department of Health maintains an emergency after hours phone number: 609-392-2020.

July 2013
www.nj.gov/health/cd

REPORTABLE WITHIN 24 HOURS OF DIAGNOSIS to the LOCAL HEALTH DEPARTMENT

- Amoebiasis
- Animal bites treated for rabies
- Arboviral diseases
- Babesiosis
- Campylobacteriosis
- Cholera
- Creutzfeldt-Jakob disease
- Cryptosporidiosis
- Cyclosporiasis
- Diarrheal disease (child in a day care center or a foodhandler)
- Ehrlichiosis
- *Escherichia coli*, shiga toxin producing strains (STEC) only
- Giardiasis
- Hansen's disease
- Hemolytic uremic syndrome, post-diarrheal
- Hepatitis B, including newly diagnosed acute, perinatal and chronic infections, and pregnant women who have tested positive for Hep B surface antigen
- Influenza-associated pediatric mortality
- Legionellosis
- Listeriosis
- Lyme disease
- Malaria
- Mumps
- Psittacosis
- Q fever
- Rocky Mountain spotted fever
- Rubella, congenital syndrome
- Salmonellosis
- Shigellosis
- *Staphylococcus aureus*, with intermediate-level resistance (VISA) or high-level-resistance (VRSA) to vancomycin only
- Streptococcal disease, invasive group A
- Streptococcal disease, invasive group B, neonatal
- Streptococcal toxic shock syndrome
- *Streptococcus pneumoniae*, invasive disease
- Tetanus
- Toxic shock syndrome (other than Streptococcal)
- Trichinellosis
- Typhoid fever
- Varicella (chickenpox)
- Vibriosis
- Viral encephalitis
- Yellow fever
- Yersiniosis

REPORTABLE DIRECTLY to the NEW JERSEY DEPARTMENT OF HEALTH

Hepatitis C, acute and chronic, newly diagnosed cases only
Written report within 24 hours

HIV/AIDS
609-984-5940 or 973-648-7500
Written report within 24 hours

- AIDS
- HIV infection
- Child exposed to HIV perinatally

Sexually Transmitted Diseases
609-826-4869
Report within 24 hours

- Chancroid
- Chlamydia, including neonatal conjunctivitis
- Gonorrhea
- Granuloma inguinale
- Lymphogranuloma venereum
- Syphilis, all stages and congenital

Tuberculosis (confirmed or suspect cases)
609-826-4878
Written report within 24 hours

Occupational and Environmental Diseases, Injuries, and Poisonings
609-826-4920
Report within 30 days after diagnosis or treatment

- Work-related asthma (possible, probable, and confirmed)
- Silicosis
- Asbestosis
- Pneumoconiosis, other and unspecified
- Extrinsic allergic alveolitis
- Lead, mercury, cadmium, arsenic toxicity in adults
- Work-related injury in children (< age 18)
- Work-related fatal injury
- Occupational dermatitis
- Poisoning caused by known or suspected occupational exposure
- Pesticide toxicity
- Work-related carpal tunnel syndrome
- Other occupational disease

H5697

Minding Miracles Learning Center
Medication Administration Policies

The protocol for providing children with medication while in our care has been developed in order to ensure child safety and limit center liability. Failure to effectively follow the protocol can result in dire consequences. Therefore, it is imperative that every staff member follow the protocol EVERY time medication is administered. Please be familiar with the following guidelines and review the center policies on the next page.

1. No medication can be given unless an authorization has been filled out and signed by the child's parent.
2. No medication can be given unless it arrives to the center in the original container. This includes the printed prescription bottle or the over-the-counter packaging.
3. Staff should read the entire authorization form and be familiar with the possible side effects of the medication before the first time the medication is administered at school.
4. EVERY dosage should be recorded on the child's recall sheet and on the medication administration log located at the front desk. The dosage record should include the time, dosage, and any observed side effects.
5. ALL medication must be kept in the classroom lock-box.
6. If a medication (and authorization) is kept at the center for 'as-needed' medication, the parent should be notified before administering the medication.

Minding Miracles
Medication Administration Policies

The following guiding principles and procedures have been developed in accordance with the Manual of Requirements from the DCFS and apply to administration of medication for children while at the center:

1. Whenever possible, it is best that medication be given at home. Dosing of medication can frequently be done so that the child receives medication prior to going to childcare, and again when returning home and/or at bedtime. The parent/guardian is encouraged to discuss this possibility with the child's health care provider.
2. The first dose of any medication should always be given at home and with sufficient time before the child returns to child care to observe the child's response to the medication given. When a child is ill due to a communicable disease that requires medication as treatment, the health care provider may require that the child be on a particular medication for 24 hours before returning to childcare. This is for the protection of the child who is ill as well as the other children in child are.
3. Medication will only be given when ordered by the child's health care provider and with written consent of the child's parent/legal guardian. A "Permission to Give Medication in Child Care" form can be attained at the center and will hereafter be referred to as Permission Form. All information on the Permission Form must be completed before the medication can be given. Copies of this form can be duplicated or requested from the childcare provider.
4. "As needed" medications may be given only when the child's health care provider completes a Permission Form that lists specific reasons and times when such medication can be given.
5. Medications given in the Center will be administered by a staff member designed by the Center Director and will have been informed of the child's health needs related to the medication and will have had training in the safe administration of medication.
6. Any prescription or over-the counter medication brought to the child care center must be specific to the child who is to receive the medication, in its original container, have a child-resistant safety cap, and be labeled with the appropriate information as follows:
   - ✓ Prescription medication must have the original pharmacist label that includes the pharmacists phone number, the child's full name, name of the health care provider prescribing the medication, name and expiration date of the medication, the date it was prescribed or updated, and dosage, route, frequency, and any special instructions for the administration and/storage. It is suggested that the parent/guardian ask the pharmacist to provide the medication in two containers, one for home and one for use in childcare.
   - ✓ Over-the-counter (OTC) medication must have the child's full name on the container, and the manufacturer's original label with dosage, route, frequency, and any special instructions for administration and storage, and expiration date must be clearly visible.
   - ✓ Any OTC without instructions for administration specific to the age of the child receiving the medication must have a completed Permission Form from the health care provider prior to being given in the childcare center.

7. Examples of over-the-counter medications that may be given include:
   * Antihistamines *Decongestants
   *Non-aspirin fever reducers/pain relievers *Cough suppressants
   *Topical ointments, such as diaper cream or sunscreen
8. All medications will be stored:
   Inaccessible to children
   Separate from staff or household medications
   Under proper temperature control

9.For the child who receives a particular medication on a long-term daily basis, the staff will advised the parent/guardian one week prior to the medication needing to be refilled so that needed doses of medication are not missed.

10. Unused or expired medication will be returned to the parent/guardian when it is no longer needed or be able to be used by the child.

11. Records of all medication given to a child are completed in ink and are signed by the staff designated to give the medication.

12.Information exchange between the parent/guardian and childcare provider about medication that a child is receiving should be shared when the child is brought to and pick-up from the Center. Parents/guardians should share with the staff any problems, observations, or suggestions that they may have in giving medication to their child at home, and likewise with the staff from the center to the parent/guardian.

13.Confidentiality related to medications and their administration will be safeguarded by the Center Director and staff. Parents/guardians may request to see/review their child's medication records maintained at the center at any time.

14.Parent/guardian will sign all necessary medication related forms that require their signature, and particularly in the case of the emergency contact form, will update the information as necessary to safeguard the health and safety of their child.

15.Parent/guardian will authorize the Director or Director Designee to contact the pharmacist or health care provider for more information about the medication the child is receiving, and will also authorize the health care provider to speak with the Director or Director's designee in the event that a situation arises that requires immediate attention to the child's health and safety particularly is the parent/guardian cannot be reached.

16.Parent/guardian will read and have an opportunity to discuss the content of this policy with the Director or Director's designee. The parent signature on this handbook is an indication that the parent accepts the guidelines and procedures listed in this policy and will follow them

to safeguard the health and safety of their child.

This form must be complete by the parent before any prescription, over the counter, homeopathic or topical substance can be given to children at the center. Please note the important elements below.

Minding Miracles Learning Center, Inc.

INDIVIDUAL PERMISSION FOR MEDICATION OR HEALTH CARE PROCEDURE

Name of Child:

Child's condition for administering medication:

- ☐ Cold
- ☐ Sore Throat
- ☐ Teething
- ☐ Ear Infection
- ☐ Rash
- ☐ Injury
- ☐ Other:

Name of medication/procedure:

- ☐ Prescription:
- ☐ Non-prescription:
- ☐ Doctor's approval required:

**Must be in original container WITH the child's full name.

Amount to be administered:

Times to be administered:

Dates to be administered: to

Refrigeration necessary: ☐ Yes ☐ No

**Must be completely filled out.

Special instructions:

Possible adverse reactions:

I authorize the administration of medication to my child.

Signature of Parent/Guardian: **PARENT MUST SIGN Date:

FOR CENTER USE:

- ☐ Is all of the above information complete?
- ☐ Has the medication been made inaccessible to children?
- ☐ Is the medication in the original container with the prescription label on it?
- ☐ Is the child's name on the container?
- ☐ Is the date of the prescription current?
- ☐ Is the name of the drug/procedure, dose, and schedule on the label the same instructions given by the parent?

Date(s) Administered:	Time(s) Administered:	Adverse Reactions Observed:	Staff Initials:

**Record administration on this sheet AND send notification home via Brightwheel

ACCIDENT/INJURY REPORT

THE CENTER SHALL MAINTAIN A WRITTEN RECORD ON FILE OF EACH INCIDENT RESULTING IN AN INJURY OCCURRING AT THE CENTER.

CHILD'S NAME:	DATE OF BIRTH:	DATE OF INJURY:	TIME OF INJURY:

PERSON COMPLETING REPORT:	DATE REPORT COMPLETED:	TIME REPORT COMPLETED:	WITNESSES:

TYPE OF INJURY: (CHECK ALL THAT APPLY)

- ☐ ACHE
- ☐ BITTEN BY ANIMAL
- ☐ BITTEN BY CHILD
- ☐ BITE THAT BREAKS THE SKIN
- ☐ BLEEDING
- ☐ BURN
- ☐ BREATHING RAPIDLY
- ☐ BREATHING SHALLOW
- ☐ BROKEN BONE SUSPECTED
- ☐ CHOKING
- ☐ CUT
- ☐ DROWSINESS
- ☐ EYE INJURY
- ☐ FOREIGN BODY IN EYE
- ☐ HEAD INJURY
- ☐ ITCHING
- ☐ NAUSEA
- ☐ NOSE BLEED
- ☐ POISIONING
- ☐ RASH
- ☐ REDNESS
- ☐ SCRAPE
- ☐ SCRATCH
- ☐ SPLINTER
- ☐ SPRAIN
- ☐ STING
- ☐ SWELLING
- ☐ OTHER:

Parent must be notified immediately after ***ANY*** head/face injury

PLACE ON BODY INJURY OCCURRED: (CIRCLE ALL THAT APPLY)

☐ ABDOMEN ☐ ARM ☐ ANKLE ☐ BACK ☐ BUTTOCKS ☐ CHEEK ☐ CHEST ☐ CHIN ☐ EAR ☐ ELBOW ☐ FINGER ☐ FOOT ☐ FOREHEAD ☐ GROIN ☐ HAND ☐ HEAD ☐ HIP ☐ KNEE ☐ LEG ☐ LIP ☐ MOUTH ☐ NECK ☐ NOSE ☐ SHOULDER ☐ TEETH ☐ THIGH ☐ TOE ☐ TONGUE ☐ WRIST ☐ OTHER:

WHERE INJURY OCCURRED: (CIRCLE ALL THAT APPLY)

☐ CLASSROOM ☐ HALLWAY ☐ KITCHEN ☐ STAIRWAY ☐ SIDEWALK ☐ BATHROOM ☐ FIELD TRIP ☐ PARKING LOT ☐ BUS ☐ CAR ☐ PLAYGROUND ☐ OTHER:

TYPE OF SURFACE

☐ CARPETING ☐ [illegible] ☐ GRASS ☐ TILE FLOOR ☐ [illegible] ☐ WOOD FLOOR ☐ RUBBER ☐ LAMINATE FLOOR ☐ ASPHALT ☐ CONCRETE ☐ OTHER:

DESCRIBE HOW INJURY/ACCIDENT HAPPENED:

Describe incident step by step

Do **NOT** name other children involved

If outside medical attention is needed, DCFS **must** be notified (whether sought out by the center or the parent)

TREATMENT/ FOLLOW UP ACTIONS: (CHECK ALL THAT APPLY)

FIRST AID GIVEN AT THE CENTER:

- ☐ CLEANED WITH SOAP AND WATER
- ☐ ICE APPLIED
- ☐ ANTISEPTIC APPLIED
- ☐ REST PROVIDED
- ☐ BANDAGE APPLIED
- ☐ CONSOLED CHILD
- ☐ MEDICATION ADMINISTERED:

OTHER (DESCRIBE):

STAFF WHO PREFORMED FIRST AID:

OUTSIDE MEDICAL ATTENTION GIVEN:
(NOTIFY OOL BY NEXT WORKING DAY AND PROVIDE DOCUMENATION WITHIN ONE WEEK)

- ☐ AMBULANCE OR 911 CALLED/ONSITE
- ☐ EMERGENCY CARE PROVIDED
- ☐ POISION CONTROL CALLED
- ☐ TRANSPORTED EMERGENCY CARE/URGENT CARE
- ☐ CONSULTATION/TREATMENT BY LICENSED PHYSICIAN OR HEALTH CARE PROVIDER

Document time AND method of notification

PARENT NOTIFICATION*:

METHOD OF NOTIFICATION:
- ☐ NOTIFIED VIA PHONE
- ☐ NOTIFIED AT PICK UP

OTHER:

TIME OF NOTIFICATION:

COMMENTS:

* THE CENTER SHALL NOTIFY THE PARENT IMMEDIATELY WHEN A CHILD SUSTAINS A HEAD OR FACIAL INJURY INCLUDING WHEN A CHILD BUMPS HIS OR HER HEAD, WHEN A BITE BREAKS THE SKIN, AND/OR WHEN A CHILD FALLS FROM A HEIGHT GREATER THAN THE HEIGHT OF THE CHILD.

STAFF SIGNATURE:	DATE:	DIRECTOR SIGNATURE:	DATE:	PARENT SIGNATURE:	DATE:

OOL/ACCIDENT AND INJURY REPORT/9.12.2017

ILLNESS LOG	SYMPTOMS (CHECK ALL THAT APPLY)	ACTION TAKEN (CHECK ALL THAT APPLY)
Child's Name: Date/Time: Date Removed: Date Returned:	☐ Cough ☐ Fever ☐ Sore throat ☐ Cold Symptoms ☐ Headache ☐ Ringworm ☐ Diarrhea ☐ Nausea ☐ Teething ☐ Ear ache ☐ Nosebleed ☐ Pink Eye ☐ Stomach Ache ☐ Vomiting ☐ Rash Other:	☐ Rested at center ☐ Called 911 ☐ Parent picked up ☐ On-site medical care provided ☐ Emergency contact picked up ☐ Child visited ER ☐ No one could be reached ☐ Child admitted to the hospital ☐ Health Dept. notified ☐ Child transported to an emergency care facility ☐ Parent called Other:
Child's Name: Date/Time: Date Removed: Date Returned:	☐ Cough ☐ Fever ☐ Sore throat ☐ Cold Symptoms ☐ Headache ☐ Ringworm ☐ Diarrhea ☐ Nausea ☐ Teething ☐ Ear ache ☐ Nosebleed ☐ Pink Eye ☐ Stomach Ache ☐ Vomiting ☐ Rash Other:	☐ Rested at center ☐ Called 911 ☐ Parent picked up ☐ On-site medical care provided ☐ Emergency contact picked up ☐ Child visited ER ☐ No one could be reached ☐ Child admitted to the hospital ☐ Health Dept. notified ☐ Child transported to an emergency care facility ☐ Parent called Other:
Child's Name: Date/Time: Date Removed: Date Returned:	☐ Cough ☐ Fever ☐ Sore throat ☐ Cold Symptoms ☐ Headache ☐ Ringworm ☐ Diarrhea ☐ Nausea ☐ Teething ☐ Ear ache ☐ Nosebleed ☐ Pink Eye ☐ Stomach Ache ☐ Vomiting ☐ Rash Other:	☐ Rested at center ☐ Called 911 ☐ Parent picked up ☐ On-site medical care provided ☐ Emergency contact picked up ☐ Child visited ER ☐ No one could be reached ☐ Child admitted to the hospital ☐ Health Dept. notified ☐ Child transported to an emergency care facility ☐ Parent called Other:
Child's Name: Date/Time: Date Removed: Date Returned:	☐ Cough ☐ Fever ☐ Sore throat ☐ Cold Symptoms ☐ Headache ☐ Ringworm ☐ Diarrhea ☐ Nausea ☐ Teething ☐ Ear ache ☐ Nosebleed ☐ Pink Eye ☐ Stomach Ache ☐ Vomiting ☐ Rash Other:	☐ Rested at center ☐ Called 911 ☐ Parent picked up ☐ On-site medical care provided ☐ Emergency contact picked up ☐ Child visited ER ☐ No one could be reached ☐ Child admitted to the hospital ☐ Health Dept. notified ☐ Child transported to an emergency care facility ☐ Parent called Other:

Centers must report to the OOL by the next working day and submit documentation within one week when an illness results in a call to 911, a child visiting the emergency room or being admitted to the hospital, or a child receiving on-site or transported emergency care/urgent care. Refer to Reporting Requirements for Communicable Diseases and Work-Related Conditions Quick Reference guide at http://www.nj.gov/health/cd/documents/reportable_disease_magnet.pdf.

The 5 Rights to Giving Medications to Children in Child Care

The 5 Rights	
CHILD **"Is this the right child—even though you think you know—you must check?"**	• Do you know the child's first and last name? • Is this the same child whose full name appears on the: ✓ Health care provider form ✓ Parental permission form ✓ Medication container label • When unsure as to the identity of the child: ✓ Photo record of child to verify identity with the Director of the child care agency, or designee who knows the child to confirm the Identity of the child
MEDICINE **"Is this the correct Medicine?"**	• Does the label on the medication container match the name of the medication as it appears on the Permission to Administer Medication form? ✓ The health care provider communication section ✓ The parental permission section • What is the expiration date on the medication container label? Has the medication expired?
DOSE **"Are you giving the exact amount of medicine?"**	• Does the dose follow the directions on the permission form and the medication container label? ✓ The health care provider communication section ✓ The parental permission section ✓ The medication container • Is the dose clearly stated? • Do you have the correct measuring device to give the medication?
ROUTE **"Are you using the proper method to give the medicine?"**	• How is this medication to be given? (By mouth, ear, eye, nose or applied to the skin) • Does the route of administration match in all the appropriate places? ✓ The health care provider communication form ✓ The parental permission form ✓ The medication container
TIME **"Is it the correct time to give the medicine?"**	• When was the last time the medicine was reported to have been given by the parent? • When was the last time the medicine was given as recorded on the Medication Administration Record? • Does the time match the instructions in all the appropriate places? ✓ The health care provider communication form ✓ The parental permission form ✓ The medication container • Are there specific instructions as to when or how the medication is to be given? Such as with food, on an empty stomach, or before/after eating. • If the medicine is to be given "as needed", does the child have symptoms that match the directions on the health care provider communication and parental permission forms?

Name of Person Being Observed _____ Date _____

HEALTHY FUTURES MEDICATION ADMINISTRATION SKILLS CHECKLIST

Circle the 'Y' in the "Yes" column, 'P' in the "Partial" column or 'N' in the "No" column to indicate if observed performance matches the details on this *SKILLS CHECKLIST*. Use the "Comments" column to indicate what needs improvement if performance of an item was not fully satisfactory.

Item to Check	Yes	Partial	No	Comments
RECEIVING MEDICATIONS				
Safety Check Person giving medication checks: □ Medication received meets criteria (original child-resistant container, label elements) □ Child health record on file □ Child had previous trial dose □ Parent gave information about when last dose was given, child's reaction to medication and medication administration techniques used at home	Y	P	N	
GIVING THE MEDICATION				
Prepare to Administer Medication □ Wash hands □ Prepare work area (clean/sanitize if needed) □ Take out medication (from locked storage) □ Relock locked storage if leaving storage area □ Check label and forms to see that they match □ Gather proper measuring devices □ Check that time is right to give dose	Y	P	N	
Prepare the Medication □ Select appropriate measuring device □ Measure amount noted on the label □ Change form of medication ONLY if label says to do so	Y	P	N	
Prepare the Child (states and demonstrates for infant, preschool and school age child)	Y	P	N	
Medication Administration Procedure Check 5 rights: child, medication, dose, time and route □ Check right child & note any special instructions in documents & on medication label □ Check medication preparation is correct □ Re-check child's name, date, time, dose, how medication is to be given (route) on both the medication container and permission slip □ Give the medication accurately, not more or less than ordered	Y	P	N	

Item to Check	Yes	Partial	No	Comments
☐ Praise the child ☐ Check the label again ☐ Return and lock medication in storage area ☐ Document medication administration right after giving dose ☐ Clean measuring device ☐ Wash hands				
Observe child's response to the medication.	Y	P	N	

DOCUMENTATION				
Documentation Forms are available to capture three types of essential information: ☐ Authorization to give medication ☐ Receiving medication ☐ Medication Log to record details of administered medication	Y	P	N	
Authorization Form to give medication is being used in the program that includes: ☐ Child's information ☐ Prescriber's information ☐ Permission to give medication from parent or guardian	Y	P	N	
Receiving Medication Form is being used that includes documentation that medication met criteria to be accepted: ☐ Presence of readable original prescription or manufacturer's label ☐ Name and strength of medication on label ☐ Date of Rx and expiration date timely ☐ Name of child (first and last) matches intended recipient ☐ Instructions for storage ☐ Instructions for administration	Y	P	N	
Medication Log Form includes: ☐ Name of child ☐ Name of medication ☐ Day, time, dose, route, staff signature ☐ Reported errors or mishaps ☐ Return or disposal of medication ☐ For "as needed" medications, reason medication was given	Y	P	N	

Printed Staff Member Name	Staff Member Signature	Date
Printed Health Professional Name	Health Professional Signature	Date

Bloodborne Pathogens

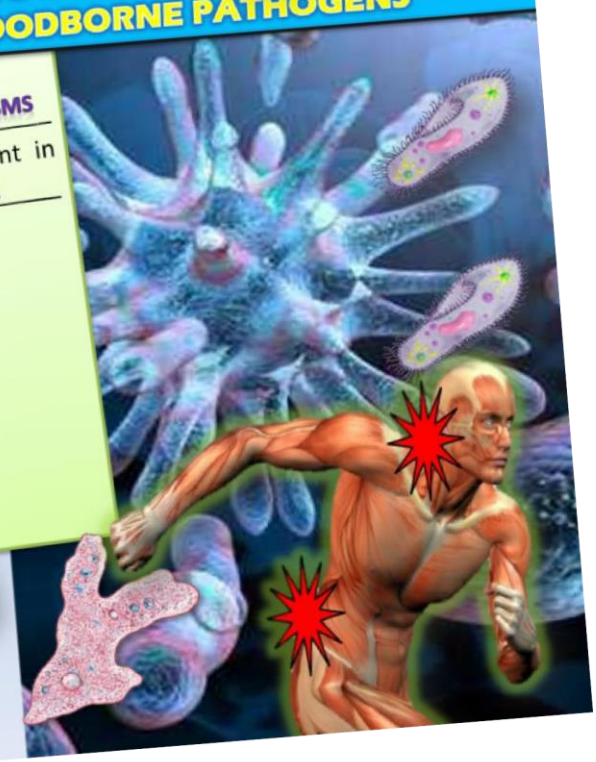
LESSON NO.1
INTRODUCTION TO BLOODBORNE PATHOGENS

What is a Bloodborne Pathogen?

"Bloodborne Pathogens" are MICROORGANISMS such as viruses or bacteria that are present in human blood and that can cause DISEASE in humans.

Examples of such pathogens include:

- Hepatitis B [HBV]
- Hepatitis C [HCV]
- Human Immunodeficiency Virus [HIV]
- Malaria
- Brucellosis
- Syphilis
- West Nile Virus



LESSON NO.5
EMERGENCY PROCEDURES: WHEN EXPOSURE OCCURES

How does exposure occur!

- Exposure in the workplace can occur as a result of:
- Needle sticks (MOST COMMON)
- Cuts from contaminated sharps
- Contaminated blood or OIM contact with the eyes, mucous membranes of the mouth or nose, or broken (cut or abraded) skin

If you think you have been exposed

- Thoroughly clean the affected area
- Wash needle sticks, cuts and skin with soap and water
- Flush with water splashes to the nose and mouth
- Irrigate eyes with clean water, saline, or sterile irrigants

"Report exposure to your immediate supervisor and fill out an Accident/Incident Report Form!"

Bloodborne Pathogens cont.

LESSON NO.4
METHODS TO CONTROL RISK OF EXPOSURE

Body Fluid Cleanup Procedures:

1. Always put on Gloves [2 pair is highly recommended]. If there is a large body fluid spill wear a disposable apron/gown, booties, mask, eye protection and a face shield. Open the kit and put on the following PPE after the gloves:

- **Disposable face mask**
- **Face shield**
- **Disposable apron/gown**
- **Disposable shoe covers**

2. ***Isolate the area.*** Do not allow unauthorized persons to enter until the spill has been cleaned up. If the spill has dried, soak the area, or scrub the area with disinfectant. Blood on carpet or upholstery needs special attention. Displace absorbent material over the spill.

[Powder will absorb 20-200 times it weight]

LESSON NO.4
METHODS TO CONTROL RISK OF EXPOSURE

3. Scoop material up and put into Red Biohazard Bag and tie shut.

4. Spray or pour disinfectant and on area and allow area to decontaminate for 10 minutes.

5. Use disposable wiping cloth to wipe up all the disinfectant, and then discard in second Red Biohazard Plastic Bag.

6. Place all items including PPE and first Red Biohazard plastic Bag into the second Red Biohazard bag. After the spill, never throw untreated biohazard waste in the regular trash.

Place the waste in throwaway waste container as soon as possible for proper disposal.

LESSON NO.4
METHODS TO CONTROL RISK OF EXPOSURE

Personal Protective Equipment [PPE]

Employers must provide PPE at __NO COST__ to employees where required. Appropriate sizes must be available.

They must ensure that PPE is properly cleaned, laundered, repaired, and disposed of at __NO COST__ to the employees.

Employees are NOT allowed to take PPE home for laundering.

Examples & uses of PPE:

- **Protective gloves:** hand contact with Blood or OPIM
- **Masks/Eye Protection:** Potential for splashes, spray spatter or droplets of blood or OPIM
- **Gowns, aprons, lab coats, caps/hoods, shoe covers/boots:** Gross contamination anticipated.
- **Mouthpieces and resuscitation devices:** Performing CPR

Emergency Preparedness

Minding Miracles Learning Center, Inc.
Emergency Evacuation & Injury Plan

(Developed in accordance with the NJ Manual of Child Care Requirements and the Office of Licensing DCF)

1. **Location of First Aid Kit:** Kitchen right-hand upper cabinet & each classroom's cabinet.
2. **Location of Emergency Materials:** (in case of evacuation) In tote under sink of each classroom.
3. **Physician/Emergency Personnel to Call in Case of Emergency:**
   Doctor/Clinic/EMT: Integrated Medical Alliance (IMA) 732-471-0400
   Nearest Hospital: Riverview Medical Center (732) 741-2700
   In case of immediate emergency call 911.
4. **Poison Control:** 1-800-222-1222
5. **Police/Fire/Emergency Medical Services: 911**
   For non-immediate emergencies, call Middletown Police Department: 732-615-2100
6. **Location of Parent Authorization for Emergency Care:** Student Files (reception area, filing cabinet)
7. **Student Allergies:** Allergy action plans located in each child's file & classroom manual. In case of exposure of allergen, implement individual plan of action immediately and contact parent. Epipens & Benedryl are located in the locked medicine box in each classroom of a child with allergies. Parents must be contacted immediately after medication is distributed.
8. **Center's Emergency Medical Procedures:**
   (1) **Assess the situation.** Does the child need first aid? Is an ambulance necessary? Is it safe or necessary to move the child? Assign one staff member to call 911, another to supervise other students, and someone to stay with the injured child at all times.
   (2) **Apply first aid.** ABC check, A&O check x4, head to toe check. Do all that is necessary to help the child while waiting for help. Try to keep the child comfortable, stable, and calm while waiting for help.
   (3) **Contact Parents.** Calmly give parents exact details about their child's condition, what has been done to help their child, and the circumstances under which the injury occurred. **Document the same on an accident/injury report**. In the event that the parent cannot be contacted, but immediate contact is needed, call the child's emergency contacts. Continue to attempt to contact the child's parents.

ALL INJURIES TO A CHILD'S HEAD, FACE OR NECK MUST BE REPORTED TO THE CHILD'S PARENTS/GUARDIAN IMMEDIATELY VIA PHONE.

Minding Miracles, Inc
Evacuation, Lockdown
and Disaster Procedures

Notify Middletown Police Department at 732-615-2100 or 911.
Notify Director/designee of the emergency.

For Evacuation:

1. Take class attendance books, family emergency numbers, allergy information, emergency medical consent forms, first aid supplies, and medical tags.
2. Take a cell phone to contact families or designated emergency contacts.
3. If long-term evacuation is expected, arrange for transportation or walk to the designated evacuation location. (Listed below).
4. Staff will count and roll call children before leaving the center, while walking or being transported, and while at the new site.

Emergency evacuation site: back of parking lot near shed. Orange cones in shed can be used to create a safety perimeter.

Alternate Indoor Location: Leonardo Post Office, 60 Thompson Avenue, (Appleton to Washington, to Thompson) 732-291-2556

Minding Miracles, Inc.
Evacuation, Lockdown and Disaster Procedures

Notify Middletown Police Department at 732-615-2100 or 911.
Notify Director/designee of the emergency.

For Lockdown:

1. Take children into an area away from windows or doors.
2. Staff will count and roll call children.
3. Lock all doors and pull-down window shades or blinds and cover classroom door windows.
4. Bring in emergency food and water supply.
5. Bring in battery powered radio, flashlight, extra batteries, & cell phone.
6. Bring in emergency blankets/covers.
7. Take class attendance books, family emergency numbers, allergy information, emergency medical consent forms, first aid supplies, and medical tags.
8. Bring quiet activities such as paper, crayons, or books to keep children occupied.
9. Remain in the designated area until the police or Director/Director's designee notify you that it is safe to leave. A safe-word will be given and periodically changed to notify staff that lock-down has, in-fact ended.

***It is important during lock-down to remember that no single procedure can possibly ensure safety in EVERY situation. Therefore, during an actual lock-down, changes may be made by the director….however, without the use of the safe-word, the standard protocol will be implemented.

Discipline

Acceptable forms of discipline:

Positive reinforcement- The most effective means of molding a child's behavior is to reward desirable behaviors as they appear. Telling a child what it is that they are doing right as apposed to scolding the child when they are breaking rules proves much more effective.

Redirection- When a child is engaging in an undesirable behavior, redirect their actions by giving them an alternative means to conduct themselves. Address the behavior as a communication of some sort; be it anger, confusion, sadness or frustration. Giving the child an alternative action to express these feeling decreases the possibility of the behavior reoccurring.

Reminder- Remind the child of the rules. Paying attention to a possible situation where rules may be broken and simply letting the child know that you see what is going on and reminding them of appropriate behavior may prevent a situation from escalating to a point where rules are being broken.

Removal- In the event that a child has deliberately broken a rule and put him/herself or another child in danger, removing the child from the group may be appropriate. The child must be supervised when removed and may only be removed for an appropriate amount of time. The instructor should briefly explain to the child why they are being removed from group; however, no other engagement of the child should exist for the duration of the removal. Before allowing the child to re-enter the group, briefly discuss the problem and alternative solutions.

Cont.

**Any form of discipline aside from the ones explained above is not aloud unless first discussed and agreed upon with the child's parents and designated in a signed behavior plan. Furthermore, there are several forms of discipline that staff members are strictly prohibited from using. They are explained as follows:

Unacceptable forms of discipline:

Singling out- No child may be singled out and scolded for a behavior that others were also engaged in. All attempts of discipline must be fair and applied to all children equally.

Assumption- In the event that the instructor did not see the actual behavior occur, no child may be assumed responsible. Even when pointed out by another child, the instructor should simply re-establish the rules and go on with the activity.

Deprivation- No child may be deprived of lunch, snack, rest time or beverage because of their behavior. Furthermore, the threat of such deprivation is also prohibited.

Physical Contact- Under no circumstances is any staff member permitted to discipline a child in a physical or physically threatening manner.

Tone of Voice:

A major consideration when disciplining a child of any age is the caregiver's tone of voice. Be firm, but kind. If/when it is necessary to raise your voice, your tone must not be derogatory, angry or berating in nature. There is a fine line between being loud and yelling- be careful not to pass that line. Many times, a whisper is far more effective than a yell.

ABC's of Behavior:

Antecedents Behavior Consequences

VANDERBILT UNIVERSITY

The ABC's of behavior help you to understand what turns your child's challenging behavior on and off. By collecting this information, you may be able to identify why your child engages in challenging behavior, strategies you can use to prevent or decrease this behavior, and new behaviors to teach your child to use instead of the challenging behavior.

Antecedents

Antecedents are the contexts or events that occur immediately BEFORE the challenging behavior. They include specific times of day, settings, people, and activites.

For example, if your child tantrums each night when it's time to transition to bed, the verbal prompt "it's time for bed"might be an antecedent or turn on your child's challenging behavior.

Antecedents are what turn the behavior ON.

Behavior

Challenging behavior is any behavior that interferes with learning or engagement with peers and adults.

Young children often engage in challenging behavior to communicate their wants and needs because they are just learning how to be social and communicate.

Consequences are what turn the behavior OFF.

Consequences

Consequences are the events or contexts that occur immediately AFTER the challenging behavior.

For example, attention from an adult in response to a child's behavior, the removal of activities or demands, or access to objects or activities provided as a result of the behavior might be consequences or turn off challenging behavior.

Click here for strategies you can use to prevent or decrease challenging behavior, teach new behaviors, and new ways to respond when challenging behavior occurs.

Important information regarding behavior:

**When a child in your class is having ongoing challenging behaviors, and you need support, start by collecting data (ABC data & frequency data can be accessed from the manager, BCBA or consulting head teacher.

**Who is the appropriate contact?

- For children with a diagnosis who are receiving ABA, contact the BCBA (Stephanie/Beth).
- For children who do not receive services, contact the consulting head teacher (Jess).

**Why the behavior is occurring is AS important as the behavior itself. No behavior occurs for 'no reason.' Taking notes and data is critical to our ability to create an effective plan. Words like always, never or constant must be replaced by actual numbers and circumstantial notes.

CRITICAL information regarding behavior:

**When provided with a behavior plan, the plan MUST be followed as written....CONSISTENTLY. These plans do not work over night and will only work when implemented properly.

**There will always be children with difficult behavior in our care. Not only is it 'par for the course' when working with children who have special needs, but it is an inherent part of working with all children. Washing your hands of a child because of their behavior is simply not an option for any Minding Miracles employee.

**Remember, it is our job to teach children how to behave in socially acceptable, safe ways...not just to address negative behaviors.

**WATCH YOUR LANGUAGE--- negative language in the presence of a child (bad, nasty, fresh, mean, bully) is not acceptable.

TIME OUT

Minding Miracles management believes that Time Out **CAN** be an effective mode of discipline, **WHEN** used appropriately. Use the following guidelines when using time out with preschoolers:

- Time-out at Minding Miracles is implemented quite literally as a TIME OUT. It is a time for the child to reflect, gain self-control and regroup. It is not a punishment or deterrent.
- Time-out can be used to initiate a correction procedure, meaning that the child is removed from an activity or situation, given a moment to employ self-regulation skills, and then prompted to re-enter the same situation with more socially appropriate behavior.
- No specified amount of time should be set for a child to remain on time-out…however, no longer than 2 minutes in any case. Most of the time, time-out can be for as short as 10 seconds before a child is prompted through the rest of the correction procedure.
- Once a child who is on time-out has calmed down, they must immediately be given the option to rejoin the group.
- Do not threaten a child using time-out as a punishment, if the behavior warrants removal from the group, do so immediately and implement procedures to prompt correct behavior.
- Children who are old enough to use language, should be prompted through a brief discussion to reflect on the behavior in question.

Staff Member tone of voice:

Yelling makes you grumpy.
Yelling makes you tired.
Yelling increases your stress.
Yelling makes your students grumpy.
Yelling makes your students tired.
Yelling increases your student's stress.

When you raise your voice often, the kids learn to tune it out.
Yelling models poor communication skills.
Yelling is disrespectful, intimidating, unprofessional, and hurtful.
The moral of this story is….
If what you have to say is important enough to hear…
Then find a way to say it so the kids will want to listen!

Yelling is a ***completely*** ineffective way of disciplining students….PERIOD!

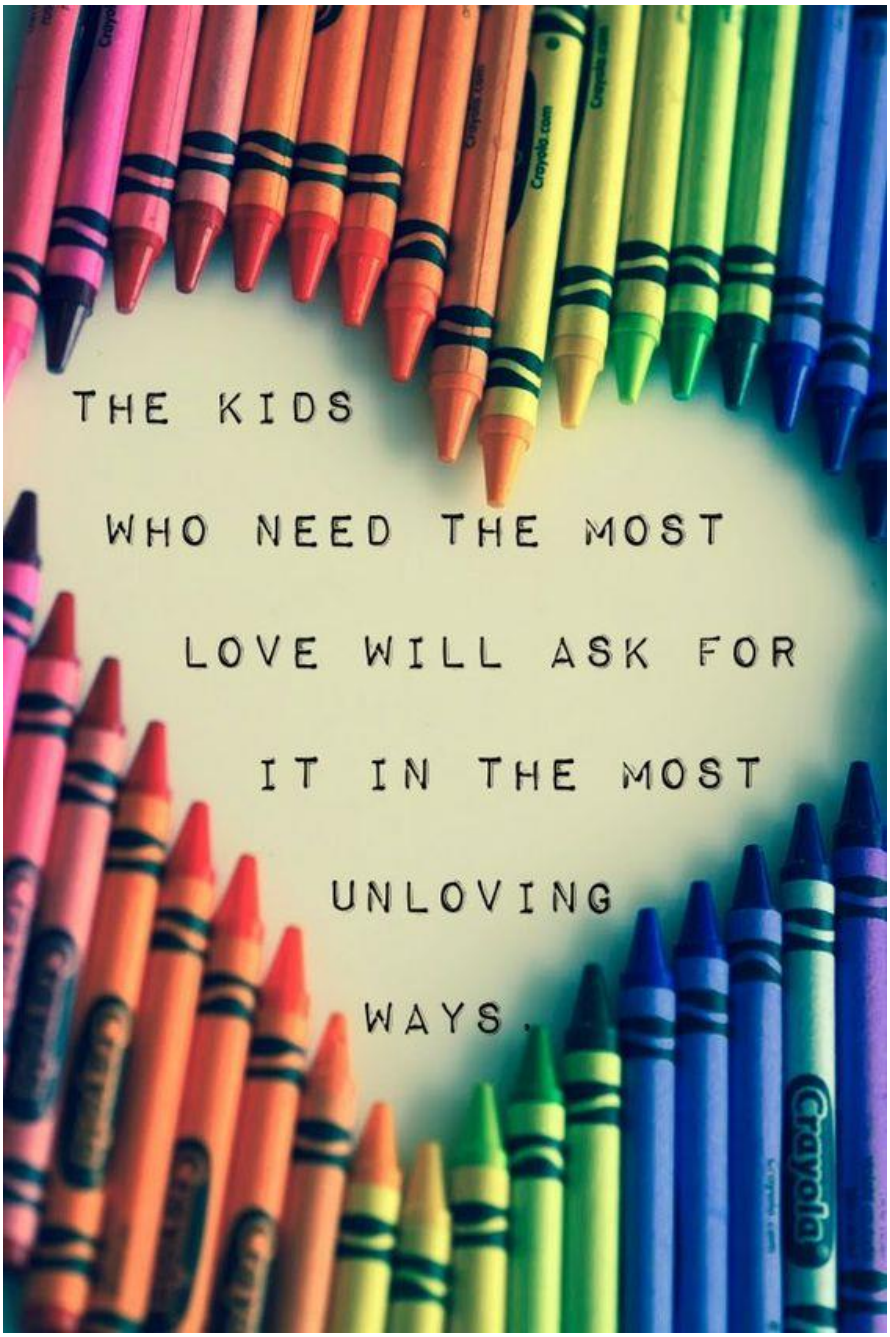
Raising your voice to get their attention or to startle a student who is about to do something dangerous (AS YOU APPROACH HIM/HER) may sometimes be necessary….However, it may not be a commonly used method of interacting with our clients.

If a child is continuously not listening, get up and prompt correct behavior or engage them in a different manner. Create an opportunity to teach correct behavior.

Whispering or using gestures is almost always more effective than yelling.

TALK TO OUR STUDENTS THE WAY YOU WOULD WANT YOUR CHILD SPOKEN TO BY THEIR TEACHERS!

Using derogatory words such as bad or bully—name calling of any type– is completely unacceptable staff member behavior.

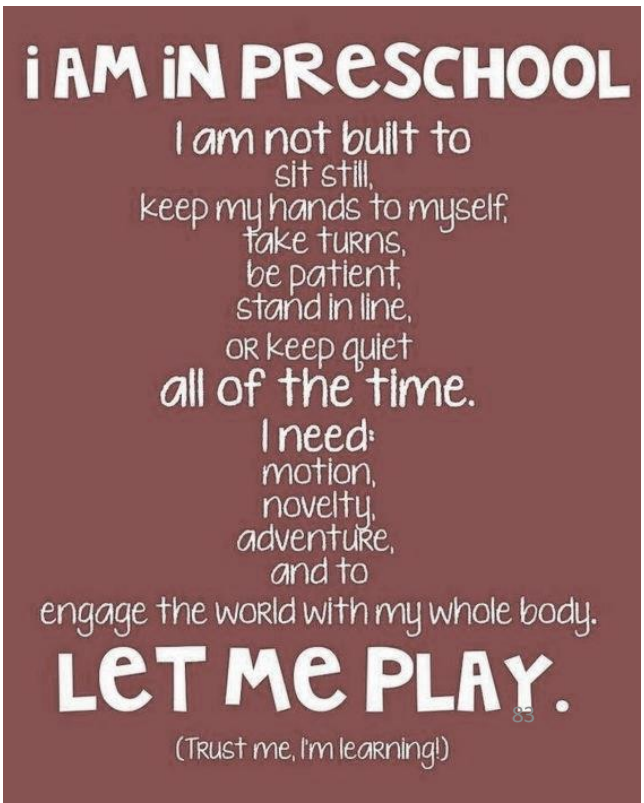

THE KIDS
WHO NEED THE MOST
LOVE WILL ASK FOR
IT IN THE MOST
UNLOVING
WAYS.

Managing Expectations

Managing the expectations we place on students is an important part of classroom management. If we set our expectations too low, our students (especially those with special needs) will not reach their potential.

If we set our expectations to high, we will cultivate behavior problems. Students need reasonable expectations from their caretakers in order to grow in an emotionally healthy environment. Our students need to be silly, active and engaged.

Successful behavior management begins with managing our own expectations for the movement, self-expression, choice-making and attention spans of our students.



inclusion

Minding Miracles was founded on the principle that all children benefit from the opportunity to learn alongside their peers in the natural environment. Every child is a myriad of strengths, challenges, likes, dislikes, and personality traits that make them unique. Embracing the uniqueness of all children is the essence of inclusive education. Inclusion offers the opportunity to teach children to understand, respect, and value diversity. This notion will enhance each child's conception of individualization, thus generating positive relationships amongst each citizen; impacting society at large.

We believe that inclusion isn't a destination to be reached after hitting prerequisite milestones but is a right that all children warrant. Children, by nature, do not discriminate based on skill levels or abilities. Inclusion gives all students the opportunity to learn from individuals who exhibit differences that teach tolerance, patience, communication, and acceptance. To that end, Minding Miracles' staff will make every attempt to support *all* students in an inclusive environment that scaffolds development and fosters friendship.

It is Minding Miracles' goal that each child in our care receive the exact supports and accommodations necessary to be successful in an inclusive environment. That often means creating support systems necessary to assist children physically, cognitively and behaviorally, **It is the <u>responsibility of every staff member</u> to ensure that students with special needs receive optimum care, patience and support.**

**Children who have specific health/sensory/behavioral needs will have a special care plan attached to the front of his/her enrollment file. This plan will be updated and maintained according to the needs of the child….each staff member must familiarize themselves with the plans of all children in their care.

De-escalation Strategies

- Act calm even if you're not.
- Give a choice.
- Use humor to lighten the mood.
- Ask them to draw a picture.
- Say, "I see where you are coming from."
- Talk about something they like.
- Try to understand their perspective.
- Let the person talk without interrupting.
- Avoid needing to get the last word.
- Remind them they are not in trouble.
- Say, "I'm here for you."
- Ignore the behavior if you can.
- Say, "What would help you right now?"
- Offer to change something you are doing.
- Let them take a walk or get a drink.

STRATEGIES FOR CHALLENGING BEHAVIORS
(MODEL THE BEHAVIORS YOU WANT TO SEE)

OBSERVE

- Observe what lead to the behavior. Is the child seeking or avoiding something? Is this a recurrent behavior? Was an intervention used before? How did it go?

ACKNOWLEDGE AND HANDLE FEELINGS

- Acknowledge your own feelings and come to a calm. You can't calm a brain without a calm brain.
- Acknowledge and validate their emotions
- Identify emotions with feeling words and charts
- Have a calm down kit to help them find their center.

ENGAGE COOPERATION

- Be clear and consistent in our expectations.

⇒ Explain what behavior you want to see

⇒ Explain why they can or can't do things.

⇒ Provide safe alternatives

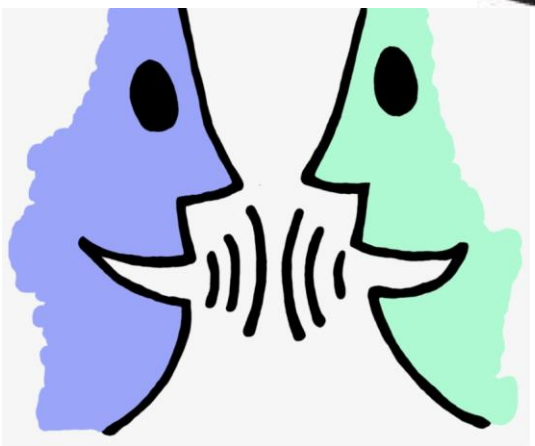
⇒ Use "When...Then..."

- Tell children what's going to happen before it happens
- Praise behaviors you want to see using specific language
- Provide choices
- Make it a game
- Use stories to explain lessons
- Make inanimate objects talk
- Pick your battles

RESOLVE CONFLICTS

- Acknowledge feelings
- Describe actions' effects on others
- Redirect
- Find duplicates
- Encourage turn taking
- Remind them of the rules
- Ask for ideas for solutions and choose one together.

Parent Communication



Five Appropriate Ways to Use "brightwheel" in the Classroom:

✓Provide updates to families via add activities tab as they occur:

-Photos (**only** mark those children in photo) -Food

- For children 3 & under record each meal.
- For children in Pre-k– only put in when there is an issue– ie- didn't eat at all, complained about new food, had a food reaction, etc)

-Videos (**only** mark those children in video) -

-Nap (time to sleep & time awake)

-Potty

- Diapering– record each change//bm or urine
- During toilet training record every accident and success
- Once fully toilet trained, only report accidents or unusual incidence

-Notes to parents

-Kudos

-Medications (administration times, reactions, etc)

-Incidents (accidents, unusual events, etc)

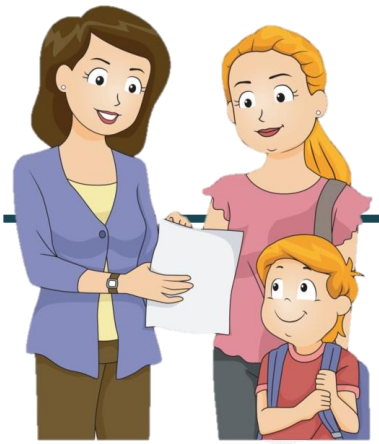
✓Upload Daily Recall Sheet--- EVERY DAY.

✓Send Reminders

✓Two-way communication between teacher and families

✓Highlight classroom celebrations or activities

VERY IMPORTANT



Parent Communication Key Points:

** Professionalism MUST be maintained at all times…in writing, tone of voice, vocabulary, mannerisms, etc.

**REMEMBER…even when reporting negative behaviors, dealing with unreasonable expectations or having to repeat yourself…You are speaking about someone's child. Be respectful of that fact–even when it is challenging.

**When posting on Brightwheel- tag ONLY the children in the photo, or who the message is intended for.

**Brightwheel is really the only window parents have into their child's day. Post…post…post. Group pics are OK!

**When in doubt, get a manager's help. Challenging conversations can often be mediated with advice from management.

**Lesson plans MUST be posted every day.

**Watch your tone…sarcasm, intonation & dismissive attitudes can often be interpreted as disrespectful.

**Be careful about what is discussed in front of children.

**Your job is MUCH easier when a positive relationship with parents is established!

Navigating Difficult Conversations

As teachers, we work hands-on with families and their children. It can be a challenge to balance the importance of our message and our relationship with the families when navigating through topics that can cause discomfort or concern. Remember these tips the next time you need to have a difficult conversation.

1. Start with what matters most
2. Acknowledge different perspectives
3. Ask open-ended questions
4. Provide strength-based observations
5. Reflect feelings and intent
6. Reiterate what you're hearing
7. Listen to the other party's perspective
8. Evaluate Options
9. Develop a Solution
10. Remember the "Third Story"
11. Accept that you will make mistakes
12. Let go of trying to control the other person's reaction

5

Keys to Building and Maintaining Relationships

Before we can expect to have successful difficult conversations, we must remember that our relationships with parents are the foundation of our conversations. They must know that you care before they can care about what you know.

1. **Establish a positive relationship with parents as early as possible.**
2. **Maintain genuine and efficient communication.**
3. **Inquire about and accommodate the needs of your parents.**
4. **Offer positive reinforcement.**
5. **Stay in touch.**

Prevent Child Abuse New Jersey

grow nj kids

Learn more about Family Engagement and Developmentally Appropriate Practice strategies by visiting our training page at https://pca-nj.teachable.com/p/pca-nj or learn more about what we do at https://www.preventchildabusenj.org/

**No parent should EVER leave our program feeling like their child is disliked or a burden.

Talking with Families about Problem Behavior: Do's and Don'ts

Do	Don't
1. Share strengths of child with the family.	1. Begin the discussion by indicating that the child's behavior is not tolerable.
2. Let the family know you are feeling concerned and want to do all you can to help their child feel safe, happy, and successful in your setting	2. Indicate that the child must be punished or "dealt with" by the parent.
3. Ask the parent if he or she has experienced similar situations and are concerned.	3. Ask the parent if something has happened at home to cause the behavior.
4. Tell the parent that you want to work with the family to help the child develop appropriate behavior and social skills.	4. Indicate that the parent should take action to resolve the problem at home.
5. Tell the parent about what is happening in the classroom but only after the parent understands that you are concerned about the child, not blaming the family.	5. Initiate the conversation by listing the child's challenging behavior. Discussions about challenging behavior should be framed as "the child is having a difficult time" rather than losing control.
6. Offer to work with the parent in the development of a behavior support plan that can be used at home and in the classroom.	6. Leave it up to the parent to manage problems at home; develop a plan without inviting family participation.
7. Emphasize that your focus will be to help the child develop the skills needed to be successful in the classroom. The child needs instruction and support.	7. Let the parent believe that the child needs more discipline.
8. Stress that if you can work together, you are more likely to be successful in helping the child learn new skills.	8. Minimize the importance of helping the family understand and implement positive behavior support.

Tips to Improve Conversations With Parents

- Remain Professional
- Actively Listen
- Reflect Back What is Being Said
- Validate Feelings
- Show Compassion or Concern
- Allow Other Party to Finish Their Statements
- Don't Use Jargon or Speak Patronizingly
- Be Solutions-Oriented
- Communicate About Positive and Enjoyable Things
- Find Common Ground
- Ask Open-Ended Questions to Learn More
- Avoid Assumptions
- Watch Non-verbal Behaviors
- Be Aware of Your Internal Voice and Be Respectful
- Do Not Provide Unsolicited Advice
- Use "I" Statements
- Do Not Equate Your Experiences with Others'
- If You Don't Know, Say You Don't Know


grow
nj
kids

GROW NJ KIDS ROAD TO QUALITY

1 ENROLL

- Apply for enrollment in Grow NJ Kids through NJCCIS.
- Receive a Welcome email and complete the online GNJK Orientation.
- Receive assignment of a Quality Improvement Specialist (QIS) after the GNJK Orientation is complete.
- Partner with your Quality Improvement Specialist (QIS) to get started.

2 INTRODUCTION

- Attend Health Safety and Child Growth and Development training.
- Review NJCCIS to ensure all staff are linked to the program.
- Receive overview of Grow NJ Kids and the Environment Rating Scales (ERS) for staff.
- Identify training and professional development goals for staff.

3 ASSESS

- Transition to a Regional Technical Assistance Center and meet your program's TA Specialist.
- Select an approved research-based curriculum and assessment pedagogy.
- Receive mentoring, coaching, and observation for the ERS tools from your TA Specialist.

4 PLAN

- Complete a customized Grow NJ Kids program Self-Assessment with support from your TA Specialist.
- Develop your program's Quality Improvement Plan goals.
- Programs that qualify submit a request for classroom enhancements and learning material needs identified in your Self-Assessment.

5 SUPPORT

- Partner with your TA Specialist to implement your Quality Improvement Plan.
- Gather and review rating documentation and professional development certifications.
- Conduct internal Environment Rating Scale observation assessments for all age groups to prepare for rating.

6 RATING

- Meet Quality Improvement Plan criteria for star rating you intend to obtain.
- Submit application and documentation for rating through NJCCIS.
- A representative from GNJK Rating at CREEHS will contact your program to arrange the rating process details.

7 CQI

- Maintain achieved level of care and professional development with continuous quality improvement and rating renewal.
- A Grow NJ Kids star rating is valid for three years.
- Apply for re-rating after 3 years. Preparation begins at least 6 months prior.

NOTE:
The rating process is tailored to your individual program needs and takes an average of 18-24 months (about 2 years) to complete. Staff will attend formal training offerings based on individualized professional development plans. This begins during the introduction and continues throughout process.

GROW NJ KIDS TRAINING SERVICES
grow nj kids
RUTGERS School of Social Work INSTITUTE FOR FAMILIES

What does grow nj kids expect of us?

Environment:

Grow is looking at our classroom set-up, quality of materials, building maintenance, cleanliness, sanitation & displays through an assessment called the Environmental Rating Scale (ERS). You may hear it referred to as ECERS or ITERS.

Developmentally Appropriate activities

Grow promotes best practice in a play-based program. In other words, they are looking to determine that the length of activities, materials used, curriculum and daily schedule are appropriate to the expectations/capabilities on each age group.

Parent involvement/communication

The program-parent relationship is paramount in Grow's expectations of our program. They look for opportunities for parents to be involved in our program through special events, trainings, communication and cultural responsiveness.

Positive interactions

During all activities & parts of the day, our interactions with our students are the cornerstone of learning. Grow is looking to ensure that staff are respectful, promoting expanded language, scaffolding learning and cultivating problem solving & conflict resolution.

What does grow nj kids expect of us?

How does this translate?

- Ongoing staff training
- Assessment of classrooms
- Assessment of lesson plans
- Implementation of a comprehensive curriculum
- Health & safety practices
- Continuously elevating our interactions
- Keeping parents informed and developing positive relationships with our families
- Focus on play-based activities

What's in it for us?

- Program improvement!
- A branded standard of quality
- Free staff trainings
- Grant opportunities
- Scholarships for staff credentialing (CDA)
- Subsidies for staff

Reading the Stars

If you are a parent or family member looking for a quality child care or early learning program, Grow NJ Kids, New Jersey's Quality Rating Improvement System, can help. Since 2013, Grow NJ Kids - which is based on recognized research - has been working with programs to raise the quality of child care and early learning across the state.

Grow NJ Kids provides you with information on choosing a quality provider, helping you to make the most of your child's early learning opportunities. Here are the five areas that are assessed:

- the health and safety of your child and the classroom,
- age appropriateness of learning environments and lesson plans,
- the relationship of your child's program with you and the community,
- staff education, and
- business operations.

Based on these assessments, each program is given a star rating, ranging from 1 to 5 stars. The standards are high and reaching the highest quality levels is often a long-term process. All participating programs are committed to making improvements that help prepare kids for school and life.

The star ratings easily help families recognize quality programs. In addition, these star ratings help guide the process and encourage programs to improve. A one-star rating means the program meets New Jersey's licensing requirements. Programs that choose to meet higher standards can apply for a three-to five-star rating. As programs move up the rating system, requirements increase. Once a program is ready to be rated, the state-designated rating entity determines how many stars a program should receive. The star ratings are valid for three years from the review date. The information below gives examples of what the programs completed to get their star rating. Grow NJ Kids also stresses to parents that star ratings are just one of several factors to consider in finding the right program for their family's needs.

☆	• A license or certificate of registration from the Department of Children and Families or a Department of Education-approved school district. • Completed the Grow NJ Kids Director's Orientation.
☆☆	• Met all of the requirements for a one-star rating. • Completed a self-assessment and quality improvement plan that identifies areas of strength and how the program will work toward higher quality.
☆☆☆	• Met all of the requirements for two stars. • All teaching staff attended a minimum of five hours of training on selected research-based curriculum/developmentally appropriate practices. • Classrooms met quality standards, using a nationally recognized rating scale.
☆☆☆☆	• Met all of the requirements for three stars. • All teaching staff attended a minimum of 10 training hours on selected research-based curriculum/developmentally appropriate practices. • Classrooms met high quality standards, using a nationally recognized rating scale.
☆☆☆☆☆	• Met all of the requirements for four stars. • Implemented research-based curriculum and developmentally appropriate practices. • Classroom met high-quality standards, using a nationally recognized rating scale.

For more information visit www.GrowNJKids.com

Play-based.....
Structured or free-for-all?

During the course of recent trainings, some comments have circulated that play-based equates to just "letting kids do what they want." This is FALSE. It is a complete mis-interpretation of the concept.

Play-based means....

...providing ample opportunity (minimum 60 min) for uninterrupted child-choice play activities.

...creating environmental and structural play cues.

...Teacher-led activities are an option for students.

...children use classroom structures and rules to self-navigate selected activities.

Social Play Development

Knowing what types of social play to expect across early childhood can help caregivers support children as they learn to play with their siblings, friends, and peers.

SOLITARY PLAY:

begins in infancy and continues in the preschool years

The child plays alone without attending to children around them. The child might explore toys through sensorimotor play or engage in more complex pretend play behaviors as they age.

Examples:

- Infant mouthing a teething toy
- Preschooler engaging in pretend play with a doll

ONLOOKER PLAY:

begins in infant & toddler years and continues in the preschool years

Child watches others play and may make comments. However, the child does not attempt to join in the play activity with peers.

Examples:

- Watching peers race cars
- Watching peers play at the water table

PARALLEL PLAY:

begins in the toddler years and continues in the preschool years

Children play near each other with similar toys in similar ways

Examples:

- Children building towers with blocks next to each other
- Children drawing with chalk on the sidewalk next to each other

ASSOCIATIVE PLAY:

begins and continues in the preschool years

Two or more children playing with similar toy sets, but play is not coordinated. Children share toys and often talk to each other about their play.

Example:

- Children playing at the water table, sharing eye droppers and beakers, and occassionally talking to each other.

COOPERATIVE PLAY:

begins in the late preschool years and continues with adult support

Two or more children playing together with common materials and a common goal. Children also often have assigned roles.

Examples:

- Children building a city with blocks and each child has a job or specific role
- Children dressing as firefighters with the shared goal of putting out a fire

This work was funded in part by the Caplan Foundation for Early Learning. For more information on the Play to Learn project click here.

Created by Barton Lab at

What Can We Say to Children...

Instead of saying "You're alright" or "What are you crying for."

Grow Children with Love and Come From the HEART

Hear what they have to say

Empathize with how they feel

Allow them time to breathe

Respond from a place of care

Treat them with respect

By following this perspective, you are well on your way toward having a more responsive, emotionally supportive environment

grow nj kids

16 Play Types

Symbolic Play

Using objects, or actions to represent other objects, actions, or ideas, e.g. using a cardboard tube like a telescope.

Rough and Tumble Play

Discovering physical flexibility, generally friendly and positive.

Socio-Dramatic Play

When children act out experiences, e.g. playing house

Creative Play

Allows children to explore, try out new ideas and use their imagination.

Social Play

Any social situation where it's expected that everyone will follow the set rules - like during a game

Communication Play

Play using words, gestures e.g. charades, telling jokes, play acting, etc.

Dramatic Play

Play where children figure out roles to play, assign them and then act them out.

Locomotor Play

Movement for movement's sake, just because it's fun. Things like chase, tag, hide and seek and tree climbing

Imaginative Play

play where the conventional rules, which govern the physical world, do not apply, like imagining you are a bee, or pretending you have wings.

Exploratory Play

using senses of smell, touch and even taste to explore and discover the texture and function of things around them

Fantasy Play

child's imagination gets to run wild and they get to play out things that are that are unlikely to occur, like being a pilot or driving a car.

Deep Play

Play which allows the child to encounter risky experiences and conquer fear like heights, snakes, and creepy crawlies

Mastery Play

control of the physical and affective ingredients of the environments, like digging holes or constructing shelters.

Object Play

play which uses sequences of hand-eye manipulations and movements, like using a paintbrush.

Role Play

play exploring ways of being, although not normally of an intense nature, like brushing with a broom, dialing with a telephone..

Recapitulative Play

play that allows the child to explore ancestry, history, rituals, stories, rhymes, fire and darkness.

Infographic created by www.encourageplay.com

Play Type Information from Hughes, B. (2002) A Playworker's Taxonomy of Play Types, 2nd edition, London:

10 Effective DAP* Teaching Strategies

An effective teacher chooses a strategy to fit a particular situation. Consider what the children already know, what they can do, and the learning goals for the specific situation. By remaining flexible and observant, we can determine the most effective strategy. Often, if one strategy doesn't work, another will.

01

"Thanks for your help, Kavi."

"You found another way to show 5."

ACKNOWLEDGE what children do or say. Let children know what we have noticed, through comments or by sitting nearby and observing.

02

"You're thinking of lots of words to describe the dog in the story. Let's keep going!"

ENCOURAGE persistence and effort rather than just praising and evaluating what the child has done.

03

"The beanbag didn't get all the way to the hoop, so you might try throwing it harder."

GIVE SPECIFIC FEEDBACK rather than general comments.

04

"Hmm, that didn't work and I need to think about why."

"I'm sorry, Ben, I missed part of what you said. Please tell me again."

MODEL attitudes, ways of approaching problems, and behavior toward others, show children rather than just tell them.

05

Such as using a wire whisk or writing the letter P

06

CREATE OR ADD CHALLENGE so that a task goes a bit beyond what the children can already do. For example, lay out a collection of chips, count them together and then ask a few children how many are left after they see you removing some of the chips. The children count the remaining chips to help come up with the answer. To add a challenge, you could hide the chips after you remove some, and the children will have to use a strategy other than counting the remaining chips to come up with the answer. To **REDUCE CHALLENGE**, you could simplify the task by guiding the children to touch each chip once as they count the remaining chips.

09

"This one that looks like a big mouse with a short tail is called a vole."

PROVIDE INFORMATION, directly giving children facts, verbal labels, and other information.

To learn more about DAP visit http://www.naeyc.org/DAP

DEMONSTRATE the correct way to do something. This usually involves a procedure that needs to be done in a certain way.

07

"If you couldn't talk to your partner, how else could you let him know what to do?"

ASK QUESTIONS that provoke children's thinking.

08

"Can you think of a word that rhymes with your name, Matt? How about bat . . . Matt/bat? "

GIVE ASSISTANCE (such as a cue or hint) to help children work on the edge of their current competence.

10

"Touch each block only once as you count them."

GIVE DIRECTIONS for children's action or behavior.

* DAP = Developmentally Appropriate Practice

Process versus Product

*There are no step-by-step instructions
*There is no sample for children to follow
*There is no right or wrong way to explore and create
*The art is focused on the experience and on exploration of techniques, tools, and materials
*The art is unique and original...no two should be the same
*The experience is relaxing or calming
*The art is entirely the children's own
*The art experience is a child's choice

Additional Policies & Procedures

Staff Cell Phone Policy

Use of cell phones while students are present is strictly prohibited at Minding Miracles. Cell phones are a distraction and can create a safety risk. Therefore, the following consequences will be enforced when any staff member is observed using their cellphone while on-duty for any reason other than that permitted below:

Permitted Uses:

- A critical family emergency that requires constant contact. Use must first be approved by the center manager and must not interfere with the classroom dynamic.
- Application use for classroom management/student benefit (ex- timers, Brightwheel, Youtube, Spotify). This stipulation applies only to the head classroom teacher and must be approved by the center manager.***In most cases, the classroom iPad should mainly be used for this purpose.***
- Use in the office or outside the building during staff breaks.

In the event that a staff member violates this policy, the following consequences will be enforced:

1st offence: Warning
2nd offence: 1 Day suspension without pay
3rd offence: 2 Day suspension without pay and meeting with management
4th offence: Dismissal

Child Release Policy

The following procedure must be followed for dismissal…..

*Children may not be released from the playground

*Be sure that all of the child's possessions are sent home (including the daily recall sheet).

*Remind parents to sign out using the Jackrabbit Care system.

*Quickly assess the individual's state-of-mind; no child may be released to persons appearing to be intoxicated or under the influence of drugs or alcohol. In the event that an individual arrives for pick-up and appears to be under the influence, do not release the child and call the police & director immediately.

*Biological or adoptive parents CONNOT be denied access to their child UNLESS a court approved document stating the restriction is on-file at the center (unless the individual is under the influence).

*If an unknown individual is picking up the child, the following procedure must be followed:

- Ask the individual for identification.
- Locate the 'Child Release Form' in the child's file and verify that the individual is on the form.
- Photocopy the identification of the designated pick-up person and attach to the child release form—unless this step has been complete at an earlier date.

If the individual has not picked-up in the past, have him/her sign the form in the designated spot.

Minding Miracles Learning Center, Inc.
Child Release Policy

The staff at Minding Miracles Learning Center can only release children to parents, guardians or those authorized by the parents or guardians. We must have a sample signature on file for people authorized to pick up your child. People who may not normally pick up your child will be asked to show identification.

*In the event that a parent or authorized individual arrives at the center and appears to be impaired physically or emotionally, the child will not be released into the care of such an individual. In case of such an event, one of the child's listed emergency contacts will be called and alternative arrangements will be made. In the event that the center is unable to make alternative arrangements, we are required to contact the Division of Youth & Family Services to report the incident and seek assistance in caring for the child.

*Copies of any court orders pertaining to the custody of a child or restricting access to the child must be kept on file at Minding Miracles. Any changes to custodial agreements, court orders, or restraining orders must be filed at the center as well. We cannot restrict access of a custodial parent of a child without such documentation.

Child's name_____

Home Phone _____ Mobile/Pager Number_____

Parent/Guardian Signature _____

Parent/Guardian Signature _____

Authorized person #1 signature		
Print name	Relationship	Phone

Authorized person #2 signature		
Print name	Relationship	Phone

Authorized person #3 signature		
Print name	Relationship	Phone

**For additional authorizations, please list on back. All listed individuals will be asked for photo ID the first time they pick your child up at the center.

Student Belongings

Juice cups/bottles: Must be labeled w/ student's name and date.

Refrigerated foods: Must be labeled with name and either disposed of or sent home at the end of EACH day.

Nap Bedding: Must be labeled with initials, kept in individual labeled storage bins and sent home each Friday to be laundered. Parents who do not supply bedding must be called and informed that they must bring bedding---extras will no longer be available.

Show and tell: Label with masking tape & send home same day!

Toys/personal belongings (non-show & tell): Should be sent home with the parent at arrival in order to prevent breakage/loss.

Pacifiers: When not in use should be kept in the child's lunch box/clipboard.

Clothing: Each student should have at least one change of clothes available at the center (more for infants and children who are potty training). Staff must monitor when a child has used his extra clothes and notify parents when more are needed).

Attendance

Attendance is CRITICAL to accurate bookkeeping and organization. Every staff member must contribute to accurate attendance by assisting in the following:

*Sign children in/out at the moment they enter or leave the program.

*In the even of a discrepancy or technical error (down internet, app issues, human error) document the issue with the correct in/out time and bring to the manager's attention so the error can be resolved.

Please remember, Minding Miracles often is responsible for billing third party payers such as CCR&R, Medicaid and Insurance Companies: Accurate attendance is critical to compliance.

Staff Schedules:

Every effort is made to accommodate personal requests and availability; however, Minding Miracles' staff schedule is created to ensure that our student:staff ratio is adequate. Unplanned absences create inefficiency and havoc. Requests made with less than 1 week's notice will not be guaranteed and requests made without 48 hours notice will be considered 'unplanned' and are subject to 'write-up.'

Please review the attendance policies provided in the employee handbook for guidelines and consequences of employee attendance issues.

NOTE: ALL UNPLANNED ABSENCES WITHOUT SUPPORTING DOCUMENTATION WILL BE SUBJECT TO EMPLOYEE WRITE-UP.

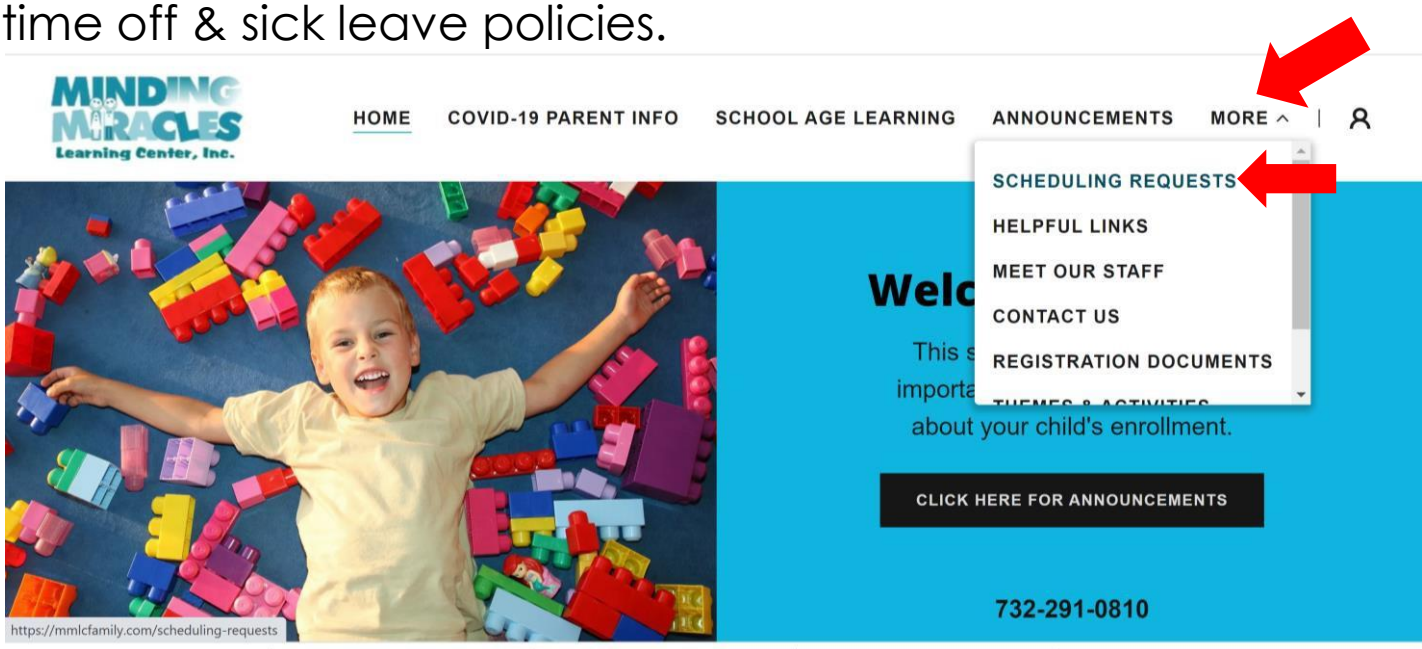
Day-off requests and schedule changes can be made by filling out the electronic form on our website at MMLCfamily.com. You will receive an email in return informing you of approval or rejection.

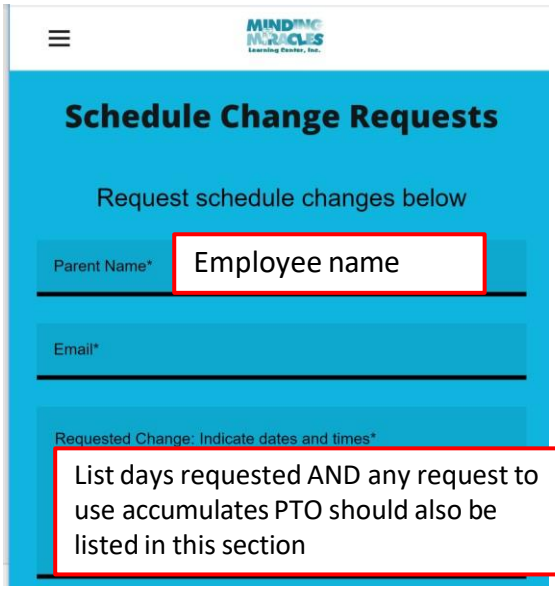
Requesting time off:

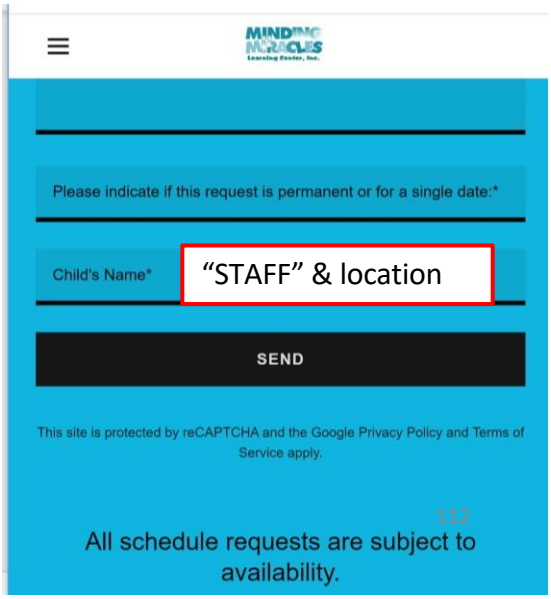
All days off must be requested through Minding Miracles website. Gina will receive the message, discuss coverage with your manager and notify you of approval.

If you do not hear from Gina within 72 hours, check-in with her or your manager to be sure the request was received.

Check the Employee Handbook (updated 8/2021) for paid time off & sick leave policies.







Social Media Policy

This social media policy applies to parents, members of staff, students, and volunteers at Minding Miracles. As part of our duty to safeguard children it is essential to maintain the privacy and security of all our families. We therefore require that no staff member may take pictures/video of the children for personal use; including to be posted or utilized on social media. Staff members who do not abide by this policy are subject to immediate termination.

Parents are allowed to take pictures/video of their own child and advised that they do not have a right to photograph anyone else's child or to upload photos of anyone else's children.

Photos and videos posted as a part of Minding Miracles' parent inclusion program (i.e. learning displays or See Saw journals) are for parent viewing only and may not be shared by parents if they include children other than their own.

This policy includes (but is not limited to) the following technologies:

- Social networking sites (e.g. Facebook, Instagram, Snap Chat, etc)
- Blogs
- Discussion forums
- Collaborative online spaces
- Media Sharing services (i.e. You Tube)
- Micro-blogging (i.e. Twitter)

Confidentiality

HIPAA COMPLIANCE

All employees of Minding Miracles are required to comply with the Health Insurance Portability & Accountability Act. This act (HIPAA) protects the personal health information (PHI) of our clients and their families. Personal health information includes, but is not limited to:

- Demographic information (last name, birthday, address, etc)
- Diagnostic information/functioning level
- Behavioral profile
- Services being received
- Anecdotal information
- Programming information

Compliance with HIPPA Laws are mandatory for all Minding Miracles employees. Failure to comply with the safeguards contained within the HIPAA guidelines will result in immediate dismissal. Compliance entails:

- Avoiding discussing a child's PHI with anyone other than parents, supervisors and staff related to the child's direct care.
- Keeping all sensitive paperwork in a secure location.
- Not answering questions from other parents or professionals about a child's PHI.
- Sharing information with others at the parent's request ONLY after signed consent has been attained.
- Refraining from any 'outside' (off-duty) conversation about clients in public places or in the presence of non-employees.

This policy applies to **ALL** Minding Miracles clients (with or without a diagnosis).

Important take-aways:

*No student information should be discussed in public places

*No student information should be shared with non-employees

*Student information pertaining to diagnosis, behavior, treatment types and family situations should only be shared as needed with appropriate staff members.

*When another child is involved in a behavioral incident, staff may not share the other child's name when discussing with parents.

Department of Children and Families
Office of Licensing

INFORMATION TO PARENTS

Under provisions of the ***Manual of Requirements for Child Care Centers (N.J.A.C. 3A:52)***, every licensed child care center in New Jersey must provide to parents of enrolled children written information on parent visitation rights, State licensing requirements, child abuse/neglect reporting requirements and other child care matters. The center must comply with this requirement by reproducing and distributing to parents and staff this written statement, prepared by the Office of Licensing, Child Care & Youth Residential Licensing, in the Department of Children and Families. In keeping with this requirement, the center must secure every parent and staff member's signature attesting to his/her receipt of the information.

Our center is required by the State Child Care Center Licensing law to be licensed by the Office of Licensing (OOL), Child Care & Youth Residential Licensing, in the Department of Children and Families (DCF). A copy of our current license must be posted in a prominent location at our center. Look for it when you're in the center.

To be licensed, our center must comply with the Manual of Requirements for Child Care Centers (the official licensing regulations). The regulations cover such areas as: physical environment/life-safety; staff qualifications, supervision, and staff/child ratios; program activities and equipment; health, food and nutrition; rest and sleep requirements; parent/community participation; administrative and record keeping requirements; and others.

Our center must have on the premises a copy of the Manual of Requirements for Child Care Centers and make it available to interested parents for review. If you would like to review our copy, just ask any staff member. Parents may view a copy of the Manual of Requirements on the DCF website at http://www.nj.gov/dcf/providers/licensing/laws/CCCmanual.pdf or obtain a copy by sending a check or money order for $5 made payable to the "Treasurer, State of New Jersey", and mailing it to: NJDCF, Office of Licensing, Publication Fees, PO Box 657, Trenton, NJ 08646-0657.

We encourage parents to discuss with us any questions or concerns about the policies and program of the center or the meaning, application or alleged violations of the Manual of Requirements for Child Care Centers. We will be happy to arrange a convenient opportunity for you to review and discuss these matters with us. If you suspect our center may be in violation of licensing requirements, you are entitled to report them to the Office of Licensing toll free at 1 (877) 667-9845. Of course, we would appreciate your bringing these concerns to our attention, too.

Our center must have a policy concerning the release of children to parents or people authorized by parents to be responsible for the child. Please discuss with us your plans for your child's departure from the center.

Our center must have a policy about administering medicine and health care procedures and the management of communicable diseases. Please talk to us about these policies so we can work together to keep our children healthy.

Our center must have a policy concerning the expulsion of children from enrollment at the center. Please review this policy so we can work together to keep your child in our center.

Parents are entitled to review the center's copy of the OOL's Inspection/Violation Reports on the center, which are available soon after every State licensing inspection of our center. If there is a licensing complaint

investigation, you are also entitled to review the OOL's Complaint Investigation Summary Report, as well as any letters of enforcement or other actions taken against the center during the current licensing period. Let us know if you wish to review them and we will make them available for your review or you can view them online at https://childcareexplorer.njccis.com/portal/.

Our center must cooperate with all DCF inspections/investigations. DCF staff may interview both staff members and children.

Our center must post its written statement of philosophy on child discipline in a prominent location and make a copy of it available to parents upon request. We encourage you to review it and to discuss with us any questions you may have about it.

Our center must post a listing or diagram of those rooms and areas approved by the OOL for the children's use. Please talk to us if you have any questions about the center's space.

Our center must offer parents of enrolled children ample opportunity to assist the center in complying with licensing requirements; and to participate in and observe the activities of the center. Parents wishing to participate in the activities or operations of the center should discuss their interest with the center director, who can advise them of what opportunities are available.

Parents of enrolled children may visit our center at any time without having to secure prior approval from the director or any staff member. Please feel free to do so when you can. We welcome visits from our parents.

Our center must inform parents in advance of every field trip, outing, or special event away from the center, and must obtain prior written consent from parents before taking a child on each such trip.

Our center is required to provide reasonable accommodations for children and/or parents with disabilities and to comply with the New Jersey Law Against Discrimination (LAD), P.L. 1945, c. 169 (N.J.S.A. 10:5-1 et seq.), and the Americans with Disabilities Act (ADA), P.L. 101-336 (42 U.S.C. 12101 et seq.). Anyone who believes the center is not in compliance with these laws may contact the Division on Civil Rights in the New Jersey Department of Law and Public Safety for information about filing an LAD claim at (609) 292-4605 (TTY users may dial 711 to reach the New Jersey Relay Operator and ask for (609) 292-7701), or may contact the United States Department of Justice for information about filing an ADA claim at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Our center is required, at least annually, to review the Consumer Product Safety Commission (CPSC), unsafe children's products list, ensure that items on the list are not at the center, and make the list accessible to staff and parents and/or provide parents with the CPSC website at https://www.cpsc.gov/Recalls. Internet access may be available at your local library. For more information call the CPSC at (800) 638-2772.

Anyone who has reasonable cause to believe that an enrolled child has been or is being subjected to any form of hitting, corporal punishment, abusive language, ridicule, harsh, humiliating or frightening treatment, or any other kind of child abuse, neglect, or exploitation by any adult, whether working at the center or not, is required by State law to report the concern immediately to the *State Central Registry Hotline, toll free at (877) NJ ABUSE/(877) 652-2873*. Such reports may be made anonymously. Parents may secure information about child abuse and neglect by contacting: DCF, Office of Communications and Legislation at (609) 292-0422 or go to www.state.nj.us/dcf/.

MINDING MIRACLES
Learning Center, Inc.

Employee Conflict Resolution Policy

Minding Miracles administration is committed to a safe, comfortable, and productive work environment. We understand that employees may have differing personalities and temperaments that may cause conflicts from time to time. However, we expect that employees work together to resolve conflicts. When conflicts arise, all employees of Minding Miracles are expected to:

- Work to resolve the conflict.
- Treat each other with respect.
- Be clear and truthful about what is really bothering them and what they want to change.
- Listen to other participants and make an effort to understand the views of others.
- Be willing to take responsibility for their behavior.
- Be willing to compromise.
- Avoid any volatile altercation, conversation or conflict while in the presence of children or families.
- At no time may any employee be physically aggressive or intimidating with other staff members.

The following steps will be taken by administration to resolve conflicts:

1. Give both parties an opportunity to confront the problem in private in order to come to a resultion satisfactory to both parties.
2. Arrange for all parties to confront the problem in the presence of a peer who has been trained to mediate conflicts.
3. Arrange for mediation with administration in order to set boundaries and settle disputes between both parties.
4. If all above steps have been taken, and resolution cannot be found, administration will make every effort to transfer one of the staff members involved to another classroom or center.
5. In the event that one or both of the staff members refuse to follow these guidelines, will not compromise, or acts-out in the presence of students or parents, termination may be necessary.

NJ Department of Children and Families requires that each employee in a child care setting perform continuing education throughout their employment.

Management & Credentialed staff must complete 20 hours of staff development each school year (8/1-7/31). All other staff must complete a minimum of 12 hours of continuing education each school year. Staff meetings, meetings-in-a-memo and in-services all count toward staff training. However, each staff member is responsible for completing the remainder of the hours by seeking out additional training opportunities.

Online and satellite training opportunities are available through the NJ Child Care Information System. If you haven't done so already, make a profile on NJCCIS.com in order to seek out training opportunities.

NJCCIS.com
- Login
  - Click on 'Registry'
  - Click on 'Find Professional Development and Training Classes'

  and perform 'CCDBG Required Trainings' (Health & Safety Basics & Mandated Reporting)

Policy Receipt and Attestation

Employee Name: _____

Position:_____ Start Date: _____

The following policies are included in the Orientation, Employee Handbook and Minding Miracles' enrollment packet, please check each policy and sign indicating receipt.

_____Student Supervision, Ratios & Playground Safety

_____Detecting & Reporting Abuse

_____USDA Meal Guidelines/Mealtime Guidelines/Allergens/Nut Policy

_____Primary Care Routines/Diapering/Napping/Toilet training

_____Information to Parents Document (issued by NJDCFS)

_____Policy on the Release of Children

_____Policy on Methods of Parental Notification

_____Inclusion & Special Needs Plans

_____Emergency/Lockdown & Evacuation Procedures

_____Policy on Comm. Disease Mngmt/Medication Administration

_____Positive Guidance and Discipline Policy

_____Policy on the Use of Technology and Social Media

_____Confidentiality/HIPAA Policy

_____Staff Cell Phone Policy

_____Staff attendance policy

_____Conflict Resolution Policy

_____Breast feeding policy

I have read and received a copy of the Minding Miracles Employee Handbook and Employee Orientation and the specific information/policies listed above.

_____ _____

Signature Date

STAFF ORIENTATION AND DEVELOPMENT RECORD

STAFF NAME:	POSITION:	YEAR/SCHOOL YEAR:

New Hire/Annual Orientation - **Required** Topics:
Newly hired staff shall receive orientation training within 2 weeks of hire and before being left alone with children.
(up to 6 hours may be counted towards annual required staff development hours)

TOPIC	PROVIDED BY/DATE	TOPIC	PROVIDED BY/DATE
Supervising & Tracking Children		Implementing the Center's Discipline Policy	
Center Operations, Policies, and Procedures		Health Practices Including Medication Administration, Responding to Symptoms of Illness	
Group Size Limits & Primary Caregiver Responsibilities		Safe Sleep Practices to Prevent SIDS *(if applicable)*	
Recognizing and Reporting Child Abuse or Neglect		Preventing Shaken Baby Syndrome and Abusive Head Trauma *(if applicable)*	
Evacuating the Center/Using Fire Alarms/Emergency Procedures & Lockdown		Recognizing and Responding to Injuries & Emergencies (Including the Prevention of and Response to Food-Related Allergies and Other Allergic Reactions)	
Implementing the Center's Release Policy		Including Children with Special Needs into the Center's Program	
Date Orientation Completed: # of Hours for Orientation:		Staff Signature:	

Credentialed staff and *designee(s) MUST* complete a ***minimum of 20 hours*** of staff development per year.
All other staff **MUST** complete a ***minimum of 12 hours*** of staff development per year. Hours can be logged below.
RECOMMENDED TOPICS INCLUDE: Child Growth & Development, Educational & Physical Activity, Special Needs Programming, Social-emotional and Behavioral Development for young children, ADA Guidelines, and Leadership & Advocacy.
INFANT/TODDLER TRAINING IS REQUIRED FOR ALL STAFF THAT WORK WITH CHILDREN UNDER 2.5 YEARS OF AGE.

NAME/DESCRIPTION	# OF HOURS	TRAINING DATE	TRAINING SOURCE (Center; Conference; Outsource; etc.)	PRESENTER NAME

In addition to the annual staff meeting, please review the training document on our website at MMLCfamily.com. Click on 'Staff Portal' and download 'Staff Orientation and Training.' Use the training document to answer the following questions.

1. What age group do you *primarily* work with and what is the student-staff ratio for that group?

2. True/False…If an infant rolls onto their belly during nap, you must roll them back over so they are sleeping on their back.

3. Other than after using the restroom, there are many other instances when children must routinely wash their hands. Name 3:

4. When changing a child's diaper, when should you remove your gloves?

5. When creating a bleach & water solution, how much bleach is added to 1 gallon of water?

6. Name three signs that a child may be experiencing abuse.

7. If you suspect (or observe) a coworker engaging in actions that may be considered abusive, aggressive, or intimidating, what should you do?

8. Where is the emergency evacuation designated meeting place for your center?

9. What should you do if a non-parent shows up to pick up a child?

10. Are there any areas of this training of which you are unsure or feel that you need clarification/additional training?

Employee name: Signature: Date: