Prime Time Children's & Youth Activity Center

Risk Management Plan

911

8816 Donald's Way, Owings, MD 20736 301-855-2221 and 301-855-2146

POISON CONTROL CENTER – 410-529-7701 (METROPOLITAN BALTIMORE)

OR 1-800-222-1222 (MARYLAND ONLY, TOLL-FREE)

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Acknowledgement

This manual was developed as a reference document for Maryland child care centers to use in developing their own Risk Management Plan. It contains the recommended best practices for managing risks based upon practices promoted in such publications as Modern Child Care Health Practices, Caring for Our Children – National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care and the Program Administration Scale. Many of the recommended practices contained in this document may exceed regulatory requirements, which are minimum standards for health and safety. You may edit this document to fit your circumstances and center policies thus tailoring it to your own unique center.

Modern Child Care Health Practices, and Caring for Our Children – National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care are the primary guides for providing care to children in group settings. This manual does not replace or preempt, but provides guidance in implementing standards presented in these documents. Every staff member in the center should become familiar with the provisions in these documents. The full text of both documents is available on the internet at

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INTRODUCTION

Prime Time Children's Center risk management plan is a resource for all staff. This risk management plan is designed to prepare us to respond appropriately to emergent situations that may occur. This plan provides systematic guidance in how to respond to emergencies uniformly and safely.

Each staff member is responsible for knowing the location of the plan and consistently following these procedures during all situations. The risk management plan must be located in a place where it is easily accessible, in each classroom and the center office.

RISK MANAGEMENT TRAINING PROCEDURES

To ensure that each situation is met efficiently and effectively, we will review a section of this manual at each monthly staff meeting.

- All staff must attend Pediatric or child first aid and infant and child CPR training annually
- A staff person trained in CPR and first aid must be present in each classroom at all times

EMERGENCY SUPPLIES

First Aid Kit –

For fire drills and all other emergencies requiring that the building be evacuated, lead staff must take the emergency cards and kit with each class to the assigned assembly location.

- Band Aids (assorted sizes) – to cover and protect cuts or open wounds
- Flashlight (operable, may be small) – to check eyes, inside nose, throat, and ears
- Gauze pads (2”x2” or 4”x4”) – to clean, cover, and protect cuts or open wounds
- Gauze pad (large, thick) or sanitary napkin – to control bleeding or cover large wounds
- Gauze, flexible rolls (2 rolls) – to hold gauze bandages in place
- Gloves (disposable vinyl-latex are acceptable) – to protect person administering aid
- Ice Bag or Chemical Ice Pack – to control swelling when filled or activated
- Paper Towels – to clean up spills and discard
- Pocket mask/face shield for CPR – to perform rescue breathing during CPR
- Safety Pins – to secure sling in place
- Scissors (blunt tip) – to cut gauze and bandages to size
- Soap (liquid, fragrance-free) – to clean injured area
- Tape (hypo-allergenic) – to hold gauze bandages to size
- Thermometer (non-glass, non-mercury) or fever strip – to take body temperature, not rectally
- Triangular bandage (pre-made or 40”x40”x64” piece of clean cotton cloth) – to immobilize body parts as a sling or a tie for a splint; to hold dressing on large wounds
- Tweezers – to remove splinters
- Wash cloths (disposable) – to clean injured area

NOTE: First aid supplies are to be kept in sufficient quantity for the size of the childcare program. First aid supplies are to be available at the childcare facility and on all field trips.

*Additional supplies and medications for children with special health care needs must be added to the first aid kit.

Recommended Emergency Evacuation Bag Supplies –

Administrative Office	Mobile Toddlers	Preschool/Kindergarten
Blanket	Blanket	Blanket
Tarp	Tarp	Tarp
Flashlight with batteries	Flashlight with batteries	Flashlight with batteries
Radio with batteries	Radio with batteries	Radio with batteries
Paper towels	Paper towels	Paper towels
Gloves	Gloves	Gloves
First aid kit	Candy	Candy
Blood borne pathogens kit	Socks	Socks
Pen and paper		

School-Age		Infants	
Blanket	Paper towels	Blanket	Diapers
Tarp	Gloves	Tarp	Formula
Flashlight with batteries	Candy	Flashlight with batteries	Baby Bottles
Radio with batteries	Socks	Radio with batteries	Extra nipples
		Paper towels	Can Opener
		Gloves	Pacifiers
		Wipes	

Recommended Shelter in Place Disaster Kit Supplies –

- **Can opener,** for canned foods
- **Cash or traveler's checks and change**
- **Cellular telephone, radio,** battery-powered or hand crank
- **NOAA Weather Radio** with tone alert and extra batteries for both.
- **Children's activities,** books, games, puzzles, etc
- **Change of clothing,** including a long sleeved shirt, long pants, sturdy shoes, and outerwear
- **Dust mask** to filter contaminated air and plastic sheeting and duct tape
- **Emergency reference material,** such as a first aid book or information from www.ready.gov
- **Feminine supplies and personal hygiene items**
- **Fire Extinguisher**
- **First aid kit**
- **Flashlight** and extra batteries
- **Food**, at least a three-day supply of non-perishable food
- **Household chlorine bleach and medicine dropper,** add ¼ cup of bleach to 1 gallon of water to use as a disinfectant—not scented, color safe or bleaches with added cleaners.
- **Infant formula and diapers**
- **Local maps**
- **Matches in a waterproof container**
- **Mess kits and paper cups, plates and plastic utensils, paper towels**
- **Moist towelettes, hand sanitizer, garbage bags,** and plastic ties for personal sanitation
- **Paper and pencil**
- **Prescription medications and glasses**
- **Sleeping bag or warm blanket,** for each person (more, if you live in a cold-weather climate)
- **Water,** one gallon per person per day for at least three days, for drinking and sanitation
- **Whistle,** to signal for help
- **Wrench or pliers,** to turn off utilities

Emergency Records Update / Maintenance –

The director or designee periodically reviews information to insure it is current.

Emergency Information
Updates to emergency information will be submitted by parents to the office staff for update of the central records and distribution to classroom staff. *Tracy Case* is responsible for updating emergency information and checking \ replacing used supplies when monthly fire drills are performed. Fire drills are scheduled each month with varying dates and times to give all staff and children the opportunity to participate.

New Students
Tracy Case is responsible for providing information on each new enrollee to the lead teachers. *The lead teachers* are responsible for making sure new information on each child enrolled in the classroom is received and added to the classroom emergency kits.

Storage
- Emergency medical kits are to be kept in closets, in each classroom, health suite, and in the administrative offices.
- Long-term emergency supplies are stored in pantry and attics.
- Emergency kit and clipboards are to be taken on all emergencies, which include, but are not limited to, fire drills, emergency evacuations, and natural disasters.

ALLERGIES, CHRONIC MEDICAL CONDITIONS, AND MEDICATION ADMINISTRATION

Allergies and Chronic Medical Conditions

- Post allergy and chronic medical information in designated locations. Post this information inside a teacher's cabinet OR hang on the wall concealed by a cover sheet. Keep any child's medical information under the allergy and chronic medical information sheet. (See pages 9-13).
- All classroom staff must review the response procedures for each child in case an allergic reaction or other medical event should occur.
- Identified staff in each classroom must update allergy and chronic medical information when a new child is added to the class or health records are updated.
- In case of multiple allergic reactions / attacks, children should have 2 epipens.
- Response procedures to allergy and chronic medical emergencies –
  - Procedures for each child's allergy emergencies and chronic medical conditions shall be listed on the medical information sheets in the classroom; copies of the medical sheets shall be accessible with posted allergy sheets.
  - the closest staff person to the child shall immediately initiate procedures to respond to the emergency or event.
  - If emergency care is needed, staff shall call 9-1-1 and notify the administrative office

- An injury report shall be completed; a copy of the report shall be given to the child's parent, the administrative office, and placed in the student record

- Notification procedures for parents or guardians – When a child has an allergic reaction or medical emergency, follow the notification procedures in the injury section of this manual
- Informing substitutes, floaters, etc. shall be done by having contingent staff review the allergy and chronic medical information pertinent to that particular classroom and date and sign off that the information has been read **each time they enter a classroom**.

Food Allergy Action Plan

Student's Name:_____ **D.O.B:**_____ **Teacher:**_____

Place Child's Picture Here

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:		**Give Checked Medication**:** (To be determined by physician authorizing treatment)	
▪	If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine	☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
▪ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
▪ Heart†	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
▪ Other†	_____	☐ Epinephrine	☐ Antihistamine
▪	If reaction is progressing (several of the above areas affected), give	☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____) . State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____
c. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

TRAINED STAFF MEMBERS

1. _____ Room _____

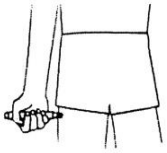
2. _____ Room _____

3. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

- **Pull off gray activation cap.**

- **Hold black tip near outer thigh (always apply to thigh).**



- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions

- **Pull off green end cap, then red end cap.**

- **Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.**

<u>SECOND DOSE ADMINISTRATION</u>:
If symptoms don't improve after 10 minutes, administer second dose:

- **Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.**
- **Slide yellow or orange collar off plunger.**

- **Put needle into thigh through skin, push plunger down all the way, and remove.**

Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

The Food Allergy & Anaphylaxis Network

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

Medication Administration (topical and oral)

Staff will administer medication to children with written approval of the parent and an order from a health provider for a specific child or a specific condition for any child in the facility for whom a plan has been made and approved by the director or nursing staff. Because administration of medication poses a safety hazard, medication administration in childcare will be limited. The first dose of medication should be given at home to see if the child has any type of reaction. Parents or legal guardians may administer medication to their own child during the child care day.

All topical medication including by not limited to diaper crème, sunscreen, and lotion. Must be administered by staff. For older children they may apply topical medications; however, staff should be present during application. Every topical medication application must also be recorded on the topical medication log sheet.

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care
MEDICATION AUTHORIZATION FORM

Regulations permit child care providers to give prescription and non-prescription medication to children in care under certain conditions with prior written permission (Section A) from the child's parent/guardian. A separate form is needed for each prescription or non-prescription medication to be administered to the child.

PRESCRIPTION MEDICATIONS AND NON-PRESCRIPTION MEDICATIONS: Prescription medications must be in a container labeled by the pharmacy or physician with the child's name, dosage, and expiration date. At least one dose of prescription medication must be given at home prior to the child's arrival at the childcare facility. **Non-prescription** medications must be in the original manufacturer's container labeled with instructions for dosage and expiration date. Except for acetaminophen (Tylenol) and other topical medications, a provider may administer only one dose of non-prescription medication to a child per illness unless a licensed health practitioner provides written approval (Section B) for the administration of the non-prescription medication and the dosage. All medication shall be administered according to the instructions on the label of the medication container or a licensed health practitioner's written instructions, whichever are more recently dated. **An adult should bring the medication to the center/provider.**

Name of Child: _____ **Date of Birth**: _____ **Age**: _____

SECTION A: (To be completed by parent/guardian for any medication to be administered to the child.)

MEDICATION	DOSAGE	WHEN TO GIVE	DATES TO ADMINISTER	
			START	STOP
This medication is being given for the following condition(s):				
Note any side effects of this medication:				
Note any reasons or conditions when this medication should be stopped or not given:				
I/We request that designated childcare providers/or staff administer medication as noted on this form. I/We certify that I/We have legal authority to consent to medical treatment for the child named above, including administration of medication while in childcare. I/We understand that at the end of the year or if the medication is discontinued or expired, an adult must pick up the medication, otherwise it will be discarded. **Signature of Parent/Guardian: _____ Date: _____**				

SECTION B: (To be completed by the Health Practitioner for approval to administer non-prescription medication more than one dose per illness, other than acetaminophen (Tylenol) or other topical medication.)

MEDICATION	DOSAGE	WHEN TO GIVE	DATES TO ADMINISTER	
			START	STOP
This medication is being given for the following condition(s):				
ADDITIONAL INSTRUCTIONS:				
Note any side effects of this medication:				
Note any reasons or conditions when this medication should be stopped or not given:				
Health Practitioner's Signature:		**Date:**		
Print, Type or Stamp: Name, Address, Phone number and Title of Health Practitioner:				

MEDICATION ADMINISTERED

Except for the application of a non-prescription diaper rash treatment, sunscreen, or insect repellent supplied by the child's parent, each administration of a medication to the child shall be noted in the child's record. Keep this form in the child's permanent record while the child remains in the care of this provider or facility.

Child's Name:			**Date of Birth:**	
Medication:				
DATE	**TIME**	**DOSAGE**	**REACTIONS OBSERVED (IF ANY)**	**SIGNATURE**

Procedures for Storing Medication

- Medications must **ALWAYS** be in the original container and labeled with:
  1. the child's name,
  2. the dosage, and
  3. the expiration date

- Stored as directed by the manufacturer, the dispensing pharmacy, or the prescribing physician; and discarded or returned to the child's parent upon expiration or discontinuation.

- All medications shall be stored to make them inaccessible to children in care but readily accessible to the provider, substitute, or additional adult.

- Medications are to be returned to the parent or discarded upon reaching the expiration date.

- Staff must document medication administered at the Center on the back of the medication administration form (see page 13).

- Staff will receive training annually on the administration of medications and documentation; staff will be informed of any updates or changes in procedures as they occur; new employees will receive training during orientation.

- Staff will not administer any drug that affects a child's behavior except as prescribed by the child's health care provider with special instructions for its use.

- Parents cannot leave any ointment, salves, vitamins, or medications in children's diaper/lunch/tote bags at any time.

Child Health Files –

- Access to children's health information is confidential. Posted information must be in secure areas (e.g., inside cabinet doors, in areas away from parents and visitors).
- The health records and emergency cards must accompany a child to a medical facility.
- After an emergency situation is stabilized, parents should be contacted, or if another staff person is available, parents should be notified of the incident while care is being provided to the child.
- Children with special health care needs will have a care plan completed (see page 15).

* For more extensive information regarding first aid for young children, refer to the latest edition of ***Pediatric First Aid for Caregivers and Teachers***, American Academy of Pediatrics, Jones and Bartlett Publishers, Massachusetts.

SPECIAL CARE PLAN

Facility Name: _____
Address: _____

Child's Name: _____ Date of Birth: _____ Parent's Name: _____

1. Describe the child's special need during care: _____

_____

2. Child's present functional level and skills: _____

_____

3. What emergency or unusual episode might arise while the child is in care? How should the situation be handled? _____

_____

(Prepare and maintain information on the "Emergency Form of children with Special Needs" available from the American Academy of Pediatrics, www.aap.org)

4. Reasonable accommodation the facility must provide for this child: _____

_____

a) Describe special instructions for sleeping, toileting, diapering, or feeding?_____

_____

b) Will the child require medication while in care? Attach physician's medication instructions.

_____

c) Are special emergency and/or medical procedures required? If so, what are they?

_____

What special training, if any, must staff have to provide that care?

_____

d) Are special materials/equipment needed?

_____

5. Other specialists \ therapists, working with the child (include contact number): _____

Primary Physician: _____ Phone: _____

Address: _____

Childcare facility case manager: _____ Phone: _____

I, _____ give my permission for _____ to release to
(parent, legal guardian name) (professional \ facility)

_____ the following information _____.
(Child care facility name) (screenings, tests, diagnoses and treatment, or recommendations)

The information will be used solely to plan and coordinate the care of my child and will be kept confidential and may only be shared with my child's caregivers.

Name of Child: _____ Date of Birth: _____

Address: _____ City \ State: _____ Zip Code: _____

Parent \ Legal Guardian Signature: _____ Date: _____

Witness Signature _____ Date: _____

Staff to be contacted for additional information _____ Phone: _____

HEALTH MONITORING -

Daily Health Checks

Designated staff shall complete the following steps for every child when they arrive at the center.

- Check each child for skin rashes, increases in body temperature (100 or higher), complaints of pain or discomfort, bruises, cuts, etc. (See Signs and Symptoms of Child Abuse and Neglect on page 17.)
- If an illness or injury is identified, use the Signs of Ill Children chart on page 19 and the Communicable Disease Summary: Guide for Schools and Child Care Settings (available in the child care office).
- If there are signs of injury that occurred prior to the child's arrival at the center, the parent shall write up the incident, sign, and date it. If the injury is noticed AFTER the parent has left, the staff will write up the injury and contact the parent about the injury. The parent should fax a statement to the center about the injury.
- Take the ill child to the designated isolation areas until the parent arrives.
- Complete incident report for exclusion.
- Parents should pick up the child within one hour of notification.
- The child should remain home until he/she is symptom free for at least 24 hours.

Entry and Exit Procedures

- Family expectations when bringing children to school (include the following):
  - Parents must park in designated areas for drop-off and pick-up of children (avoid parking in neighbor's driveways or otherwise obstructing other vehicles).
  - All vehicles must be turned off while the child(ren) is brought into the center. Other children may not be left in vehicles without adult supervision.
  - Parents will walk children to their classrooms.
  - Parents follow the established procedures of their child's room for putting away coat, lunch, and tote bags and will notify the teachers of any illness and/or medications given or any problems their child may be experiencing.
  - Parents will sign their children "in" in the morning and out when leaving the center using the appropriate documentation procedure.
  - Children must be placed in car safety seats prior to leaving the parking lot.
  - Parents will ensure that no ointments, salves, vitamins, or medications are in the child's diaper/lunch/tote bag.

- Teaching staff expectations when children and parents come to the center
  - Greet children and parents
  - Receive information about children's feelings, experiences prior to arrival
  - Complete the daily health check (see above)
  - Check children's diaper/lunch/tote bags for any ointments, salves, vitamins, or medications. If found remove and store with other medications. Return to parents at pick up.

Signs and Symptoms of Child Abuse, Neglect, and Mental Injury

The following information is provided to familiarize you with physical and behavioral indicators that are often associated with child abuse, neglect, and mental injury. Please note that the list is not inclusive. Nor does the presence of any of these indicators necessarily mean that a child is being abused or neglected or is a victim of mental injury. However, the repeated occurrence of an indicator, the presence of several indicators in combination, or the appearance of serious injury or harm should alert you to the possibility of abuse or neglect.

Possible indicators of child physical abuse include:

Physical Indicators

- Unexplained welts or bruises (especially facial bruises on infants), burns, fractures, lacerations, abrasions, human bite marks.
- Appearance of injuries after school absence, weekend, or vacation.
- Absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair pulling.
- Cigar or cigarette burns, especially on feet, hands, or buttocks.
- Burns or cuts patterned like an electric burner, iron, belt buckle, etc.
- Immersion burns indicating dunking in a hot liquid (glove-like or sock-like burns on hands or feet, doughnut-shaped burns on buttocks).
- Rope burns that indicate confinement (on arms, legs, neck, and torso).

Behavioral Indicators

- Easily frightened or fearful of adults and parents.
- Wary of physical contact initiated by parents or anyone else.
- Apprehensive when adults approach another crying child.
- Constantly on the alert for danger, is guarded and distrustful.
- Destructive to self or others.
- Extremes of behavior – aggressive and withdrawn.
- Runaway or delinquent behavior.
- Reporting unbelievable reasons for injuries.
- Cautious when asked about the sudden appearance of an injury, looks at parent for an answer.
- Wears clothing that is clearly meant to cover the body when not appropriate.
- Seems afraid or reluctant to go home.

Possible indicators of child sexual abuse include:

Physical Indicators

- Difficulty in walking or sitting.
- Torn, stained or bloody underwear.
- Genital/anal itching, pain, swelling or bleeding or burning.
- Frequent urinary tract or yeast infections.
- Venereal disease.
- Pregnancy.
- Frequent psychosomatic illnesses.

Behavioral Indicators

- Extreme fear for no apparent reason.
- Inability to trust.
- Anger and hostility.
- Inappropriate sexual behavior.
- Depression.
- Guilt or shame.
- Sudden drop in school performance.
- Somatic complaints.
- Sleep disturbances (nightmares, bed wetting, sleeping in clothing)
- Eating disorders.
- Withdrawal, fantasy, or infantile behavior.
- Suicidal gestures or statements.
- Running away (especially for females).
- Fire setting; fascination with fire.

Communicable Diseases

- For information on communicable diseases, go to ***Communicable Disease Summary: A Guide for Schools and Child Care Settings*** (www.edcp.org).

- When a child is diagnosed with a communicable disease a notice will be given to all parents of children in the class. The notice will list the:
  1. Name of the disease,
  2. Date the symptoms were first observed,
  3. Date of diagnosis and the incubation period.

- Due to confidentiality, the staff will not reveal the name of the child.

- Staff shall urge parents to consult their child's physician for advice about precautions to take with their own child.

- Some communicable diseases must be reported to public health authorities so that control measures can be used. The director \ assistant director will make the information available to child care staff and a copy of the list will be shared with each parent and legal guardian at the time a child is enrollment in the center.

- Annually, the policy will be distributed to families and staff regarding notifying office staff within 24 hours after a child or staff member has developed a known or suspected communicable disease. Parents, guardians and staff will also inform the director \ assistant director if any member of their immediate household has contracted a reportable communicable disease.

- A list of ***Reportable Diseases*** has been compiled by the Maryland Department of Health and Mental Hygiene (see ***Communicable Disease Summary: A Guide for Schools and Child Care Settings*** in the office or on the Internet at www.edcp.org.

- While respecting the confidentiality requirements of medical information, the director/ assistant director will notify the appropriate health department authority about any suspected or confirmed reportable disease among children, staff, or family members of the children and staff.

- Families of children who may have been exposed to a child with a communicable disease or reportable condition will be informed about the exposure according to the recommendations of the local health department.

Signs of Illness in Children

- If a child in your care exhibits any of the following common signs of acute illness, you should contact the child's parent immediately and try to keep the child separated from the other children until the parent arrives.

General Appearance	• Excessive crying, clinginess, fussiness • Doubled over in pain, unable to move • Listless, lethargic, unresponsive • Vomiting, diarrhea • Feverish • Seizure (although child has no history of seizure disorder)
Breathing	• Fast, shallow, gasping breaths • Difficulty breathing, wheezing • Sucking in around ribs • Flaring nostrils • Persistent or uncontrollable coughing
Skin	• Pale, grayish, flushed, yellowish skin • Hot or cold and clammy skin • Skin rashes, sores, swelling, or bruising • Scratching at skin or scalp • Skin doesn't spring back when pinched
Eyes, Nose, Ears, and Mouth	Eyes swollen, red, crusty, watery, yellowish, or sunken • Nose congested or runny • Ears draining pus or blood • Pulling at ears • Mouth or lips with sores • Sore throat, difficulty swallowing • Excessive drooling
Appearance of Urine/Stool	• Gray or white stool • Black or blood-flecked stool • Unusually dark or tea-colored urine

- Children who are carriers of a communicable disease, who pose an increased risk to themselves or other children or adults with whom they come into contact, may not be admitted to the center.

- If a communicable disease is identified during the day, contact the parent to come and remove the child from care until they are no longer contagious.

Return after Illness Policy

A child may return to the center after an illness if they meet the ***Communicable Disease Summary: A Guide for Schools and Child Care Settings*** (www.edcp.org) conditions for return or have not had a fever of 100 or higher, vomiting or diarrhea for at least 24 hours and does not exhibit exclusion symptoms on Signs of Illness chart on page 19.

Children may attend the center if they do not have a fever higher than 101, and are not experiencing vomiting, diarrhea, or any signs of illness listed on the chart on page 19.

Illness and Injury Reporting

- Health records and emergency cards are to be taken if injury or illness occurs requiring transporting a child to the hospital.
- A staff person is to accompany a child being transported to the hospital when a parent or authorized family member is unavailable.
- Any time a child is taken to seek immediate medical attention, the center's Office of Child Care licensing specialist will be notified within 24 hours.
- Staff will fill out the Incident Report Form and have parent/guardian sign it when they arrive to pick the child up.
- A copy of the /Incident Report will be filed in the child's permanent file.
- Examples of situations which may require immediate medical attention are located on page 21. Insert Appendix L from Model Child Care Health Policies

Identifying an Illness

- Staff evaluates the child's symptoms. The Signs of Illness in Children table on page 18 and the ***Communicable Disease Summary: A Guide for Schools and Child Care Settings*** (www.edcp.org) will be used to identify the illness.

- Based on the evaluation, staff may discuss the symptoms with the child and make a call to the parent to gather more information.

- Staff will notify the Director if symptoms meet center standards for isolation or removal from the classroom, see page 19 for symptoms to be excluded from the classroom.

- Director will notify the child's parents/guardian for pick up if the child is isolated from other children and should be removed from the center.

- Director will monitor the child until pick up.

- A sample document for tracking attendance and documenting illnesses is located on page 22.

Situations That Require Medical Attention Right Away

In the two boxes below, you will find lists of common medical emergencies or urgent situations you may encounter as a child care provider. To prepare for such situations:

1. Know how to access Emergency Medical Services (EMS) in your area.
2. Educate Staff on the recognition of an emergency.
3. Know the phone number for each child's guardian and primary health care provider.
4. Develop plans for children with special medical needs with their family and physician.

At any time you believe the child's life may be at risk, or you believe there is a risk of permanent injury, seek immediate medical treatment.

Call Emergency Medical Services (EMS) immediately if:

- You believe the child's life is at risk or there is a risk of permanent injury.
- The child is acting strangely, much less alert, or much more withdrawn than usual.
- The child has difficulty breathing or is unable to speak.
- The child's skin or lips look blue, purple, or gray.
- The child has rhythmic jerking of arms and legs and a loss of consciousness (seizure).
- The child is unconscious.
- The child is less and less responsive.
- The child has any of the following after a head injury: decrease in level of alertness, confusion, headache, vomiting, irritability, or difficulty walking.
- The child has increasing or severe pain anywhere.
- The child has a cut or burn that is large, deep, and/or won't stop bleeding.
- The child is vomiting blood.
- The child has a severe stiff neck, headache, and fever.
- The child is significantly dehydrated: sunken eyes, lethargic, not making tears, not urinating.

After you have called EMS, remember to call the child's legal guardian.

Some children may have urgent situations that do not necessarily require ambulance transport but still need medical attention. The box below lists some of these more common situations. The legal guardian should be informed of the following conditions. If you or the guardian cannot reach the physician within one hour, the child should be brought to a hospital.

Get medical attention within one hour for:

- Fever in any age child who looks more than mildly ill.
- Fever in a child less than 2 months (8 weeks) of age.
- A quickly spreading purple or red rash.
- A large volume of blood in the stools.
- A cut that may require stitches.
- Any medical condition specifically outlined in a child's care plan requiring parental notification.

Approved by the American Academy of Pediatrics Committee on Pediatric Emergency Medicine, January 2001.

DAILY ATTENDENCE REPORT 'SNAPSHOT' Today's Date: ___|___|_____

Pass Around at 9:45AM – Due in Office at 10:30AM (*If child arrives after attendance let the office know*)

CHILD'S NAME	**REASON FOR ABSENCE IF KNOWN**	NUMBER of DAYS OUT	# CHILDREN PRESENT
INFANT 1 – ROOM 1			
INFANT 2 – ROOM 2			
TODDLER 1 – ROOM 3			
TODDLER 2 – ROOM 4			
TWO'S 1 – ROOM 5			
TWO'S 2 – ROOM 6			
THREE'S – ROOM 7			
FOUR'S – ROOM 8			

This is a snapshot at the time you receive the form. Please let the office know of changes.

Identifying an Injury-

- Staff will evaluate the child's injury and use appropriate first aid measures.
- Teacher will notify designated staff if the injury is serious.
- For a serious injury, designated staff will call 9-1-1, if necessary, and contact the parent or guardian.
- Staff will alert the child's teacher if the injured child is enrolled in another class.
- All injuries, no matter how slight, are documented on the appropriate form.
- Parents will be contacted when a child:
  1. Has any injury that draws significant blood,
  2. Has a head injury, or
  3. Has been bitten and the skin is broken – because biting is a normal expression of emotion at 0–36 months age we will not reveal the name of the biter due to confidentiality.
- If the child is taken to the hospital, a staff person will accompany the child and take the child's emergency information with them.

Other Medical Concerns (Blood Borne Pathogens)

Staff will follow the standard precautions for child care recommended by the ***Centers for Disease Control and Prevention*** in handling any fluid that might contain blood or other body fluids. Standard precautions require treating all blood, fluids that may contain blood or blood products, and other bodily fluids as potentially infectious. The instructions for implementing standard precautions are:

- Use a barrier such as nonporous gloves (e.g., latex or vinyl) and a sufficient quantity of paper or cloth to clean it up without hand contact with the spilled material.
- Spills of body fluids, feces, nasal and eye discharges, saliva, urine, and vomit should be cleaned up immediately.
- Be careful not to get any of the fluid you are handling in your eyes, nose, mouth or any open sores you may have.
- Clean and disinfect with 1 tablespoon of bleach to 1 quart of cold water any surfaces, such as countertops and floors, on to which body fluids have been spilled.
- Discard fluid contaminated material in a plastic bag that has been securely sealed.
- Mops used to clean up body fluids should be cleaned, rinsed with a disinfecting solution, wrung as dry as possible, and hung to dry completely.
- Wash your hands after cleaning any spill.

The director \ assistant director is responsible for: developing the Blood Borne Pathogens Exposure Plan (required by the United States Occupational Safety and Health Administration (OSHA) for any facility with employees), ensuring all staff members are trained in ways to protect themselves, and ensuring that the facility follows the recommendations for immunization against Hepatitis B for those whose job includes the risk of exposure to blood.

The facility's Blood Borne Pathogens Exposure Plan will conform to the requirements reflected in the model plan provided by OSHA.

PERSONAL SAFETY AND INJURY PREVENTION

Care of Pets

Pets and children must be supervised at all times when contact is allowed. Hands must be washed after handling any pet or items that have been used or touched by the pet. Any pet required to have shots and be licensed by local authorities must have evidence on file at the center before the pet is allowed on the premises.

Staff are responsible for checking that the appropriate care instructions for pets are followed.

- Any center or visiting pet or animal must be in good health, show no evidence of carrying any disease, and be a friendly companion for children.
- Dogs, cats, and other furry animals will be immunized for any disease which can be transmitted to humans and will be maintained on a flea, tick, and worm control program.
- Animals not permitted in the center include: ferrets, turtles or other reptiles that can carry salmonella, birds of the parrot family, and any wild or dangerous animals.
- Pets will be kept clean and housed in clean living spaces.
- Children will not be allowed access to the pet food or excrement.
- Animal tanks and cages will be secured in a manner that prevents children from climbing on the structure and prevents the structure from tipping over.
- Child and staff will use proper hand washing procedures after handling animals.
- In the event of an animal bite or scratch, procedures for first aid and notification of parents or guardians will be followed.

Children and Staff must wash hands after handling pets!

Adapted from Model Child Care Health Policies, 4th Edition

Care of Plants

All staff should follow the safety guidelines listed in the Indoor \ Outdoor Plant Safety guide (see page 25).

Indoor \ Outdoor Plant Safety

Plants

The following is a list of toxic plants often found in homes or backyards that should be removed or kept out of children's reach. However, it is not a complete list of all poisonous plants. If you are unsure whether a plant in your home or yard may be poisonous, you should call the **Maryland Poison Control Center at 1-800-222-1222** for information about the plant.

NOTE: The following plants are listed by their most common names. Several of these plants are also often known by other names, which are italicized and shown in parentheses.

Garden/Outdoor Plants

Autumn Crocus
Azalea
Boxwood
Buttercups
Caladium
Castor Bean
Chinaberry
Daffodil
Foxglove *(Amaryllis)*
Giant Elephant Ear
Gladiolus
Holly
Hyacinth
Hydrangea
Iris
Ivy
Jack-in-the-Pulpit
Jimson Weed *(Datura)*
Jonquil
Juniper
Larkspur *(Delphinium)*
Lantana
Ligustrum
Lily of the Valley
Mayapple
Mistletoe
Monkshood *(Aconite)*
Morning Glory
Mountain Laurel
Mushrooms - certain ones
Narcissus
Nightshade/Deadly Nightshade *(Belladonna)*
Oleander
Poison Hemlock/Ivy/Oak /Sumac
Pokeweed
Potato - sprouts and green parts
Rhododendron
Rhubarb - leaves
Skunk Cabbage
Tobacco
Tomato - green parts
Yew *(Taxus)*

House/Indoor Plants

Arrowhead
Bird of Paradise
Caladium
Candelabra Cactus *(Euphorbia)*
Castor Bean
Cyclamen
Dumbcane *(Dieffenbachia)*
Eucalyptus
Ivy
Jequirty Bean *(Rosary Pea)*
Jerusalem Cherry *(Solanus)*
Lily of Peace
Mistletoe
Oleander
Pencil Cactus
Philodendron
Poinsettia
Rhododendron

Crib Safety

Infant room staff must review the **Consumer Product Safety Commission's Crib Safety Tips** below (Document #5030). For more information or product recall, go to www.cpsc.gov.

For infants under 12 months of age, follow these practices to reduce the risk of SIDS (Sudden Infant Death Syndrome) and prevent suffocation:

- Place baby on his/her back in a crib with a firm, tight-fitting mattress (there should be no gaps between the mattress and the sides of the crib).
- Do not put pillows, quilts, comforters, sheepskins, pillow-like bumper pads or pillow-like stuffed toys in the crib.
- Consider using a sleeper instead of a blanket.
- If you do use a blanket, place baby with feet to foot of the crib. Tuck a thin blanket around the crib mattress, covering baby only as high as his/her chest.
- Use only a fitted bottom sheet made specifically for crib use.

Check your crib for safety – there should be:

- A firm, tight-fitting mattress so a baby cannot get trapped between the mattress and the crib.
- No missing, loose, broken or improperly installed screws, brackets or other hardware on the crib or mattress support.
- No more than 3 3/8th inches (about the width of a soda can) between crib slats so a baby's body cannot fit through the slats; no missing or cracked slats.
- No corner posts over 1/16th inch high so a baby's clothing cannot catch.
- No cutouts in the headboard or foot board so a baby's head cannot get trapped.

For mesh-sided cribs or playpens, look for:

- Mesh less than ¼ inch in size, smaller than the tiny buttons on a baby's clothing.
- Mesh with no tears, holes or loose threads that could entangle a baby.
- Mesh securely attached to top rail and floor plate.
- Top rail cover with no tears or holes.
- If staples are used, they are not missing, loose or exposed.

Field Trips

- Parental Consent – a signed parental consent form must be received for every child prior to taking them on a field trip. Consent forms for outings may be obtained from office staff.

- A first aid kit, emergency contact information, and emergency transport authorization information for the group will be taken on all trips. Medication or equipment for children with special health care needs must also be taken on all trips.

- Children will be counted when entering and leaving the classroom.

- The following precautions will always be performed prior to leaving the center on a field trip:

    - Parents sign their children in upon arrival at the beginning of the day or program.
    - Staff takes attendance at the start of the day or program and will ensure that all children are signed in.
    - A child shall be in the presence of a staff member at all times.
    - Staff takes the Attendance Sheet and a mobile phone or walkie-talkie with them whenever they leave the classroom.

- Once on the bus OR when gathered at a meeting sight, the teachers will call the children by name and touch their heads to take attendance PRIOR to leaving or beginning a walk/tour. For very young or non-verbal children, the teaching staff will ensure that the children in their care are accounted for.

- Safety Seats – refer to Maryland Kids in Safety Seats (K.I.S.S) for proper seating requirements for infants and toddlers (see pages 28-31 for further information). Infants and toddlers should not ride on buses without safety seats.

- Preventing lost or missing children – A staff member must be assigned responsibility for performing a 'sweep' of the area and vehicle to ensure that no child is overlooked.

- Every 20 children must have one adult trained in CPR and First Aid assigned to them.

- Child Identification – all children will be dressed in the center t-shirt or have an identifying label on their clothing for easy identification. ***The child's name should not be on the label.*** The center name and telephone number should be visible.

- Once arriving (when taking a bus or other means of transportation), if children remain with their entire class OR if the class is split up into smaller groups, a staff member will be assigned to each group and will have a list of the children's names.

- Every 15 minutes, the staff member will ensure that all of the children within that particular group are present.

- Before departing on a bus, the teachers will call children by name to take attendance.

- Once the bus arrives back at the center, the parents will sign their children out on the Attendance Sheet before taking their children home.

- If children are departing with their parents from the field trip site, the parents will sign their children out on the Attendance Sheet.

MARYLAND KIDS IN SAFETY SEATS (K.I.S.S.)

About KISS

Since the 1980s, Maryland Kids in Safety Seats (KISS) has been the state's lead agency in child passenger safety. KISS is housed in the Maryland Department of Health and Mental Hygiene and funded by the Department of Transportation. Our mission is to help reduce the number of needless injuries and deaths by educating the public on child passenger safety. The goal of KISS is to help people use safety seats correctly each time a child rides in a car. KISS works to achieve these goals by:

- Educating the public on the state's child passenger safety law
- Offering literature and program materials for Maryland residents
- Providing training and technical assistance in child passenger safety throughout the state

NewsNotes

KISS produces a newsletter called ***NewsNotes***, which discusses issues and challenges within child passenger safety. The newsletter includes new product information, safety seat recalls, as well as program updates. It also keeps readers abreast of the many nuances within the field. Contact us, if you would like to be added to our mailing list.

KISS Rents Safety Seats, Too!

KISS coordinates loaner sites throughout the state which offer seats at a low cost to families who otherwise can't afford them. Call KISS to locate a program in your area: 1-800-370-SEAT or (410) 767-6016.

KISS Helpline (1-800-370-SEAT)

KISS provides a helpline to the public. Contact KISS to find out:

- types of safety seats available
- how to properly install safety seats
- about safety seats and air bags
- seatbelt safety tips
- safety seat recalls
- how to schedule a training, presentation, or seat check

KISS email: **kiss@dhmh.state.md.us**
KISS online: www.mdkiss.org

IMPORTANT NOTE! As of October 1, 2003, Maryland's Child Passenger Safety Law requires all children who are **younger than 6 years old, regardless of weight**, or who weigh **40 pounds or less**, **regardless of age**, to be secured in a federally approved child safety seat according to the safety seat and vehicle manufacturer's instructions.

Selecting the Appropriate Seat for Your Child

INFANTS
Place your baby in the back seat, rear-facing until they are one year and weigh at least twenty pounds. Choose an infant carrier used with or without a base or a convertible seat, preferably with a five-point harness. When the child nears one year or 20lbs., look for convertible seats with an upper weight limit of 30 pounds rear facing. Never put your baby in the front seat if your vehicle has a passenger-side air bag.

TODDLERS
Use a fully upright, forward-facing child seat after the child reaches 1 year old and weighs between 20 and 40 pounds. Read the instructions to learn how to install the safety seat and adjust the harness around the child.

PRE-SCHOOLERS
It is "best practice" for a child to remain in a safety seat with a harness system until 40 pounds. After 40 pounds, it is time for a booster seat to raise the child so that the vehicle lap and shoulder belt fit correctly. Use a booster seat until your child weighs 60 to 80 pounds, can bend his or her legs over the seat and is about four feet, six inches tall.

SCHOOL AGE CHILDREN
Many school age children should remain in booster seats (see pre-schoolers). For proper restraint make sure the lap belt fits low over the top of the thighs and the shoulder belt is across the chest. Never place the shoulder belt under the arm or behind the back. The safest position for a child is in the back seat.

Safety Belt Safe U.S.A Five-Step Test

1. Does the child sit all the way back against the auto seat?
2. Do the child's knees bend comfortably at the edge of the auto seat?
3. Is the lap belt on the tops of the thighs?
4. Is the shoulder belt centered on the and chest?
5. Can the child stay seated like this for the whole trip?

If you answered "no" to any of these, your child needs a booster seat to ride safely in the car.

Frequently Asked Questions

Q.: Which safety seat is the best?
A: The best safety seat is one that you can afford, that fits your child and your car, and that you can use correctly each time. There are several different brands of child safety seats. Maryland KISS does not endorse a particular brand. All safety seats are certified by their manufacturers to meet Federal Motor Vehicle Safety Standard 213. Since compatibility between safety seats and vehicles varies, it is a good idea to try and install the safety seat in your car before making a purchase. Remember to follow both the child safety seat and vehicle manufacturer's instructions.

Q: When can I turn my infant around to the forward-facing position?
A: The American Academy of Pediatrics recommends that infants remain in the rear-facing seating position until reaching **at least one year and at least 20 pounds**. Many safety seats go up to 22 pounds in the rear-facing position. However, some infants reach 20 pounds well before the age of one year. In this case, you will need to look for a safety seat that has a higher weight limit for the rear-facing position. There are a few options for seats that can accommodate larger babies up to 30 or 35 pounds rear facing:

- Britax Roundabout
- Century Smart Move (manufactured after 3-31-97)

- Bravo, Accel, Encore (manufactured after 5-1-00)
- Ovation (manufactured after 5-1-00)
- Cosco Touriva (manufactured after 1-99),
- Alpha Omega (manufactured after 9-1-99),
- Olympian (manufactured after 9-1-99),
- Touriva (Regal Ride) (manufactured after 9-1-99),
- Triad, Evenflo Horizon, Secure Choice, Medallion (manufactured after 1-4-99),
- Secure Advantage, Town Country, Ultara (manufactured after 9-1-99)
- Safeline Sit-n-Stroll
- Fisher Price Safe Embrace

Q: Why should children sit in the back seat?
A: Airbags save lives when used properly; however, at least 43 children have been killed in crashes when air bags deployed in front of them. Airbags deploy quickly and with great force. Most children under 13 can be at great risk in the front seat position, especially if they are not properly restrained. The National Highway Traffic Safety Administration recommends that all children under 12 ride in the back seat.

A recent study by the Insurance Institute for Highway Safety found that children restrained in the back of the car had a 38% lower death rate than those in front of the vehicle.
Drivers, make sure that you and everyone who rides with you are properly restrained:

- Small children should ride in an approved restraint system appropriate for their weight, height, and age
- Wear both the lap and shoulder belt
- Be sure that the shoulder belt is worn correctly over the collarbone, not behind the back.
- The lap belt should be low and snug on the hips.

Q: When should I put my toddler into a booster seat? What's the best way to protect my preschooler?
A: Finding the best way to buckle up a toddler can be confusing. It is very important that parents recognize boosters as the best option for children over 40 pounds. However, do not push your child out of a convertible or toddler seat too soon. A child should remain in a child safety seat with a harness as long as he/she fits, which means until:

- the child has exceeded the weight limit of the seat, usually 40 pounds
- the/she has grown too tall for the seat (ears are above the back of the car seat)
- the shoulders are above the highest strap slots

If any of these apply, the next step is to move to a booster. Most 40 pound children are not tall enough for a combination lap and shoulder belt to fit properly (across the shoulder and low on the hips). In addition, many children do not sit still enough to keep the lap belt positioned low on the hips. Belts that ride up on the abdomen can cause serious injury in the event of a crash. Booster seats are designed to improve the fit of safety belts. Most children will get better protection by using a booster seat with a lap-shoulder belt than a lap-shoulder belt alone. Most children should remain in a booster seat until they can properly fit into the vehicle restraint correctly, which means until:

• the child is approximately 80 pounds and 4 ½ feet tall
• the child can sit up straight with his/her legs bent over the edge of the seat
• the lap belt fits low and tight across the top of the thighs, not up on the belly
• the shoulder belt is across the shoulder and chest

One Minute Safety Seat Checklist

Source: National Highway Traffic Safety Administration
www.nhtsa.dot.gov/people/injury/childps/ChilSS/OneMinuteChecklist/Index.html

Using a safety seat correctly makes a big difference. A child safety seat may not protect a child in a crash if it isn't used correctly and installed properly in your vehicle. *Take a minute to Check To Be Sure*...

- All children age 12 and under should ride properly restrained in the back seat!!!
- Never place a child safety seat in the front seat where a front mounted passenger air bag is present.

Do You Have and Understand the Instructions?

- Always read the child seat use and installation instruction manual.
- Read your vehicle owner's manual seat belt and child seat installation section.

Does Your Child Ride in the Correct Safety Seat?

- Infants, from birth to about age one, and at least 20 pounds should ride in the back seat in a rear facing safety seat.
  - Harness straps should be at or below the infant's shoulders.
  - Harness straps should fit snugly. The straps should lie in a relatively straight line without sagging.
  - The harness chest clip should be placed at the infant's armpit level. This keeps the harness straps positioned properly.

- Infants weighing 20 pounds or more before one year should ride in a safety seat rated for heavier infants (some convertible seats are rated up to 30-35 pounds rear facing).
- Children over one year and at least 20 pounds may ride forward facing in the back seat. Children should ride in a safety seat with full harness until they weigh about 40 pounds.
  - Harness straps should be at or above child's shoulders.
  - Harness straps should be threaded through the top slots, in most cases.
  - Harness should be snug. Straps should lie in a relatively straight line without sagging.
  - Harness chest clip should be at the child's armpit level, which helps keep the harness straps positioned properly on the child's shoulders.

The Lower Anchors and Tethers for Children (LATCH) System is designed to make installation of child safety seats easier by requiring child safety seats to be installed without using the vehicle's seat belt system. As of September, 1999, all new forward facing child safety seats (not including booster seats) have to meet stricter head protection requirements, which calls for a top tether strap. This adjustable strap is attached to the back of a child safety seat. It has a hook for securing the seat to a tether anchor found either on the rear shelf area of the vehicle or, in the case of mini-vans and station wagons, on the rear floor or on the back of the rear seat of the vehicle. As of September 2000, all new cars, minivans, and light trucks have this tether anchor.

As of September 2002, two rear seating positions of all new cars, minivans, and light trucks come equipped with lower child safety seat anchorage points located between a vehicle's seat cushion and seat back. Also, all new child safety seats will have two attachments which will connect to the vehicle's lower anchorage attachment points. Together, the lower anchors and upper tethers make up the LATCH system.

National Highway Traffic Safety Administration

Food Safety

- Staff will be made aware of children in their classrooms who have allergies and the information will be posted. (See page 7 Allergies and Chronic Medical Conditions)

- Staff and children will wash hands upon arrival, before snack, after toileting, before lunch, before leaving the center and any other time that is necessary.

- Staff will ensure milk is returned to the refrigerator as soon as possible after use during snack and lunch.

- Staff will wash tables before and after snack and lunch with a solution of 1 tablespoon of bleach to 1 quart of cold water.

- A procedure is in place in which the children's lunch boxes are checked to ensure that perishable food (meat, cheese, eggs or dairy products) is refrigerated and labeled with the name of the child and date.

- After snack and lunch, staff will ensure that the children throw away any opened and uneaten food.

- When preparing any meal, staff will wash his/her hands prior to handling any food or food service items.

- Staff will ensure that all non-perishable food is kept in sanitary containers in a locked cabinet and that all perishable food is keep in either the refrigerator or freezer as appropriate in clearly designated areas.

- All infant bottles are required to have a top on the bottles when placed in the refrigerator. Leftover contents of the bottle will be discarded after two hours. Unused bottles will be returned to the parent at the end of the day. All bottles and lids must be clearly marked with the child's name. Breast milk must be in labeled bottles with name and date. All breast milk must be used within 24 hours. Frozen breast milk must be used within six months. Bottles will be rinsed but not washed when they are used. Parents will need to wash and sanitize all bottles thoroughly at home. ***Glass bottles will not be accepted***.

- Infant food items must be in unopened jars or microwavable containers. Leftovers will be discarded. Unused items will be returned to the parent at the end of the day. Parents will be asked to provide extra formula and food marked with the child's name to be left at the center for emergencies.

- Staff will ensure that all infant foods are labeled with the infant's name, dated and refrigerated at 40 F or below if potentially hazardous.

- Staff will ensure that all bottle nipples are protected.

- Staff will ensure that all breast milk or formula, which has been bottled for an infant, is placed immediately in a refrigerator when brought to the center and warmed to desired temperature immediately before feeding the infant.

- Staff will ensure that any foods that pr high risk of choking for infants and toddlers not be served.

- Staff will rinse useable bottles and nipples and return them to the infant's parent daily.

Indoor Safety

- Staff will take attendance at the start of the day or program and will ensure that all children in attendance are signed in.

- Every twenty children must have one adult trained in CPR and First Aid assigned to them.

- A child shall always be within sight of one or more staff members at all times.

- Cribs – Infant room staff must review the publication Crib Safety Tips – Use Your Crib Safely (see PAGE 26) and sign-off on the Crib Safety Tips sheet.

- Before entering the infant room(s), adults and children will remove shoes or wear disposable covers over their shoes.

- Children will be counted when entering and leaving the classroom.

- Maintain toys, supplies, and equipment in a safe manner. All items should be inspected on a daily basis and removed if found to be unsafe until repaired or replaced.

Open Door Policy for Parents and Extended Family

- Parents and guardians may visit in the classroom at any time. As stated in the MSDE Child Care Resource Documents, "An operator shall permit the parent of a child in care to freely observe all areas of the center used for child care during operation hours and have access to their child at any time during the center's hours of operation without appointment." Issues involving non-custodial parents must be handled on a case by case basis.

- Extended family members will be encouraged to participate in classroom activities, field trips, and special events.

Procedures for Arrival and Departure

Parking Lot Safety

- Parents must park in designated areas for drop-off and pick-up of children (avoid parking in neighbor's driveways or otherwise obstructing other vehicles)

- All vehicles must be turned off while children are brought into the center.
- Supervise children carefully while walking on the parking lot.
- Other children may not be left in the vehicle without adult supervision.
- The front entrance to the center must be clear for buses and emergency vehicles at all times.

Arrival / Entering the Center

- Upon arrival at the center, parents must bring their child into the classroom and follow the sign-in procedures.
- Provide information to the teacher regarding health and other issues that will help teaching staff respond appropriately to their child.

Departure / Pick-up

- Only persons authorized by the parent / guardian may pick-up children from the center.
- Center sign-out procedures must be followed.
- Center must maintain on file written authorization of persons permitted to pick-up children and take them out of the facility on trips with names, addresses, and telephone numbers.
- In emergency situations, either a written note or a telephone call must be received from the parents stating the name of the person who will pick-up the child. They must should identification upon arrival.
- Children must be placed in car safety seats prior to leaving the parking lot.

Playground Safety

- All staff shall follow playground safety protocols contained in the MSDE Office of Child Care ***Playground and Water Safety Guidelines***. (available at www.marylandpublicschools.org)

- For more information on playground safety, refer to CPSC's Handbook for Public Playground Safety. To obtain a copy, send a postcard with your name, address, and name of the publication to U.S. Consumer Product Safety Commission, Washington, D.C. 20207

- A child shall be within sight of a staff member at all times.

- Staff will take the Attendance Sheet with them, as well as the walkie-talkie whenever they leave the classroom.

- When on the playground, teachers will have the children line up prior to returning to the building and the teachers will count and call the children by name before coming inside.

Each year, about 200,000 children are treated in U.S. hospital emergency rooms for playground equipment-related injuries - an estimated 148,000 of these injuries involve public playground equipment and an estimated 51,000 involve home playground equipment. Also, about 15 children die each year as a result of playground equipment-related incidents. Most of the injuries are the result of falls. These are primarily falls to the ground below the equipment, but falls from one piece of equipment to another are also reported. Most of the deaths are due to strangulations, though some are due to falls.

- Protective Surfacing - Since almost 60% of all injuries are caused by falls to the ground, protective surfacing under and around all playground equipment can reduce the risk of serious head injury (see chart on page below).

- Falls on asphalt and concrete can result in serious head injury and death. Do not place playground equipment over these surfaces. In addition, grass and turf lose their ability to absorb shock through wear and environmental conditions. Always use protective surfacing.

- Certain loose-fill surfacing materials are acceptable, such as the types and depths shown in the table.

- Certain manufactured synthetic surfaces also are acceptable; however, test data on shock absorbing performance should be requested from the manufacturer

Fall Height In Feet From Which A Life Threatening Head Injury Would Not Be Expected			
Type of Material	**6" Depth**	**9" Depth**	**12" Depth**
Double Shredded Bark Mulch	6	10	11
Wood Chips	6	7	12
Fine Sand	5	5	9
Fine Gravel	6	7	10

- Fall Zones - A fall zone, covered with a protective surfacing material, is essential under and around equipment where a child might fall. This area should be free of other equipment and obstacles onto which a child might fall.

- Stationary climbing equipment and slides should have a fall zone extending a minimum of 6' in all directions from the perimeter of the equipment.

- Swings should have a fall zone extending a minimum of 6' from the outer edge of the support structure on each side. The fall zone in front and back of the swing should extend out a minimum distance of twice the height of the swing as measured from the ground to the swing hangers on support structure.

- Swing Spacing - To prevent injuries from impact with moving swings, swings should not be too close together or too close to support structures. Swing spacing should be:
  - At least 8 inches between suspended swings and between a swing and the support frame.
  - At least 16 inches from swing support frame to a pendulum see- saw.
  - Minimum clearance between the ground and underside of swing seat should be 8 inches.

- Swing sets should be securely anchored.

- Elevated Surfaces - Platforms more than 30" above the ground should have guardrails to prevent falls.

- Pinch or Crush Points - There should be no exposed moving parts, which may present a pinching or crushing hazard.

- Potential Head Entrapment Hazards - In general, openings that are closed on all sides, should be less than 3 1/2" or greater than 9". Openings that are between 3' 1/2" and 9" present a head entrapment hazard because they are large enough to permit a child's body to go through, but are too small to permit the head to go through. When children enter such openings, feet first, they may become entrapped by the head and strangle.

- Potential Entrapment and Strangulation Hazards - Open "S" hooks, especially on swings, and any protrusions or equipment component/hardware, which may act as hooks or catch-points, can entangle with children's clothing and cause strangulation incidents. Close "S" hooks as tightly as possible and eliminate protrusions or catch-points on playground equipment.

- Playground Maintenance - Playgrounds should be inspected on a regular basis. Inspect protective surfacing especially mulch, and maintain the proper depth. If any of the following conditions are noted, they should be removed, corrected or repaired immediately to prevent injuries:
  - Hardware is loose or worn, or that has protrusions or projections.
  - Ropes, and items with cords placed around the neck can get caught on playground equipment and strangle a child. Many children have died when a rope they were wearing was caught on playground equipment, or they became entangled in a rope.
  - Supervise, and teach your child safe play. Teach your child not to walk or play close to a moving swing, and not to tie ropes to playground equipment.
  - Exposed equipment footings.
  - Scattered debris, litter, rocks, or tree roots.
  - Rust and chipped paint on metal components.
  - Splinters, large cracks, and decayed wood components.
  - Deterioration and corrosion on structural components, which connect to the ground.
  - Missing or damaged equipment components, such as handholds, guardrails, swing seats.

* To report a dangerous product or a product-related injury and for information on CPSC's fax-on-demand service, call CPSC's hotline at (800)638-2772 or CPSC's teletypewriter at (800)638-8270. To order a press release through fax-on-demand, call (301)501-0051 from

the handset of your fax machine and enter the release number. Consumers can obtain releases and recall information from CPSC's web site at http://www.cpsc.gov, gopher site at cpsc.gov or report product hazards to info@cpsc.gov

Office of Child Care Resource Documents
Division of Early Childhood Development, Maryland State Department of Education

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Release of Children to Authorized and Unauthorized Persons

Authorized Persons -

Authorized persons are those listed by the parent or guardian on the emergency card or identified by the parent or guardian via a written note or telephone call.

- Greet each person arriving to pick-up a child from the center.
- Ask who the person the name of the child he or she has come to pick-up
- Get the person's name and verify identity by checking a driver's license or official identification card and verify with the office that permission has been granted.

Unauthorized Persons

- Have the unauthorized person to wait in a designated space and the child remains in the classroom, is taken to the office or another safe place.
- Immediately contact the custodial parent or guardian for instruction.
- If the custodial parent says they sent this person, follow release of child to non-custodial parent procedures above.
- If the custodial parent says they did not send this person, then child cannot be released.
- If the custodial parent **cannot** be reached, the child **cannot** be released.
- If the situation becomes difficult: (the unauthorized person appears to be in an impaired condition, hostile, or combative), please follow the procedure for an intruder on page 57.

Sanitation & Hygiene

Excerpts from Office of Child Care Resource Documents related to sanitation and hygiene are presented below.

Diapering Procedures

Two different diaper changing methods may be used to minimize the risk of transmitting infection from one child to another or to a provider. One method involves the use of gloves and the other does not. The method you select should be used consistently in your child care setting. Whichever method you choose, you should never wash or rinse diapers or clothes soiled with fecal material in the child care setting. Because of the risk of splashing, and gross contamination

of hands, sinks, and bathroom surfaces, rinsing increases the risk that you, other providers, and the children would be exposed to germs that cause infection. All soiled clothing should be bagged and sent home with the child without rinsing. (You may dump solid feces into a toilet.) You should tell parents about this procedure and why it is important.

The following recommended procedure notes additional steps to be included when using gloves. Gloves are not required, but some people prefer to use gloves to prevent fecal material from getting under their nails. Child care providers should keep their fingernails short, groomed, and clean. Using a soft nail brush to clean under the nails during handwashing will remove soil under the nails. Always maintain a pleasant attitude while changing a child's diaper. Never show disgust or scold a child who has had a loose stool.

Recommended Procedure for Diapering a Child

1. **Organize needed supplies within reach:**
   - Fresh diaper and clean clothes (if necessary)
   - Dampened paper towels or premoistened towelettes for cleaning child's bottom
   - child's personal, labeled, ointment (if provided by parents)
   - trash disposal bag
2. **Place a disposable covering (such as roll paper) on the portion of the diapering table where you will place the child's bottom.** Diapering surfaces should be smooth, nonabsorbent, and easy to clean. Don't use areas that come in close contact with children during play, such as couches, floor areas where children play, etc.
3. **If using gloves, put them on now.**
4. **Using only your hands, pick up and hold the child away from your body.** Don't cradle the child in your arms and risk soiling your clothing.
5. **Lay the child on the paper or towel.**
6. **Remove soiled diaper (and soiled clothes)**.
7. **Put disposable diapers in a plastic-lined trash receptacle.**
8. **Put soiled reusable diaper and/or soiled clothes WITHOUT RINSING in a plastic bag to give to parents.**
9. **Clean child's bottom with a premoistened disposable towelette or a dampened, single-use, disposable towel.**
10. **Place the soiled towelette or towel in a plastic-lined trash receptacle.**
11. **If the child needs a more thorough washing, use soap, running water, and paper towels.**
12. **Remove the disposable covering from beneath the child. Discard it in a plastic-lined receptacle.**
13. **If you are wearing gloves, remove and dispose of them now in a plastic-lined receptacle**.
14. **Wash your hands. NOTE:** The diapering table should be next to a sink with running water so that you can wash your hands without leaving the diapered child unattended. However, if a sink is not within reach of the diapering table, **don't leave the child unattended on the diapering table** to go to a sink; wipe your hands with a premoistened towelette instead. **NEVER** leave a child alone on the diapering table.
15. **Wash the child's hands under running water.**
16. **Wash baby's hand with a premoistened disposable towelette.**
17. **Diaper and dress the child.**
18. **Disinfect the diapering surface immediately after you finish diapering the child.**
19. **Return the child to the activity area.**
20. **Clean and disinfect:**
    - The diapering area,
    - all equipment or supplies that were touched, and
    - the soiled crib or cot, if needed.
21. **Wash your hands under running water.**

Handwashing Procedures

- Most experts agree that the single most effective practice that prevents the spread of germs in the childcare setting is good hand washing by childcare providers, children, and others. Some activities in particular expose children and providers to germs or the opportunity to spread them. You can stop the spread of germs by washing your hands and teaching the children in your care good hand washing practices. (See page 37)

When hands should be washed:

Children:	**Child Care Staff**:
• Upon arrival at the center. • Immediately before and after eating. • After using the toileting or diapering. • Before using water tables. • After playing on the playground. • After handling pets, cages, or pet objects. • Whenever hands are visibly dirty. • Before going home.	• Upon arrival at the center. • Immediately before handling food. • After using the toilet, assisting a child in toileting or diapering. • After contacting body fluids, including wet or soiled diapers, runny noses, spit, vomit, etc. • After handling pets, cages, or pet objects. • Whenever hands are visibly dirty or after cleaning a child, room, bathroom items, or toys. • Always after removing gloves. • Before giving or applying medication or ointment to a child or self. • Before going home.

- If gloves are being used, hands should be washed immediately after gloves are removed even if hands are not visibly contaminated. Use of gloves alone will not prevent contamination of hands or spread of germs and should not be considered a substitute for hand washing. Rubbing hands together under running water is the most important part of washing away infectious germs. Pre-moistened towelettes or wipes and waterless hand cleaners should **not** be used as a substitute for washing hands with soap and running water. Towelettes should only be used to remove residue, such as food off a baby's face or feces from a baby's bottom during diaper changing. When running water is unavailable, such as during an outing, towelettes may be used as a temporary measure until hands can be washed under running water. A childcare provider may use a towelette to clean hands while diapering a child who cannot be left alone on a changing table that is not within reach of running water. However, hands should be washed as soon as diapering is completed and the child is removed from the changing table. Water basins should **not** be used as an alternative to running water. If forced to use a water basin as a temporary measure, clean and disinfect the basin between each use. Outbreaks of disease have been linked with sharing wash water and washbasins. All staff must, at all times, follow the hand washing procedure posted in classrooms, bathrooms, and kitchens.

How to Wash Hands

- Always use warm, running water and a mild, preferably liquid, soap. Antibacterial soaps may be used, but are not required. Pre-moistened cleansing towelettes do not effectively clean hands and do not take the place of handwashing.
- Wet the hands and apply a small amount (dime to quarter size) of liquid soap to hands.
- Rub hands together vigorously until a soapy lather appears and continue for at least 15 seconds. Be sure to scrub between fingers, under fingernails, and around the tops and palms of the hands.
- Rinse hands under warm running water. Leave the water running while drying hands.
- Dry hands with a clean, disposable (or single use) towel, being careful to avoid touching the faucet handles or towel holder with clean hands.
- Turn the faucet off using the towel as a barrier between your hands and the faucet handle.
- Discard the used towel in a trash can lined with a fluid-resistant (plastic) bag. Trash cans with foot-pedal operated lids are preferable.
- Consider using hand lotion to prevent chapping of hands. If using lotions, use liquids or tubes that can be squirted so that the hands do not have direct contact with container spout. Direct contact with the spout could contaminate the lotion inside the container.
- When assisting a child in handwashing, either hold the child (if an infant) or have the child stand on a safety step at a height at which the child's hands can hang freely under the running water. Assist the child in performing all of the above steps and then wash your own hands.

Office of Child Care Resource Documents
Division of Early Childhood Development, Maryland State Department of Education

Toys & Classroom Supplies

- All staff should follow the General Sanitation Guidelines as required by the Office of Child Care (see pages 42-45).

- Staff should follow a designated checklist to ensure that all cleaning and sanitizing is completed at the end of each day and on a regular schedule. (See page 46-49)

- A Cleaning and Sanitizing Schedule is shown on p. 46.

- Sample Cleaning and Sanitizing Records are shown on p. 47-49.

GENERAL SANITATION GUIDELINES

CLEANING AND SANITIZING

Keeping a clean and sanitary child care environment is one of the most important defenses against the spread of illness or infection among children and providers.

Carefully washing surfaces, materials, and equipment with detergent and water or other cleansers is sufficient for cleaning them and for removing many germs that could present a health risk. However, some surfaces and items must be sanitized with a disinfectant after they are washed or cleaned because they are especially likely to become contaminated and serve as vehicles for transmitting illness. In these cases, only use of a disinfecting agent will ensure that germs are virtually eliminated or reduced to a level where the transmission of illness is unlikely.

Cleaning agents (soap, detergent) are not disinfectants, and disinfectants are not cleaning agents. Disinfectants will not work effectively if the surface has not been cleaned first. Before being sanitized with a disinfectant, an object or surface should be washed with a cleaning agent and rinsed with clean water.

SELECTING AND USING AN APPROPRIATE SANITIZER

The Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) recommend using a solution of household chlorine bleach and water for all sanitizing purposes. A bleach-and-water solution is inexpensive, easy to mix, nontoxic and safe if handled properly, and kills most infectious agents. Accordingly, CCA recommends that providers use only a bleach-and-water solution for sanitizing tasks.

There are a number of commercial disinfectants that are available in stores. Products that meet the Environmental Protection Agency's (EPA's) standards for "hospital grade" germicides (solutions that kill germs) are effective for sanitizing purposes. However, many commercial products advertise themselves as "disinfectants," having "germicidal action," or "kills germs." Although they may have some effect on germs, these products are often less effective than bleach. In addition, commercial disinfectants usually contain additives such as perfume or dye and may leave a chemical residue that could be harmful or cause distress for children with allergies or respiratory difficulties. Before using anything other than a bleach-and-water solution for sanitizing, consult with your CCA Regional Office.

Cautions:

- When using a bleach-and-water solution, make sure the bleach concentration is intended for household use, not for industrial application. Household bleach is typically sold in one of two concentrations: 5.25% hypochlorite (“regular” strength), or 6.00% hypochlorite (“ultra” strength). Both are suitable for use in child care settings.

- Never mix bleach or a bleach-and-water solution with other fluids (particularly ammonia or acidic fluids like vinegar) because this will rapidly create highly toxic fumes.

- Whenever children are present, bleach solution (or any other disinfectant) should be applied by dipping, soaking, or wiping the item or surface with a cloth (but not a sponge, since sponges harbor bacteria and are hard to clean). Spraying is acceptable only when:
  - Children are not present, or
  - Dipping/soaking is not feasible and wiping with a cloth is likely to spread the contamination – for example, when sanitizing diapering stations and toilets.

Whenever a disinfectant of any kind is used, there should always be adequate ventilation. This is especially important in confined or enclosed areas such as bathrooms. A child who is asthmatic or sensitive to the disinfectant should be kept away from the immediate area until it can dissipate completely. If this step is not sufficient, the operator or provider should discuss with the child's parent other alternatives for reasonably accommodating the child's sensitivity.

- If using a commercial disinfectant, always read the label carefully and follow the manufacturer's instructions for use.

- Bleach-and-water solutions lose their strength and are weakened by heat and sunlight. For maximum effectiveness, mix a fresh solution every day. Discard any leftover solution at the end of the day.

- Keep all containers and bottles of diluted and undiluted sanitizer out of the reach of children. Label containers in which sanitizers have been diluted for direct application with the name of the solution (such as "Bleach Sanitizer") and the dilution of the mixture.

How strong a disinfectant solution should be and how long it should remain in contact with a particular surface will depend on how the solution is applied and on how contaminated the surface might be. A stronger concentration is required when a cloth or objects are dipped into the solution because each dipping releases some germs into the solution, potentially contaminating the solution. In general, it is best not to rinse off the solution or wipe the object dry right away. A disinfectant must be in contact with germs long enough kill them.

Because chlorine evaporates into the air leaving no residue, surfaces sanitized with bleach-and-water may be left to air dry. Many industrial sanitizers require rinsing with fresh water before the object can be used again.

The following two bleach-and-water solution strengths are recommended by the CDC:

Strong Bleach Solution
- **Recipe:** ¼ cup of bleach to 1 gallon of cool water OR 1 tablespoon of bleach to 1 quart of cool water (add the bleach to the water in either case).
- **Minimum contact time:** 2 minutes

Weak Bleach Solution
- **Recipe:** 1 tablespoon bleach + 1 gallon of cool water
- **Minimum contact time:** 1 minute

SCHEDULE FOR CLEANING AND DISINFECTING SPECIFIC ITEMS

Toys and Mouthed Items:
- Clean at least once a week, then disinfect with Strong Bleach Solution, then air dry.
- Items placed in a child's mouth should be cleaned as needed and not be allowed to pass from one child to another without being cleaned and disinfected.

Food Preparation and Service Area (including Tables and Chairs used for Meals or Snacks):
- After each use, wipe off, clean, and sanitize with Strong Bleach Solution all surfaces and equipment used for food preparation and service.

Eating Utensils and Dishes:

- Clean and rinse utensils and dishes, then submerge in Weak Bleach Solution.

Washable Equipment and Furniture:

- Clean at least two times each year.
- Equipment and furniture should be checked at least once each week for cleanliness and cleaned as appropriate.

Cots:

- Clean at least twice each year.
- Always clean and disinfect with Strong Bleach Solution before reassigning a cot to another child.

Blankets and Sheets Belonging to the Home:

- Launder at least once each week or when they become soiled (whichever occurs first), and between uses if used by another child.

Blankets and Sheets Belonging to the Children:

- Send home at least every week to be laundered.

Toilets:

- Disinfect with Strong Bleach Solution at least once daily or more frequently as needed.

Bathroom Sinks and Water Fixtures:

- Clean and disinfect with Strong Bleach Solution daily.

Potties:

- After each use, empty, clean if soiled, disinfect with Strong Bleach Solution, then rinse.
- Dispose of the rinse-water by pouring it into the toilet, not into the sink.
- Cloths used for cleaning a potty should be:
  - If disposable, used once and then thrown away, or
  - If reusable, store in Strong Bleach Solution before laundering.

Stuffed Animals:

- Launder at least once each week (provide and/or allow stuffed animals that can be laundered).

Low Shelves, Doorknobs, and Other Surfaces that are Frequently Touched by Diapered Children:

- Wash and disinfect with Strong Bleach Solution daily.

Walls and Ceilings:

- Spot-clean when visibly soiled.

Wastebaskets:

- Empty daily. Use paper or plastic liners.

Floors (non-Carpeted):

- Wash and disinfect with Strong Bleach Solution at least once a week.

Carpets:

- Vacuum daily.
- Shampoo several times per year, as needed.

CLEANING UP BODY FLUIDS

NOTE: Always treat urine, stool, vomit, blood, and body fluids as potentially infectious. Always clean up spills of body fluid and sanitize contaminated surfaces immediately.

- For small amounts of urine and stool on smooth surfaces:
  - Wipe off urine/stool and wash affected area with a detergent solution.
  - Rinse the surface with clean water.
  - Apply a Strong Bleach Solution to the surface for at least the minimum required contact time.

- For larger spills on floors, or any spills on rugs or carpets:
  - Wear gloves while cleaning. Disposable gloves can be used, but household rubber gloves are adequate for all spills except blood and bloody body fluids. Disposable gloves (latex or vinyl – vinyl is less likely to cause an allergic skin reaction) should be used whenever blood may be present in the spill.
  - Take care to avoid splashing any contaminated material onto the mucous membranes of your eyes, nose or mouth, or into any open sores you may have.
  - Wipe up as much of the visible material as possible with disposable paper towels and carefully place the soiled paper towels and other soiled disposable material in a leak-proof, plastic bag – then securely tie or seal the plastic bag.
  - Use a wet/dry vacuum on carpets, if such equipment is available.
  - Immediately use a detergent, or a disinfectant-detergent to clean the spill area. Then rinse the area with clean water.
  - For blood and body fluid spills on carpeting, blot to remove body fluids from the fabric as quickly as possible. Then spot-clean the area with a detergent-disinfectant instead of a bleach solution. Additional cleaning by shampooing or steam cleaning the contaminated surface may be necessary.
  - Sanitize the cleaned and rinsed surface by wetting the entire surface with a Strong Bleach Solution.
  - Dry the surface.
  - Clean and rinse reusable household rubber gloves, then treat them as a contaminated surface in applying the Strong Bleach Solution to them. Remove, dry and store these gloves away from food or food surfaces. Discard disposable gloves.

- Mops and other equipment used to clean up body fluids should be:
  - Cleaned with detergent and rinsed with water,
  - Rinsed with a fresh batch of Strong Bleach Solution,
  - Wrung as dry as possible, and
  - Air-dried.

- Wash your hands afterward, even though you wore gloves.

- Remove and bag clothing items (yours and those worn by children) that have been soiled by body fluids.

- Put on fresh clothes after washing the soiled skin and hands of everyone involved.

CLEANING AND SANITATION SCHEDULE

AREA	CLEAN	SANITIZE	FREQUENCY
Classrooms/Child Care/Food Areas			
Countertops/tabletops, Floors, Door and cabinet handles	X	X	Daily and when soiled.
Food preparation & service surfaces	X	X	Before and after contact with food activity; between preparation of raw and cooked foods.
Carpets and large area rugs	X		Vacuum daily when children are not present. Clean with a carpet cleaning method approved by the local health authority. Clean carpets only when children will not be present until the carpet is dry. Clean carpets at least monthly in infant areas, at least every 3 months in other areas and when soiled.
Small rugs	X		Shake outdoors or vacuum daily. Launder weekly.
Utensils, surfaces and toys that go into the mouth or have been in contact with saliva or other body fluids	X	X	After each child's use, or use disposable, one-time utensils or toys.
Toys that are not contaminated with body fluids. Dress-up clothes not worn on the head. Sheets and pillowcases, individual cloth towels (if used), combs and hairbrushes, wash cloth and machine-washable cloth toys. (None of these items should be shared among children.)	X		Weekly and when visibly soiled.
Blankets, sleeping bags, Cubbies	X		Monthly and when soiled.
Hats	X		After each child's use or use disposable hats that only one child wears.
Cribs and crib mattresses	X		Weekly, before use by a different child, and whenever soiled or wet.
Phone receivers	X	X	Weekly.
Toilet and Diapering Areas			
Handwashing sinks, faucets, surrounding counters, soap dispensers, door knobs	X	X	Daily and when soiled.
Toilet seats, toilet handles, door knobs or cubicle handles, floors	X	X	Daily, or immediately if visibly soiled.
Toilet bowls	X	X	Daily.
Changing tables, potty chairs (Use of potty chairs in child care is discouraged because of high risk of contamination).	X	X	After each child's use.
General Facility			
Mops and cleaning rags	X	X	Before and after a day of use, wash mops and rags in detergent and water, rinse in water, immerse in sanitizing solution, and wring as dry as possible. After cleaning and sanitizing, hang mops and rags to dry.
Waste and diaper containers	X		Daily.
Any surface contaminated with body fluids: Blood, mucus, vomit, urine, stool	X	X	Immediately, as specified in STANDARD 3.026.

Adapted from Keeping Healthy, National Association for the Education of Chapter, Young Children. 1999.

From Modern Child Care Health Policies, Pennsylvania American Academy of Pediatrics

CLEANING AND SANITATION RECORD

	Date: _____				
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Door Handles					
Cabinets					
Floors					
Carpets					
Sinks					
Faucets					
Counters					
Toilets					
Toilet Seats					
Toilet Handles					
Kitchen Floor					
Bathroom Floors					
Mirrors					
Lead Staff Signature					

- The staff records their initials beside the task under the day of the week that the task was completed.
- The lead staff person in the room signs-off indicating he/she has checked that the tasks are complete and turns the sheet in to the director or assistant director, as appropriate.

WEEKLY OFFICE CLEANING DUTIES

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
OFFICE ASSISTANT					
Dust all surfaces (counter, file cabs, shelves, etc.)					
Wash front windows					
Sweep floor					
Sweep front porch and front steps					
Vacuum carpet					
Empty trash					
CLOSER					
Make sure kitchen is clean:					
wash dirty dishes					
put dishes away					
put snack away					
wipe counters					
Sweep/mop floors if necessary					
Trash out					
Make sure outside areas are cleaned up					
Adjust all thermostats:					
(80 in the spring/summer & 68 in fall/winter)					
infant room					
hall near staff bathroom					
upstairs					
Close and lock all external doors					
Turn off all lights and fans using wall switches					
INITIAL AFTER COMPLETING EACH DUTY					

Director/Assistant Director Sign Off: _____ Date: _____

MONTHLY CLASSROOM CLEANING DUTIES

	APRIL	MAY	JUNE	JULY	AUG.
Dust fans and transoms					
Clean windows/windowsills/transom windows					
Dust all shelves and counters					
Sweep behind and under shelves/cabinets/toys/any other furniture					
Clean out cubbies (throw away trash, send non-necessities home)					
Wipe down/wash bathroom curtains					
Disinfect toys (can be done one area at a time throughout month)					
Disinfect cots					
Wipe down all baseboard molding/trim					
Wash and disinfect trash cans					
Wipe down walls (especially near trash can)					
****DISINFECT USING BLEACH SOLUTION (1 TBS. BLEACH PER 1 GALLON OF WATER)**					
INITIAL AFTER COMPLETING EACH DUTY					

Director/Assistant Director Sign Off: _____ Date: _____

DAILY CLASSROOM CLEANING DUTIES

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
NAPTIME DUTIES					
Wipe down and disinfect common sinks					
Check/Fill soap dispensers					
Check/Fill paper towels					
Check stock of:					
soap					
tissues					
gloves					
paper towels					
trash bags					
AFTERNOON DUTIES					
Wipe down and disinfect common sinks					
Sweep hardwood floors in classroom					
Vacuum carpet areas in classroom					
Put all toys in proper places					
Remove clutter on shelves/cubbies					
Sweep & organize porch play area					
CLOSING DUTIES					
Take out trash					
Empty & unplug crockpot					
Lock all outside doors (2)					
Check thermostat 78 summer/65 winter					
Place shades in the middle of the windows					
****DISINFECT USING BLEACH SOLUTION (1 TBS. BLEACH PER 1 GALLON OF WATER)**					
Initial after completing each duty					

Director/Assistant Director Sign Off: _____ Date: _____

DAILY CLASSROOM CLEANING DUTIES

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
NAPTIME DUTIES					
Wipe down and disinfect staff toilet & sinks					
Sweep bathroom and classroom					
Mop bathroom w/disinfectant					
Sweep common areas					
Sweep front steps and porch					
Check/Fill soap dispensers					
Check/Fill paper towels					
Check/Fill toilet paper					
Check all supplies *soap*					
tissues					
toilet paper					
paper towels					
trash bags					
gloves					
AFTERNOON DUTIES					
Wipe down and disinfect staff toilet & sinks					
Sweep bathroom and classroom					
Mop bathroom w/disinfectant					
Vacuum carpet areas					
Put all toys in proper places					
Remove clutter on shelves/cubbies					
CLOSING DUTIES					
Take out trash classroom & bathroom					
Lock front door (*Bears' entrance*)					
Check thermostat 78 summer/65 winter					
Place the shade in the middle of the window					
****DISINFECT USING BLEACH SOLUTION (1 TBS. BLEACH PER 1 GALLON OF WATER)**					
Initial after completing each duty					

Director/Assistant Director Sign Off: _____ Date: _____

Policies Regarding Allegations of Child Abuse and Neglect

Staff should learn the Signs and Symptoms of Child Abuse and Neglect. (See page 17) The policies and procedures below were designed to encourage behaviors in staff that will greatly prevent/reduce the allegations of child abuse in your center.

Bathroom Procedures

- Volunteers and other visitors to the center shall **not** take children to the bathroom.
- Children will be taken to the bathroom in groups or the staff person should remain outside the bathroom.

Child Discipline

- To foster a child's own ability to become self-disciplined, center staff will equitably use:
  - Positive guidance,
  - Redirection
  - Planning ahead to prevent problems
  - Encouragement of appropriate behavior
  - Consistent clear rules
  - Involving children in problem solving
- Where the child understands words, discipline will be explained to the child before and at the time of any disciplinary action.
- Staff will encourage children to respect other people, to be fair, respect property, and learn to be responsible for their actions.
- Staff will guide children to develop self-control and orderly conduct in relationship to peers and adults.
- Aggressive physical behavior toward staff or children is unacceptable.
- Staff will intervene immediately when a child becomes physically aggressive to protect all of the children and encourage behavior that is more acceptable.
- Staff will use discipline that is consistent, clear, and understandable to the child.
- In the event that challenging behaviors occurs, the staff will never:
  - Hit, shake, grab or threaten a child with physical harm
  - Yell at, berate, shame or blame a child
  - Withhold food, toys and activities
  - Embarrass or humiliate a child

- Isolate a child

Diapering

- Diapering procedures must be reviewed by all infant and toddler staff. Procedures are contained in the publication ***Diapering Procedure*** (see page 37-38).
- Diapering stations need to be in highly visible areas.

Open Door Policy for Parents and Extended Family

The open door policy on page 33 of this manual helps to enable parents to see the quality of care that is provided to their children in a safe and healthy environment. When parents are able to see how staff interacts with their children in a positive and professional manner, it inspires confidence in the quality of the program and staff.

Staff Ratios / Classroom Coverage

- There will be two unrelated staff with every class at all times.
- The center will maintain the Maryland State Department of Education licensing requirements as to staff/child ratios at all times (see below).
- More than one adult should be in the building at all times when children are present.

Unobstructed Views

- Children should be able to be seen by a staff person at all times when in the classroom.
- All windows, including those in doors, should remain uncovered and open for viewing.
- A door may be closed only if a window is available that allows visibility from the outside.
- If possible, an electronic monitoring system or observation booth can be set up to monitor the classroom.
- Furniture and equipment should not be placed where the view is obstructed.
- Half doors and walls should be used if possible.
- Additional safety measures which may be implemented include closed circuit monitoring, doors with safety codes, intercom systems and "nanny" cams.

STAFF/CHILD RATIO – GROUP SIZE CHARTS

FOR CHILDREN WHO ARE:	STAFF/CHILD RATIO	MAXIMUM GROUP SIZE
Infants (6 weeks – 18 months)	1 : 3	6
Toddlers (18 months – 2 years)	1 : 3	9
Infants & Toddlers (w/ 1-2 infants)	1 : 3	9
Infants & Toddlers (w/ 3 or more infants)	1 : 3	6
2 year olds	1 : 6	12
3-4 year olds	1 : 10	20
5 years and older	1 : 15	30

When infants or toddlers are in a mixed age group with preschoolers - - -	
AND THERE ARE:	**THE MAXIMUM GROUP SIZE IS:**
1 – 2 infants	9
3 or more infants	6
1 – 2 toddlers	12
3 or more toddlers	9

Office of Child Care Resource Documents
Division of Early Childhood Development, Maryland State Department of Education

MIXED AGE GROUPS:

Group size	# of infants/toddlers in each group	2 year olds	# of staff required
1 – 6	Up to 6		2
1 – 6	0	Up to 6	1
7 – 9	Not more than: 2 infants, **or** 3 toddlers, **or** 1 infant and 2 toddlers, **or** 1 infant and 1 toddler	Up to 9	2
7 – 10	0	1 – 3	1
7 – 10	0	4 or more	2
10 – 12	0 infants & not more than 1 – 2 toddlers	1 – 5	2
10 – 12	0 infants & not more than 1 – 2 toddlers	6 or more	3

11 – 12	0	Up to 12	2
13 – 20	0	1 – 3	2
13 – 20	0	4 – 6	3

Office of Child Care Resource Documents
Division of Early Childhood Development, Maryland State Department of Education

EMERGENCY MANAGEMENT

Electrical Emergencies \ Power Outages

In the event of a loss of electricity, staff will check the circuit breakers first. If nothing out of order is detected, the Director (or designee) will proceed to notify the electric company or building maintenance. (The local power company emergency phone number is: **Reporting Outages:** BGE customers can report outages online or call 877.778.2222

We rely on you to report outages. **Report your outage online** with your smart phone or tablet device or call **877.778.2222**. We verify the phone number on the account, please have that ready. Online and phone services are available 24 hours a day, 7 days a week.

- If there is danger of fire, evacuate the center following the evacuation procedures located below.
- The Director will assess the status of the emergency and determine if the children and staff should remain in their classrooms, seek shelter within the building, prepare to evacuate the building or prepare to go home.
- During extreme weather conditions (i.e.: below 32 F) the Director will make the decision to close the center if a long-term outage is suspected.

Evacuation Procedures

In the event of an actual emergency, follow the evacuation procedures below:

- At the sound of the alarm, all staff should move quickly to prepare children to exit the building through assigned exit doors. (See page 55 for escape plan document).
- All staff, students, and visitors must evacuate a building whenever a fire alarm sounds.
- Staff should follow emergency procedures for children with disabilities requiring additional assistance.
- Each class should go quickly to their assigned location.
- Lead staff are responsible for taking the emergency cards and kits and sign in /out sheets with them to the assigned assembly location.
- Role must be taken as soon as possible after exiting the building.
- If a child or staff person is not present the local emergency responders will be notified immediately.
- For long-term emergencies, evacuate to the Windy Hill Elementary School as dictated by the County Government. Follow the above procedures and notify parents as soon as possible of the evacuation. We would use our buses and van and if necessary staff's vehicles to transport.

Fire Safety

Fire Drills –

- When an alarm is heard, all staff should respond as if it is a fire emergency.
- Follow the evacuation procedures above.
- In the event of a fire within the building, always leave as if not to return.
- Fire drills will be conducted and documented on a monthly basis.

Fire Drill Log –

- Immediately following a fire drill, assigned staff must update the log. Comments must be written in the log regarding problems and concerns about the drill.
- Administrators should address the problems and concerns so that they do not reoccur.
- Emergency Drill Log is on page 56.

Alerting Center Staff of a Fire Emergency –

- Sound the fire alarm immediately to evacuate the building.
- Notify the fire department by calling 9-1-1. Provide important details including location, extent, what is burning, and possible breaks in gas or electric lines or other special hazards.
- A fire or explosion at the center shall be reported to the licensing agency within 24 hours.

Fire Safety Precautions -

- Fire doors will be kept closed at all times to prevent the spread of fire and smoke.
- Fire doors may never be blocked, propped open, locked, or otherwise tampered with.
- Supervisors shall make sure all employees become familiar with exits nearest their work area and the location of the fire pull alarm.
- Exit pathways should be kept clear of obstructions at all times.

EMERGENCY EVACUATION PLAN

For

Prime Time Children's and Youth Activity Center

8816 Donald's Way, Owings, MD 20736

DATE PREPARED 01/01/2017

EMERGENCY PERSONNEL NAMES AND PHONE NUMBERS

DESIGNATED RESPONSIBLE OFFICIAL

EMERGENCY COORDINATORS
BRENDA TYRRELL
RON TYRRELL
SUSAN NEWTON
TRACY CASE
JUSTIN CASE
RYAN TYRRELL

ASSISTANTS TO PHYSICALLY CHALLENGED (If applicable)
SUSAN NEWTON

DATE 01/01/2017

EMERGENCY EVACUATION PLAN

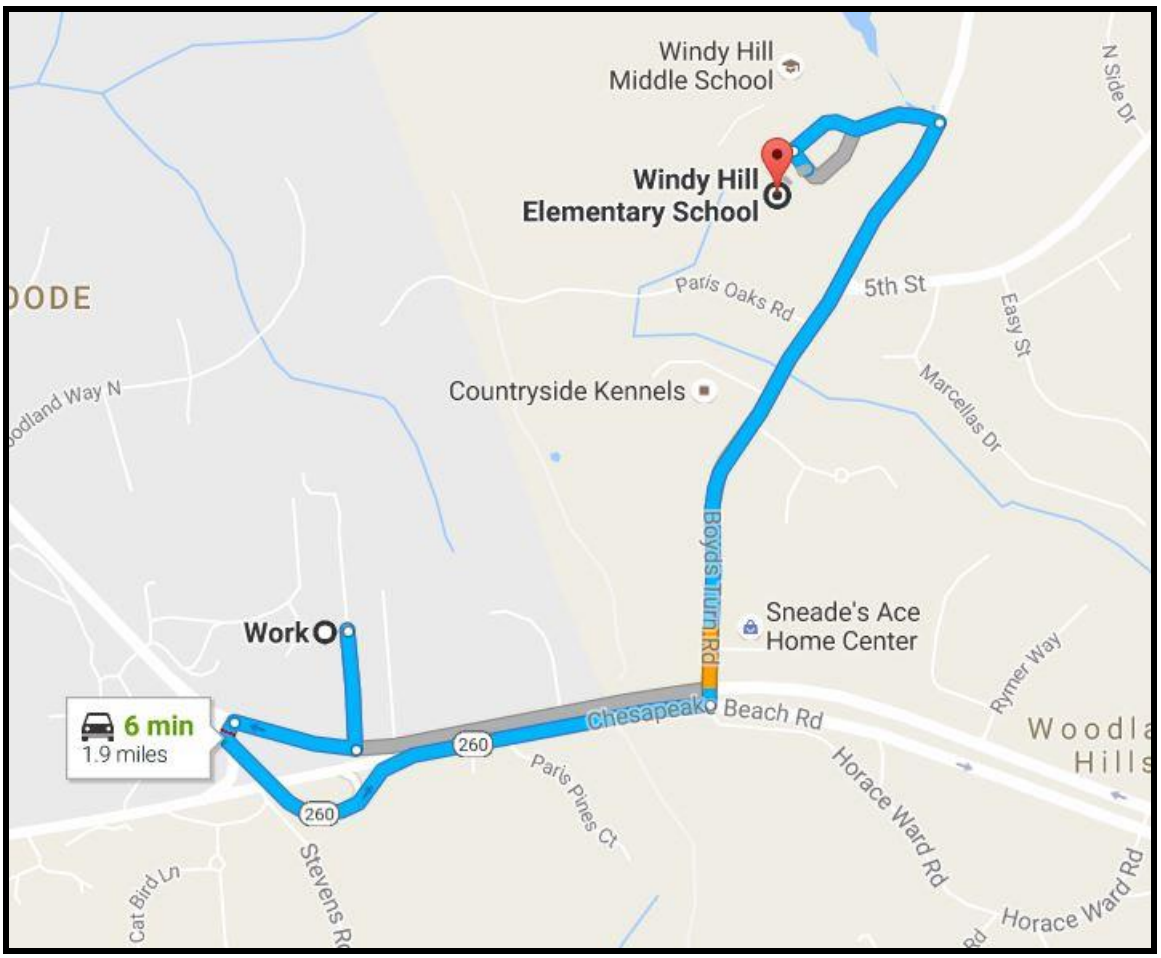
EVACUATION ROUTES

Evacuation route maps have been posted in teachers offices. The following information is marked on evacuation maps:

1. Emergency exits
2. Primary and secondary evacuation routes
3. Locations of fire extinguishers
4. Fire alarm pull station locations
5. Assembly points

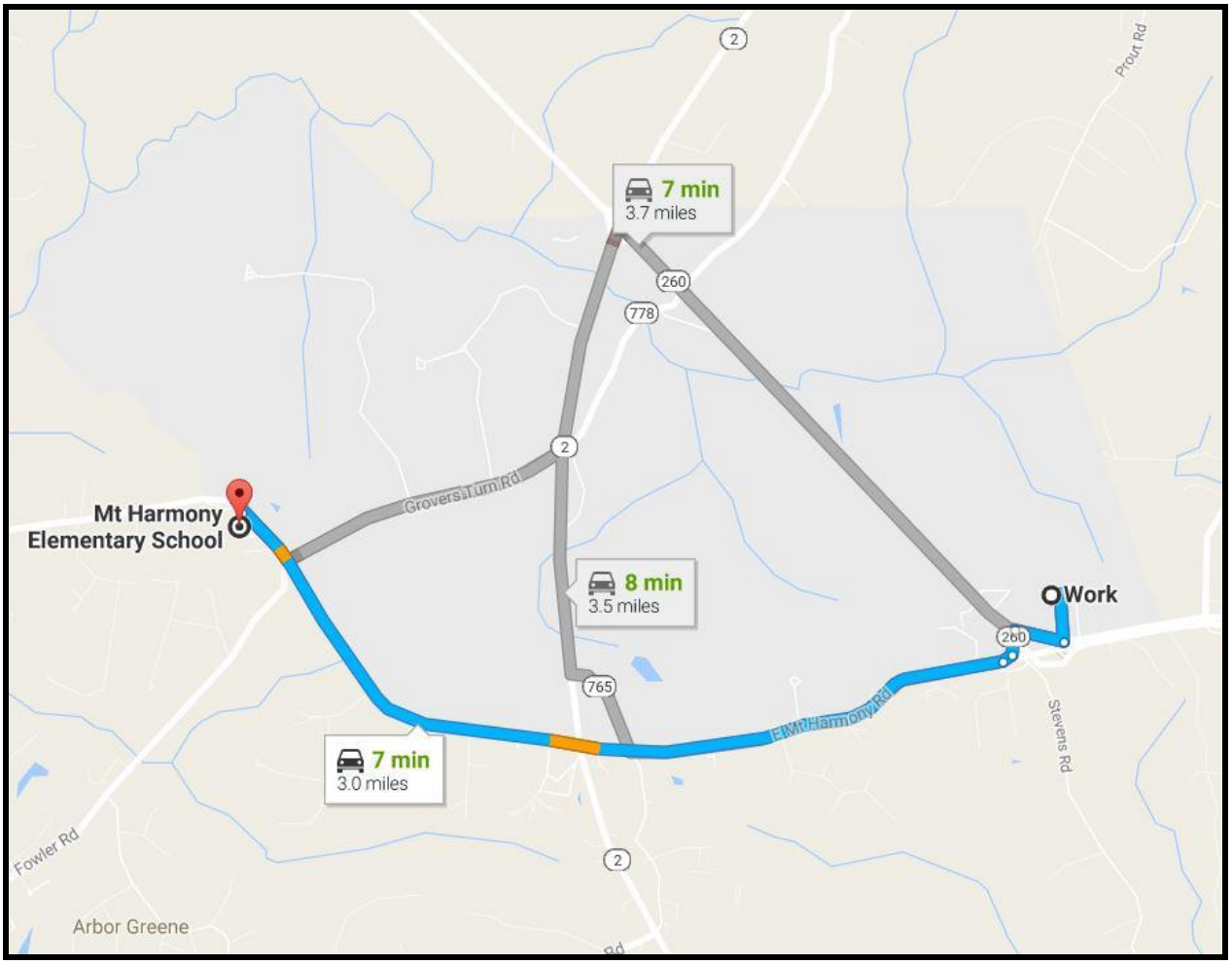
Site personnel should know at least two evacuation routes.

CHILDREN'S & YOUTH ACTIVITY CENTER PRIMARY EVACUATION ROUTE



In the event of an emergency that requires us to vacate the premises our primary evacuation location is Windy Hill Elementary School.

CHILDREN'S & YOUTH ACTIVITY CENTER SECONDARY EVACUATION ROUTE



In the event of an emergency that requires us to vacate the premises our secondary evacuation location is Mount Harmony Elementary School.

EMERGENCY PHONE NUMBERS

FIRE DEPARTMENT: (301) 855-0520

PARAMEDICS: (301) 855-0520

AMBULANCE: (301) 855-0520

POLICE: (410) 535-2800

FEDERAL PROTECTIVE SERVICE: (202) 282-8000

UTILITY COMPANY EMERGENCY CONTACTS

ELECTRIC: B.G.E. (800) 685-0123

TELEPHONE COMPANY: VERIZON (800) 922-0204

DATE: 01/01/2017

EMERGENCY REPORTING AND EVACUATION PROCEDURES

Types of emergencies to be reported by site personnel are:

- MEDICAL
- FIRE
- SEVERE WEATHER
- BOMB THREAT
- CHEMICAL SPILL
- STRUCTURAL CLIMBING/DESCENDING
- EXTENDED POWER LOSS
- CRISIS PLAN

MEDICAL EMERGENCY

Call medical emergency phone number

- Paramedics
- Ambulance
- Fire Department

Provide the following information

a) Nature of medical emergency,
b) Location of emergency (8816/8812 Donald's way, Owings, MD 20736)
c) Your name and phone number from which you are calling.

Do not move victim unless absolutely necessary.
All staff are trained in first aid and CPR; however, if unable to assist in first aid or CPR call one of the following staff for assistance prior to the arrival of the profession al medical help:

Susan Newton (443) 684-0320
Heather Bronson (240) 643-4235

Is Personnel trained in First Aid are not available, as a minimum, attempt to provide the following assistance:

1. Stop the bleeding with firm pressure on the wounds (note: avoid contact with blood or other bodily fluids)
2. Clear the air passage using the Heimlich maneuver in case of choking.

In case of rendering assistance to personnel exposed to hazardous materials. Consult the material safety Data Sheet (MSDS) and wear the appropriate personal protective equipment. Attempt first aid ONLY if trained and qualified.

FIRE EMERGENCY

When fire is discovered:

- Activate the nearest fire alarm
- Notify the local fire department by calling either 911 or (301) 855-0520
- If the fire alarm is not available, notify the site personnel about the fire emergency by the following means:

    - Voice Communication
    - Radio
    - Or Phone

Fight the fire ONLY if:

- The fire department has been notified.
- The fire is small and is not spreading to other areas.
- Escaping the area is possible by backing up to our nearest exit.
- The fire extinguisher is in working condition and personnel are trained to use it.

Upon being notified about the fire emergency, occupants must:

- Leave the building using the designated escape routes.
- Assemble in the designated area.
- Remain outside until the competent authority announces that it is safe to reenter.

Designated official, Emergency Coordinatormust:

- Coordinate an orderly evacuation of all staff and children.
- Perform and accurate head count of staff and children.
- Determine a rescue method to locate missing staff or children.
- Provide the Fire Department with the necessary information about the facility.

Assistance to Physically Challenged staff or children

- Assist all physically challenged employees in emergency evacuation.

Emergency Drill Log

FIRE DRILLS

Planned Month	Type of Drill	Date & Time	# of Participants Children	Staff	Duration	Comments / Issue to be Addressed
JANUARY	FIRE					
FEBRUARY	FIRE					
MARCH	FIRE					
APRIL	FIRE					
MAY	FIRE					
JUNE	FIRE					
JULY	FIRE					
AUGUST	FIRE					
SEPTEMBER	FIRE					
OCTOBER	FIRE					
NOVEMBER	FIRE					
DECEMBER	FIRE					

SEVERE STORM DRILLS

Planned Month	Type of Drill	Date & Time	# of Participants Children	Staff	Duration	Comments / Issue to be Addressed
	Shelter in Place					
	Shelter in Place					
	Shelter in Place					
	Shelter in Place					

OTHER EMERGENCY DRILLS

Planned Month	Type of Drill	Date & Time	# of Participants Children	Staff	Duration	Comments / Issue to be Addressed

Other Important Information:

Date of Last Check/Change/Rotation

Fire Extinguisher Expiration Date: _____

Smoke Detector Batteries Changed: _____

Rotate Stored Emergency Water Supply: _____

Emergency Food Supply Expiration: _____

Division of Early Childhood Development Resource Document, Maryland State Department of Education

Hazardous and Radioactive Materials Leak

Each center should be connected to the local emergency management alert system.

- The center will be notified of an accident involving hazardous or radioactive materials by the local Emergency Alert System or by local government/emergency officials.
- The Director (or director designee) will contact emergency personnel to determine if it is necessary to evacuate or to seek shelter within the building.
- If evacuating the building, relocation evacuation procedures will be followed.
- If the center is evacuated, the children and staff will not return until the emergency services personnel have declared the area safe.

Lockdown

- An announcement will be made alerting the staff of an emergency that requires all areas of the center to be secured (lock down).
- Staff should remain with the children.
- Remain in the classroom or get to the nearest room possible quickly.
- Staff members should lock classroom doors.
- Take attendance, make a list of children not accounted for, and notify Director if possible.
- Await further instructions from the Director or other members of the emergency services team.

Shelter in Place

Identifying a location:

- Identify a location within the building where each class will shelter in case of severe storm or similar event.
- Shelter locations should be areas within the building away from windows and doors to avoid flying glass or other objects.
- Preference for shelter locations should be given to rooms that do not have exits to the outdoors or windows and hallways.
- If shelter areas do contain windows, children should shelter behind/under items that provide some protection from flying objects such as tables or desks.
- Emergency kits, attendance records, etc. should be taken to the shelter location by the staff.
- Practice drills should be held at least 2 times per year.

Procedure in a real emergency:

- Ensure that the designated shelter area is ready to receive and shelter children and staff.
- Alert staff to the need to relocate to the shelter area by a designated announcement.
- Staff will follow normal evacuation procedures while relocating to the designated area.
- Take attendance to establish accountability for all children and staff.
- Remain in place and await further instructions from designated staff person.
- Notify 9-1-1 if possible.
- Staff will maintain control of their group until instructed otherwise.
- Close any windows, blinds, drapes, and doors.

    - If sheltering in place is due to smoke or toxic chemicals, all air intakes and openings should be closed to protect the atmosphere inside.
    - If sheltering in place is due to flooding, water should be shut off at mains so contaminated water will not back-up into facility supplies.

- If sheltering in place is due to storms, pre-determined measures should be taken to secure the facility against storm damage such as bursting pipes, etc.

- A sign will be posted on the front entrance to the facility informing parents/visitors of "Sheltering In-Place Emergency" and under what circumstances entry and exit will be permitted.
- To minimize the introduction of outside air, it may be necessary to prohibit entry and exit.
- It is recommended that a telephone tree, email distribution list or some alternate method of communication with parents be established and tested to relieve the number of phone calls that may be coming in to the center during this event.
- All staff and children will remain in the designated area until the emergency services personnel or the Center Director have notified them

Threats of Violence

Hostage \ Armed Intruder –

- If you are directly involved, follow the instructions of the intruder.
- Attempt to summon help or call 911 if it can be accomplished without placing yourself or others in further danger.
- Await arrival of the police – DO NOT threaten, attempt to intimidate, or disarm the intruder.
- If children are involved as victims, attempt to keep them calm and minimize their involvement with the intruder.
- Take attendance and make a list of students not accounted for.
- If you are not directly involved, follow instructions from the emergency services quickly and without comment.
- If notified of an emergency requiring a lock down, follow established procedures.

Intruder/Trespasser –

- Move the individual away from children and/or classrooms.
- Do not argue, challenge, or touch the individual.
- Notify the person in charge as quickly as possible or call 911.
- Make an announcement alerting the staff that an emergency has occurred that requires the center to be locked down.
- If the situation becomes difficult: (impaired condition, hostile, combative adult, unauthorized person trying to pick up), you must take action to safeguard children and staff in the center. A code word or phrase may be developed for your center to alert staff that a problem exists such as: *"Take the laundry out of the dryer," when you do not have a dryer.*

Threats of Violence -

- Take all oral, physical gestures and written threats seriously.
- Move the individual away from children and/or classrooms.
- Notify the person in charge as quickly as possible or call 911.
- Make an announcement alerting the staff that an emergency has occurred that requires the center to be locked down.

Weather Related Emergencies

- Possible weather conditions that may occur include: hurricanes, tornadoes, severe thunderstorms, flooding and severe winter storms.
- When weather conditions indicate any storm conditions, staff should monitor The National Oceanographic and Atmosphere Administration (NOAA) weather radio or a local TV station for public warnings.
- During hurricane conditions, staff should follow "shelter in place" procedures.
- When a tornado warning or sighting is reported, staff and children should seek shelter within the building following "shelter in place" procedures.
- During a severe storm warning, or during periods of particularly high winds, keep children away from windows and doors.
- During times of possible flooding in the area, staff should locate children to a location above the first floor, if possible, otherwise the director should monitor the situation and seek shelter as far away from the flooding as possible.
- After the Director assesses the weather related threat, he/she will determine if the staff and children should remain in the classrooms or seek shelter within the building
- Severe storm drills will be conducted twice annually.

Bomb Threat Response (actions)

- Record, document and preserve threat
- Report threat to administration and notify staff as appropriate
- Assemble Bomb Threat Response Team at Command Center
- Asses the threat and determine response (Search or Evacuate)

Search

- Assemble and deploy Search Teams per plan
- Teams are designated per classroom. One teacher from each class will be responsible for evacuation of children while the other is responsible for searching their area.

- Teams search assigned areas; teachers and staff search own areas
- Hang indicator tags and record search results. If suspicious item found, initiate suspicious item protocol

Analysis of Potential Emergencies

Evacuate (if necessary)

- Select Evacuation routes and assembly areas these can be found on page () in Crisis hndbook
- Notify other police departments, fire department and ambulance services, request assistance
- Search teams clear routes and assembly areas
- Notify staff/faculty to prepare for evacuation
- Give evacuation order. Faculty and staff check own areas, hang indicator tags on door knob. Faculty, staff and students gather belongings and evacuate
- Units supervise, track and report evacuation progress
- Evacuation Coordinator confirms that the building is empty
- Debrief emergency services and coordinate further actions
- Take attendance and report
- As appropriate, determine Reoccupy or Dismiss action. Reoccupy when suspicious item not found or when it has been cleared by law enforcement. Dismiss in consultation with administration
- Site Decision Maker remains on-scene until situation resolved or until relieved by another administrator

If A Suspicious Item Is Found

- DO NOT TOUCH THE ITEM: Notify Administration
- Person or Search Team who found the item report it to the Site Decision Maker
- Notify Police, Fire, and EMS
- Notify other search teams and continue search if necessary
- Secure area where item is located, DO NOT GUARD IT, (stay away from item). If possible and can be done on the way out of area, open doors and windows near item
- Hang indicator tag
- Notify faculty/staff of the situation and direct them to prepare for evacuation
- Select evacuation routes and assembly areas that are away from the suspicious item
- Redeploy search Teams to clear evacuation routes and assembly areas.
- Meet arriving emergency responders and brief those, letting them speak with person who found item and informing them where the item is located
- When evacuation routes and assembly areas are cleared, conduct evacuation as per evacuation protocol Pg. ()
- Incident Commander will assume command of the scene, manage evacuees, media, parents, and assign individuals to others as appropriate
- Continue with Reoccupy or Dismiss action, as appropriate.

Incident Coordinator

_____

January 1, 2017

Hazardous Materials

- If evacuation is necessary and possible evacuate to designated location on Pg. ()
- If evacuation is not possible close all windows and blinds and lock tight. Make sure all doors are locked and sealed.

- Turn all HVAC systems off. This will allow containiments to remain outside of the building.
- DO NOT Open any doors or windows unless directed by Incident Coordinator, Police, Fire, or EMS.
- Keep children in designated rooms until told otherwise.

Incident Coordinator

_____

January 1, 2017

BUILDING SAFETY

Entry & Egress-

- All outside doors should remain closed and locked at all times.

- All doors, stairways, corridors, and other means of egress must be kept free of any kind of obstruction In the event of an emergency evacuation.

- These areas may not be used for equipment and storage as they create hazards.

Infestation

Head Lice Infestation

Treatment for head lice is recommended for persons diagnosed with an active infestation. When head lice are identified on any child, all children and staff should be checked. Everyone with evidence of an active infestation should be treated at the same time. NOTE: Parents and staff identified with head lice are responsible for treatment under the care of their physicians.

To control an outbreak of head lice in the child care center staff must implement the steps below when an outbreak of head lice is discovered.

- All hats, scarves, pillow cases, bedding, clothing, and towels worn or used by the infested person in the 2-day period just before treatment is started must be machine washed and

Adapted from Centers for Disease Control - http://www.cdc.gov/lice/head/treatment.html#treat

dried using the hot water and hot air cycles because lice and eggs are killed by exposure for 5 minutes to temperatures greater than 53.5°C (128.3°F). Items that cannot be laundered may be dry-cleaned or sealed in a plastic bag for two weeks.
- Items such as hats, grooming aids, and towels that come in contact with the hair of an infested person should not be shared.

- Vacuum furniture and floors to remove an infested person's hairs that might have viable nits attached.
- Have the infested person put on clean clothing after treatment.
- If a few live lice are still found 8-12 hours after treatment, but are moving more slowly than before, do not tell parent to retreat. The medicine may take longer to kill all the lice. Comb dead and any remaining live lice out of the hair using a fine-toothed nit comb.
- If, after 8-12 hours of treatment, no dead lice are found and lice seem as active as before, the medicine may not be working. Speak with the parent; a different lice medicine may be necessary.
- Maintain close communication with parents to monitor progress of treatment. After each home treatment, check the hair and comb with a nit comb to remove nits and lice every 2-3 days to decrease the chance of self-reinfestation.
- Continue to check for 2-3 weeks to be sure all lice and nits are gone.
- Soak combs and brushes in hot water (at least 130°F) for 5-10 minutes.

Prevent Reinfestation:

- Avoid head-to-head (hair-to-hair) contact during play and other activities at home, school, and elsewhere (sports activities, playground, slumber parties, camp). Lice are spread most commonly by direct head-to-head (hair-to-hair) contact and much less frequently by sharing clothing or belongings onto which lice or nits may have crawled or fallen.
- Do not share clothing such as hats, scarves, coats, sports uniforms, hair ribbons, or barrettes.
- Do not share infested combs, brushes, or towels.
- Do not lie on beds, couches, pillows, rugs, carpets, or stuffed animals that have recently been in contact with an infested person.
- To help control head lice outbreaks in child care or camp, children should be taught to avoid activities that may spread head lice.

Adapted from Centers for Disease Control - http://www.cdc.gov/lice/head/treatment.html#treat

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Rodent Infestation

Worldwide, rats and mice spread over 35 diseases. These diseases can be spread to humans directly, through handling rodents, through contact with rodent feces, urine, or saliva, or through rodent bites. Diseases carried by rodents can also be spread to humans indirectly, through ticks, mites or fleas that have fed on an infected rodent.

Centers for Disease Control o- http://www.cdc.gov/rodents/

The primary strategy for preventing human exposure to rodent diseases is effective rodent control in the child care environment. This is achieved by eliminating any food sources,

sealing even the smallest entries into homes, and successfully trapping rodents in and around the home.

1. Inside the Center – Report to the director/assistant director gaps in and around the walls of the child care center that need to be filled. Examples of places where gaps may be big enough for rodents to get in:
    1. Inside, under, and behind kitchen cabinets, refrigerators and stoves.
    2. Inside closets near the floor corners.
    3. Around the fireplace.
    4. Around doors.
    5. Around pipes under sinks and washing machines.
    6. Around pipes going to hot water heaters and furnaces.
    7. Around floor vents and dryer vents.
    8. Inside the attic.
    9. In the basement or crawl space.
    10. In the basement and laundry room floor drains.
    11. Between the floor and wall juncture.

- Outside the Center – Report any gaps seen along the outer walls of the center to the director or assistant director. Examples of places where gaps may be big enough for rodents to get in:
    1. In the roof among the rafters, gables, and eaves.
    2. Around windows, doors, and the foundation.
    3. Attic vents and crawl space vents.
    4. Under doors.
    5. Around holes for electrical, plumbing, cable, and gas lines.

Seal Gaps that Rodents Might Enter

- Fill small holes with steel wool.
- Put caulk around the steel wool to keep it in place.
- Use lath screen or lath metal, cement, hardware cloth, or metal sheeting to fix large holes. These materials can be found at your local hardware store.
- Fix gaps in trailer skirtings and use flashing around the base of the building.
- If you do not remember to seal up entry holes, rodents will continue to get inside. Outbuildings and garages should also be sealed to prevent the entrance of rodents.

Eliminate possible rodent food sources

- Keep food in thick plastic or metal containers with tight lids.
- Clean up spilled food right away and wash dishes and cooking utensils soon after use.
- Keep outside cooking areas and grills clean.
- Always put pet food away after use and do not leave food or water out overnight.

Centers for Disease Control o- http://www.cdc.gov/rodents/

- Keep bird feeders away from the building and use squirrel guards to limit access to the feeder by squirrels and other rodents.
- Use a thick plastic or metal garbage can with a tight lid.
- Keep compost bins as far away from the building as possible (100 feet or more).
- Keep grains and animal feed in thick plastic or metal containers with tight lids. In the evening, uneaten animal feed should be returned to containers with lids.

Storing Trash and Food Waste

- If storing trash and food waste inside the center, place in rodent-proof containers, and frequently clean the containers with soap and water.
- Dispose of trash and garbage on a frequent and regular basis, and pick up or eliminate clutter.
- Eliminate possible nesting sites outside the home.
- Elevate hay, woodpiles, and garbage cans at least 1 foot off the ground.
- Move woodpiles far away from the house (100 feet or more).
- Get old unused items that mice and rats could use as homes.
- Keep grass cut short and shrubbery within 100 feet of the home well trimmed.

Clean-up After Rodents

Take precautions before and during clean up of rodent-infested areas by following the directions above. Then:

- When possible, allow 1 week to pass before beginning clean-up so that any infectious virus in the rodent's urine/droppings or nesting material is no longer infectious.
- Before starting clean up of the space, ventilate the space by opening the doors and windows for at least 30 minutes to allow fresh air to enter the area. Use cross-ventilation and leave the area during the airing-out period.
- Clean-up any urine and droppings using a bleach solution of 1 part bleach to 10 parts water.
- **Do not** stir up dust by sweeping or vacuuming up droppings, urine, or nesting materials.
- When you begin cleaning, it is important that you:
  1. Wear rubber, latex, or vinyl gloves when cleaning urine and droppings.
  2. Spray the urine and droppings with a disinfectant or a mixture of bleach and water and let soak 5 minutes. The recommended concentration of bleach solution is 1 part bleach to 10 parts water. When using a commercial disinfectant, follow the manufacturer's instructions on the label for dilution and disinfection time.
  3. Use a paper towel to pick up the urine and droppings, and dispose of the waste in the garbage.
  4. After the rodent droppings and urine have been removed, disinfect items that might have been contaminated by rodents or their urine and droppings.

Centers for Disease Control o- http://www.cdc.gov/rodents/

Lead

- Information regarding lead is contained in the publication, ***Frequently Asked Questions on Lead and Lead Poisoning***

FREQUENTLY ASKED QUESTIONS ON LEAD AND LEAD POISONING

What is lead poisoning?
Lead poisoning is one of the most common environmental child health problems in the United States and is caused by too much lead in the body. Lead is especially harmful to children younger than 6, but anyone who eats, drinks, or breathes something which has too much lead can get lead poisoning.

Large amounts of lead in a child's blood can cause brain damage, mental retardation, behavior problems, anemia, liver and kidney damage, hearing loss, hyperactivity, developmental delays, other physical and mental problems, and in extreme cases, death.

Lead poisoning affects three to four million young children - one in six under age 6.

Where does lead come from?
Unlike many environmental health problems, lead contamination is most often found at home, in paint and dust from old chipping, peeling or flaking paint. It is also may be found in drinking water, toys, painted ceramic dishes, home remedies and soil.

Lead in paint:
About 75 percent of houses and apartments built before 1978 in the United States contain lead paint. Houses built before 1960 may contain old lead paint with concentrations up to 50 percent lead by weight. Children can get poisoned by chewing on a lead painted window sill or eating lead paint chips. The more common cause, however, is getting lead dust on their hands and into their mouths. Lead dust is released from chipping and peeling paint; home renovation projects that disturb lead paint; and lead paint ground up by friction, such as on window sashes, porch floors or the like.

Lead in dust:
Window sills and window wells often have high levels of lead dust. In addition to lead dust from paint, lead dust may also come from soil and airborne emissions, such as incinerators, smelters and other industries. Some children are poisoned by lead dust brought home by their parents from the workplace - millions of people are exposed to lead in their jobs.

Lead dust is very fine, can be invisible, and is hard to clean up. It gets on children's hands and toys and then into their mouths through normal behavior, such as thumb sucking.

Lead in soil:
Outside, in public playgrounds and in their own yards, the dirt where children play may contain high lead levels. Decades of peeling exterior building paint, air emissions from leaded car exhaust and pollution from smelters and other industries are significant sources. The highest levels of lead in soil usually are found close to foundations of homes painted with exterior leaded paint.

Lead in water:
The Environmental Protection Agency (EPA) estimates drinking water is the source of about 20 percent of Americans' lead exposure. Lead leaches out into the water from old lead pipes and service lines in city systems and from home plumbing. Even after lead pipes were banned, leaded solder was legal for use on drinking water lines until the 1980's and is still for sale in hardware stores. Faucets and plumbing fittings may legally contain up to 8 percent lead. The greatest risk is to infants using formula mixed with contaminated water.

Other lead sources:
Lead can leach into food or beverages stored in imported ceramics or pottery and leaded crystal and china. Certain hobbies use products with lead in them (fishing sinkers, stained glass, ceramics). Lead can be found in some folk remedies, "health foods" and cosmetics.
Source: Coalition to End Child Lead Poisoning (www.leadsafe.org/Parents/faq.html)

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Why is there concern about low lead levels in children?
Even small amounts of lead can harm a child's brain, kidneys and stomach. Lead poisoning can slow a child's development and cause learning and behavior problems.

A child may have lead poisoning and not feel sick. Or the child may have stomach aches, headaches, a poor appetite or trouble sleeping, or be cranky, tired or restless.

There is new evidence that lead poisoning is harmful at blood levels once thought safe. Lower IQ scores, slower development and more attention problems have been observed in children with lead levels as low as 10 micrograms per deciliter. (Micrograms per deciliter, written µg/dL, indicates the amount of lead in a deciliter of blood.)

How can parents find out if their child has too much lead?
A blood test is the only way to find out if a child has too much lead. The Centers for Disease Control and Prevention (CDC) recommends testing every child at 12 months of age, and if resources allow, at 24 months. Screening should start at 6 months if the child is at risk of lead exposure (for example, if the child lives in an older home built before 1960 which has peeling or chipping paint). Decisions about further testing should be based on previous blood-lead test results, and the child's risk of lead exposure. In some states, more frequent lead screening is required by law.

What do the test results mean?
The test will identify how many micrograms of lead are found in one deciliter of the child's blood. Based on what is known today, children should have under 10 micrograms per deciliter (10 µg/dL) of blood lead concentration. If higher levels are found, there are certain steps that can be taken.

At 10-19 µg/dL, a child has mild lead poisoning. He or she should be re-tested in a few months. The home and all the places the child spends time should be checked for lead sources. Identified lead hazards should be controlled. Frequent wet cleaning and handwashing will help reduce lead dust. Good nutrition can help the child fight lead.

A blood lead level between 20-44 µg/dL means the child has moderate lead poisoning. Sources of lead in the child's environment must be removed. Such a child may need chelation therapy to remove lead from the body. Chelation therapy means the child is given a drug capable of binding lead and reducing its acute toxicity. All drugs have potential side effects and must be used with caution.

A blood lead concentration of 45-69 µg/dL is severe lead poisoning. A child needs both medical treatment and lead removed from the environment.

If the child's blood lead level tests over 70 µg/dL, it is an acute medical emergency. The child may stay in the hospital for treatment and not be released until he or she can return to a lead-free safe home.

What can parents do to reduce blood-lead levels?
Housekeeping
- Keep children away from peeling or chipping paint and accessible or chewable surfaces painted with lead-based paint, especially windows, window sills, and window wells.
- Wet mop and wet wipe hard surfaces, using tri-sodium phosphate detergent (found at hardware stores) or automatic dishwasher soap and water.

- Do not vacuum hard surfaces with a regular vacuum (use a HEPA filtered vacuum) because this activity is believed to scatter dust. HEPA Vacuums are available for rental, loan or purchase. Please contact the Lead Coalition at (800) 370-5323 for information.

Handwashing
- Wash children's hands and faces before they eat.
- Wash toys and pacifiers frequently.

Nutrition
- Make sure children eat regular nutritious meals, since more lead is absorbed on an empty stomach.
- Make sure children's diets contain plenty of iron and calcium:

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- Examples of foods high in iron are liver, fortified cereal, cooked beans, spinach, and raisins.
- Examples of foods high in calcium are milk, yogurt, cheese, and cooked greens.

Soil
If soil around the home is likely to be lead-contaminated (such as around a home built before 1960 or near a major highway), plant grass or other ground cover. If lead-based paint is the source of soil contamination, most lead will be near painted surfaces such as exterior walls. In such cases, plant bushes next to the house to keep children away. If the soil is contaminated with lead, provide a sandbox with a solid bottom and top cover, and clean sand for children to play and dig in.

Water
If the lead content of tap water in the home is higher than the drinking water standard, let the cold water run for several minutes (until it is as cold as possible) before using it. Use only fully-flushed water from the cold-water tap for drinking and cooking. To conserve water, collect drinking water in bottles at night after water has been fully flushed from the tap. (This procedure will help if the source of lead is from the home's plumbing. It will not help if the city water supply is lead contaminated. For information on how to get drinking water tested, call 1-800-426-4791.)

Food
Do not store food in open cans, especially imported cans. Do not store or serve food in pottery that is meant for decorative use. Also, do not store food or beverages in lead crystal or china.

Parents' Work or Hobbies
If members of the family work with lead, make sure children are not exposed through any lead contaminated clothing or scrap material brought home.

What about removing lead-based paint from a house?
If inspection shows the house has lead-based paint, the family should not renovate or attempt to remove the paint themselves. Work should be done by someone who knows how to protect workers, the family and the environment. The family should not be in the home during renovations or paint removal.

For more information, contact:
Coalition To End Childhood Lead Poisoning at 1-800-370-LEAD (1-800-370-5323)
2714 Hudson Street
Baltimore, MD 21224
Fax: 1-410-534-6475
Internet: www.leadsafe.org

The Coalition has a vast array of materials and information on Lead Poisoning Prevention Education, Outreach, Advocacy and Resources (including pamphlets, books, videos, grant applications, Lead Safe Housing Registry and lead cleaning kits). Staff does one on one and group prevention training. The Coalition also specializes in education on state, local and federal lead poisoning prevention laws and programs. Its services include Qualified Offer Counseling, Lead Safe Housing Relocation and assistance with Notices of Defects and Rent Escrow.

The Maryland Department of the Environment (MDE) at 1-800-776-2706
Lead Prevention Program
2500 Broening Highway
Baltimore, MD 21224

Baltimore City Health Department (for Lead Cleaning Kits) at 410-396-6970

Lead Abatement Action Project (Baltimore City Healthy Start) at 410-396-7225 For Grants or Loans for Lead Hazard Reduction (Baltimore City only)

Maryland Department of Housing and Community Development at 410-514-7565 For Lead Hazard Reduction Grant and Loan Programs (Maryland statewide)

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The National Lead Information Center at 1-800-LEAD-FYI (1-800-532-3394).
General Education materials in Spanish and English.

The Alliance to End Childhood Lead Poisoning at 202-543-1147
600 Pennsylvania Ave., SE, Suite 100;
Washington, D.C., 20003. Contact for a list of publications and further resources.

The National Conference of State Legislatures Lead Hazards Project at 303-830-2200
National Conference of State Legislatures
1560 Broadway; Suite 700
Denver, CO 80202
For information regarding state legislative and regulatory programs.

The National Center for Lead-Safe Housing at 410-964-1230
205 American City Building
Columbia, MD 21044

The Environmental Protection Agency's Safe Drinking Water Hotline at 1-800-426-4791
For information on laboratories certified to test for lead in water.

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Safety Hazards /Structural Concerns-

- Rooms and doorways must remain free of obstruction and debris; all items to be discarded should be disposed of properly and not stored in hallways or other critical areas.
- Ride-on toys should be stored in designated areas outside of the building or in the indoor playroom only.
- Fire doors prevent the spread of fire and smoke. Fire doors at stairwells and in corridors should be kept closed at all times unless held open by the door's magnetic device. This device will release automatically when a fire alarm sounds. Fire doors should never be blocked open or otherwise tampered with. Supervisors should make sure that all employees become familiar with exits nearest their work area and the location of the fire pull alarm.

Storage of Equipment & Supplies-

- Only designated areas will be used for storage. Do not use machine, electrical, or transformer rooms for storage. These areas are prime places for fires and explosions.

Storage of Hazardous Materials-

- All cleaning supplies, maintenance supplies, building materials, etc. will be kept in separate storage areas inaccessible to all children.

Bibliography

Caring for Our Children – National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care, Second Edition; American Academy of Pediatrics, 141 Northwest Point Blvd., Elk GroveVilliage, IL 60007-1098; American Public Health Association, 8001 I Street, N.W., Washington, DC 20001-3710; National Resource Center for Health and Safety in Child Care, University of Colorado Health Sciences Center at Fitzsimons, campus Mail Stop F541, PO Box 6508, Aurora, CO 80045-0508. Support for this project was provided by the Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services (Cooperative Agreement # U93 MC 00098).

Children with Special Needs – Applicable Standards from: Caring for Our Children – National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care, Second Edition; American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL 60007-1098; American Public Health Association, 8001 I Street, N.W., Washington, DC 20001-3710; National Resource Center for Health and Safety in Child Care, University of Colorado Health Sciences Center at Fitzsimons, campus Mail Stop F541, PO Box 6508, Aurora , CO 80045-0508. Support for this project was provided by the Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services (Cooperative Agreement # U93 MC 00098).

Model Child Care Health Policies; Healthy Child Care Pennsylvania, The Early Childhood Education Linkage System, 1400 N. Providence Road, Rose Tree Media Corporate Center, Suite 3007, Media, PA 19063-2043.

Office of Child Care Resource Documents; Office of Child Care, Division of Early Childhood Development, Maryland State Department of Education, 200 W. Baltimore St., Baltimore, MD 21201

The Therapeutic Nursery Family Handbook; PACT: Helping Children with Special Needs, Kennedy Krieger Institute, 128 W. Franklin St., Baltimore, MD 21201; Kim Cosgrove, Manager of Therapeutic Nurseries.