

# Family Child Care Toolkit



# Table of Contents

<b>Acknowledgements</b> .....	<b>iii</b>	Report of Tuberculosis Screening – Children’s Programs ..	27
<b>Chapter 1: Getting Started</b> .....	<b>1</b>	Provider Record Checklist .....	28
Types of Family Child Care .....	1	Assistant/Substitute Provider Record .....	29
Licensed Family Day Homes.....	1	Caregiver Reference .....	31
Voluntary Registered Family Day Home.....	3	Documentation of Assistant and Substitute Provider Orientation Training.....	32
Family Day System .....	3	Confidentiality Policy for Caregivers .....	33
Family Child Care Programs Approved by Local Ordinance.....	3	Career Lattice.....	34
Unregulated Care .....	3	Professional Development Plan.....	36
Philosophy, Goals, and Objectives.....	5	Performance and Development Plan .....	39
Philosophy .....	5	Record of Annual Training .....	44
Goals .....	5	Staff Observation Form .....	45
Objectives.....	6	Receipt for Child Care Services .....	47
Provider Records and Responsibilities .....	6	<b>Chapter 2: Policies and Procedures.....</b>	<b>49</b>
Provider Records .....	6	Policies .....	49
Provider Responsibilities .....	7	Procedures .....	49
Employees .....	8	Risk Management Policies.....	50
Resources.....	8	Culturally Responsive Care .....	50
Employee Checklists.....	8	Parent Handbook .....	50
Professional Development .....	9	Communication.....	51
Competencies for Early Childhood Professionals .....	9	Daily Communication.....	51
Performance and Professional Development Planning...	10	Annual Survey .....	51
Finding Professional Development Activities .....	11	Daily Schedule .....	52
Colleges, Universities, and Continuing Education.....	11	Children’s Records .....	52
Virginia Child Care Provider Scholarship Program....	11	Sample Forms and Materials .....	55
Virginia Department of Social Services Sponsored Classes.....	11	Record of Daily Attendance.....	56
Other Agencies, Organizations and Associations for Professional Development .....	11	Infant/Toddler Daily Report .....	57
Virginia Child Care Resource and Referral Network....	12	Family Child Care Program Parent Survey.....	58
Virginia Infant & Toddler Specialist Network.....	12	Child’s Record.....	59
Virginia Alliance of Family Child Care Associations .....	12	Pre-Enrollment Information.....	61
Virginia Association for Early Childhood Education.....	12	Commonwealth of Virginia School Entrance Health Form.....	63
National Association for Family Child Care.....	12	Information for Parents .....	67
National Association for Early Childhood Education .....	12	Policy for the Administration of Medications.....	69
Financial Budget .....	13	Liability Insurance Declaration.....	71
Developing and Operating Budget.....	13	Provisions of the Emergency Preparedness and Response Plan .....	72
Recordkeeping .....	13	Staffing Recommendations for Child with Special Needs .....	73
Expenses .....	13	Individual Health Care Plan for Child with Special Health Care Needs .....	75
Business Hours.....	14	<b>Chapter 3: Health and Safety .....</b>	<b>77</b>
Year-End Statement for Families .....	14	Promoting Wellness.....	77
Sample Forms and Materials .....	15	Morning Inspection .....	77
Checklist for Adult Household Member Record .....	16	Handwashing Procedures .....	78
Checklist for Household Member Record .....	17	Diapering/Toileting Procedures.....	78
Sworn Statement or Affirmation for Child Day Programs .....	18	Preparing for Diapering .....	78
Criminal History Record Name Search Request .....	20	Diapering Procedures .....	79
Criminal History Record/Sex Offender and Crimes Against Minors Registry Search .....	22	Nap and Rest Time Routines.....	79
Virginia Department of Social Services/Child Protective Services Central Registry Release of Information.....	25	Infants .....	80
		Toddler, preschool, and school-age children.....	80
		Sudden Infant Death Syndrome .....	80



Nutrition.....	81	Emergency Preparedness and Response – Completed Sample.....	149
Child and Adult Care Food Program .....	81	Provisions of the Emergency Preparedness and Response Plan .....	155
Food Allergies .....	82	Record of Emergency Response Drills.....	156
Table Sanitizing .....	82	Daily Routine .....	157
Additional Precautions.....	83	Daily Routine – Completed Sample .....	158
Common Illness.....	83	Health and Safety Checklist.....	159
Creating an Illness Policy .....	85	Injury Record .....	160
Communicable Diseases.....	85	Injury Record – Completed Sample .....	161
When to Report a Disease to the Health Department.....	85	Field Trip Permission .....	162
How to Notify Parents of Illness and Disease .....	91	General Permission for Regularly Scheduled Trips .....	163
Medication .....	91	Transportation Information for Parents .....	164
Protecting Children in Your Family Child Care Program .....	91	Child Passenger Safety Fact Sheet.....	165
Child Abuse and Neglect in Virginia .....	91	Emergency Information and Transportation Checklist ..	166
What is Child Abuse and Neglect.....	91	Permission to Participate in Swimming and Wading Activities.....	167
Reporting .....	93	<b>Chapter 4: Child Development .....</b>	<b>169</b>
Local Department of Social Services Response .....	93	Virginia’s Milestones of Child Development .....	169
Additional Information.....	93	Mixed Age Groups .....	171
Emergency Planning .....	94	Stages of Play .....	172
Reducing the Risks.....	94	Outdoor Play.....	173
Evacuation, Relocation, and Shelter-in-Place .....	95	Interest Areas.....	173
Emergency Preparedness and Response Plan .....	95	Family Child Care Environment Rating Scale .....	174
Accidents and Injuries.....	96	Recommended Materials.....	175
First Aid and CPR .....	96	Toilet Training.....	179
Parent Notification for Accidents and Injuries.....	96	Children’s Behavior.....	179
Poison Control Information .....	97	Behavior Management.....	180
Playground Safety.....	97	Challenges from Your Own Children .....	180
Air Quality Index.....	98	Early Intervention .....	181
Field Trips and Transporting Children .....	99	Infant & Toddler Connection .....	181
Sample Forms and Materials .....	101	Care Connection for Children.....	182
Infant Handwashing .....	103	Inclusion .....	182
Wash Your Hands (English and Spanish).....	104	Components of Early Literacy .....	183
Gloving (English and Spanish) .....	106	Foundation Blocks for Early Learning Programs.....	184
Diapering Procedures (English and Spanish).....	108	School Readiness.....	185
Safe Sleep Policy .....	112	Virginia’s Plan for Smart Beginnings.....	185
A Child Care Providers’ Guide to Safe Sleep .....	113	Virginia Star Quality Initiative .....	185
A Parent’s Guide to Safe Sleep.....	115	Virginia’s Definition of School Readiness .....	186
Weekly Menu.....	117	Kindergarten Transitions .....	186
Food Allergy Action Plan (English and Spanish).....	119	Interactions .....	187
Family Checklist for Nutrition in Early Care and Education.....	123	Sample Forms and Materials .....	189
Family Checklist for Physical Activity in Early Care and Education.....	125	Infant & Toddler Connection – Child Development Checklist (English and Spanish) .....	190
Guidelines for the Use of Sanitizers and Disinfectants in Child Care Facilities .....	127	Born Learning – Fun and Games with Songs .....	198
Disinfecting Solution (English and Spanish).....	132	A Planning Guide for Kindergarten .....	200
Cover Your Cough (English and Spanish).....	134	Kindergarten Readiness Skills Checklist.....	201
Keep Me Home If ... (English and Spanish) .....	136	Sample Parent Letter #1 .....	205
Notice of Exposure to Illness/ Communicable Disease.....	138	Sample Parent Letter #2.....	207
Shaken Baby Syndrome (English and Spanish) .....	139	Mind in the Making: The Science of Early Learning ...	208
Emergency Preparedness and Response.....	143	<b>Chapter 5: Resources .....</b>	<b>213</b>
		Program Management Resources .....	213
		Resources to Share with Families .....	214
		<b>Endnotes/References.....</b>	<b>217</b>



# Family Child Care Toolkit

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Virginia Department of Social Services

Contact Arlene Kasper at the Division of Child Care and Early Childhood Development, Virginia Department of Social Services, 801 East Main Street, Richmond, VA 23219-2901 or [arlene.kasper@dss.virginia.gov](mailto:arlene.kasper@dss.virginia.gov).

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Additional copies of this toolkit are available for download from:  
[www.smartbeginnings.org/Home/StarQualityInitiative/ForEarlyChildhoodProfessionals.aspx](http://www.smartbeginnings.org/Home/StarQualityInitiative/ForEarlyChildhoodProfessionals.aspx)

We encourage replication and use of these materials for non-profit purposes.

## ***Acknowledgements:***

The Family Child Care Toolkit was developed by the Virginia Early Childhood Foundation as part of the Family Child Care Demonstration of the Virginia Star Quality Initiative. Contributors included Shirley R. Blake; Brenda L. Cubero; Barbie Gallini; Bethany Geldmaker, PNP, PhD; Mickie McInnis; David K. Mills; Marilyn Rice; Claire Wood, RN, CCHC; Carole Whitener; and staff from the Virginia Department of Social Services Division of Child Care and Development and Division of Licensing Programs.

*The Director's Toolbox* was an essential resource in the development of this toolkit.





Chapter 1

# Getting Started



# Chapter 1: Getting Started

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Family child care is the most common form of child care in this country. Family child care providers are independent, self-employed business people who have assumed one of society's most important responsibilities, that of caring for our youngest children. Young children thrive in a stable long term relationship with the same provider in the comfort of a home environment and in small groups where each child's needs can be met. Family child care can allow families flexibility in their work schedules such as early morning, night, or weekend care. Families are able to work more productively when their children are in safe, quality care.<sup>1</sup>

This toolkit is designed to assist family child care providers in providing quality care and education to the children they serve. It contains guides and outlines, sample policies and procedures, and forms and checklists to help family child care providers.

The toolkit and its references to regulating authorities such as the Virginia Department of Social Services Standards for Licensed Family Day Homes, Local Ordinances, or licensed Family Day Systems are, to the best of our knowledge, accurate as of April 1, 2011. Should discrepancies exist between this toolkit and the regulating authority, the regulating authority must take precedence.

Please be aware that regulations are under constant revision due to changes in research findings, generally acceptable practices in child care, and laws enacted by the General Assembly. Family child care providers should contact the appropriate regulating authority with specific questions about requirements.

Included at the end of each chapter are sample forms and other materials that you may copy, post, and share with assistants, substitutes, and the families you serve.

## Types of Family Child Care

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In Virginia, family child care providers are subject to regulation based on the number of children in care, the ages of the children, and/or the locality in which they operate.

### *Licensed Family Day Homes*

The Code of Virginia mandates that a family day home be licensed if the provider cares for six to twelve children (exclusive of the provider's

own children and any children who reside in the home). The care may be offered in the home of the provider or in the home of any of the children in care. During the (less than 24 hour) absence of a parent or guardian, the licensed family day home provider assumes responsibility for the supervision, protection, and well-being of a child less than 13 years of age. All adult residents of the applicant's household, assistants, and substitutes must complete a criminal history background check, central registry clearance, sworn disclosure statement, and a tuberculosis screening. Licensed Family Day Homes comply with licensing standards, which are proposed by the State Board of Social Services and enforced by the Division of Licensing Programs, to ensure that the activities, services, and facilities of the family day home are conducive to the welfare



**Licensing Information Line:** 1-800-KIDS-LIL (1-800-543-7545)

**Home Office**  
**Virginia Department of Social Services**  
**Division of Licensing Programs**

**801 E. Main Street, 9th Floor**  
**Richmond, Virginia 23219**  
**Main Phone: (804) 726-7165**

**Regional Offices:**

**Central Licensing Office**

1604 Santa Rosa Road, Suite 130  
Richmond, VA 23229-5008  
Phone: (804) 662-9743

**Counties:** Albemarle, Amelia, Brunswick, Buckingham, Caroline, Charlottesville, Chesterfield, Cumberland, Dinwiddie, Essex, Goochland, Hanover, Henrico, King and Queen, King George, King William, Lancaster, Lunenburg, Mecklenburg, Northumberland, Nottoway, Powhatan, Richmond, Westmoreland.

**Cities:** Blackstone, Colonial Heights, Farmville, Hopewell, Lawrenceville, Petersburg, Richmond, South Boston, West Point

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**Eastern Licensing Office**

Pembroke Office Park  
291 Independence Boulevard  
Pembroke IV Office Building, Suite 300  
Virginia Beach, VA 23462-5496  
Phone: (757) 491-3990

**Counties:** Accomack, Greensville, Isle of Wight, Northampton, Southampton

**Cities:** Chesapeake, Emporia, Franklin, Norfolk, Portsmouth, Suffolk, Virginia Beach

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**Fairfax Licensing Office**

3701 Pender Drive, Suite 125  
Fairfax, VA 22030  
Phone: (703) 934-1505

**Counties:** Arlington, Loudoun, Fairfax

**Cities:** Alexandria, Annandale, Centreville, Fairfax, Falls Church, Herndon

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**Northern Licensing Office**

170 West Shirley Avenue, Suite 200  
Warrenton, Virginia 20186  
Phone: (540) 347-6345

**Counties:** Fauquier, Prince William, Rappahannock, Spotsylvania, Stafford

**Cities:** Fredericksburg, Manassas, Manassas Park, Woodbridge, Dale City

**Peninsula Licensing Office**

2600 Washington Avenue, Suite 202  
Newport News, VA 23607  
Phone: (757) 247-8020

**Counties:** Charles City, Gloucester, James City, Mathews, Middlesex, New Kent, Prince George, Surry, Sussex, York

**Cities:** Franklin, Hampton, Newport News, Poquoson, Williamsburg

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**Piedmont Licensing Office**

Commonwealth of Virginia Bldg.  
1351 Hershberger Road, Suite 210  
Roanoke, VA 24012  
Phone: (540) 204-9632

**Counties:** Alleghany, Amherst, Appomattox, Bath, Bedford, Botetourt, Campbell, Charlotte, Craig, Franklin, Halifax, Henry, Nelson, Patrick, Pittsylvania, Prince Edward, Roanoke, Rockbridge

**Cities:** Bedford, Buena Vista, Covington, Danville, Lexington, Lynchburg, Martinsville, Roanoke, Salem

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**Valley Licensing Office**

Augusta Professional Park  
57 Beam Lane, Suite 303  
Fishersville, VA 22939  
Phone: (540) 332-2330

**Counties:** Augusta, Clarke, Culpeper, Fluvanna, Frederick, Greene, Highland, Louisa, Madison, Orange, Page, Rockingham, Shenandoah, Warren

**Cities:** Harrisonburg, Staunton, Waynesboro, Winchester

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**Western Licensing Office**

190 Patton Street  
Abingdon, VA 24210  
Phone: (276) 676-5490

**Counties:** Bland, Buchanan, Carroll, Dickenson, Floyd, Giles, Grayson, Lee, Montgomery, Pulaski, Russell, Scott, Smyth, Tazewell, Washington, Wise, Wythe

**Cities:** Blacksburg, Christiansburg, Bristol, Galax, Norton, Radford



of the children in care. For the most recent set of licensing standards; effective July 1, 2010 visit [www.dss.virginia.gov/facility/child\\_care/licensed/fdh/index.cgi](http://www.dss.virginia.gov/facility/child_care/licensed/fdh/index.cgi).

### ***Voluntary Registered Family Day Home***

Voluntary Registration is a form of regulation offered to family day homes that are not required to be licensed. These homes have five or fewer children in care, not including the provider's own children and any children who reside in the home. Voluntary registration is not available in areas where local ordinances regulate unlicensed providers (Arlington, Fairfax, and Alexandria). The program is administered by agencies that have contracted with the Virginia Department of Social Services (VDSS) to perform this function in a specific area of the state.

To register, a family day home provider pays a contracting agency \$50.00 for a two-year certificate. All adult residents of the applicant's household, assistants, and substitutes must complete a criminal history background check, central registry clearance, sworn disclosure statement, and a tuberculosis screening at the time of their initial application and subsequent renewals. The provider must complete a health and safety checklist assessing the home and meet any local fire and zoning regulations.

The contract agency completes a home inspection to make sure basic child safeguards are adequate. During the two-year period, the contracting agency and VDSS licensing staff monitor ten percent of registered homes for compliance with staffing requirements and a health and safety checklist.

### ***Family Day System***

The Code of Virginia requires licensure of any person who approves family day homes as a member of its system or refers children to available day homes in that system. The system refers children to member homes, as well as provides the operators with training, technical assistance and consultation, inspection, supervision, and monitoring. The system is also responsible for referring children to available health and social services. The only licensed Family Day System in Virginia is operated by Infant Toddler Family Day Care. More information about this system can be found on their website, [www.infanttoddler.com](http://www.infanttoddler.com).

### ***Family Child Care Programs Approved by a Local Ordinance***

Three localities in Virginia — Arlington, Alexandria and Fairfax — have local ordinances for operating family child care providers. To learn more contact:

Arlington County Department of Human Services  
Child and Family Services Division  
3033 Wilson Boulevard, Suite 600A  
Arlington, VA 22201  
(703) 228-1685

City of Alexandria Department of Human Services  
2525 Mt. Vernon Avenue  
Alexandria, VA 22301  
(703) 746-5700

Fairfax County Office for Children  
12011 Government Center Parkway, Suite 920  
Fairfax, VA 22035  
(703) 324-8100

[www.fairfaxcounty.gov/childcare/](http://www.fairfaxcounty.gov/childcare/)

### ***Unregulated care***

Unregulated care also known as "family, friend and neighbor care," is a family child care home that is not inspected by the state or any contracting agency. A provider can legally provide care for no more than five children, in addition to the provider's own children or children residing in the home, or no more than four children under the age of two, including the provider's own children or children residing in the home, at any one time. Unregulated care includes many local providers who are paid to work with small groups of children in their homes and who do so as a business enterprise that contributes to the economic and social fabric of their communities. It also includes grandparents, aunts, and other relatives who open their homes daily to help family members, often for free.

Regardless of the setting, it is in the child's best interest that family child care providers provide an environment that is safe, nurturing, caring and stimulating. An environment where children can grow and learn the foundational skills they will need to be successful in school.



**Voluntary Registration Contract Agencies - Child Care Information Line**  
**For information on training or filing complaints, call 1-800-KIDS-LIL (1-800-543-7545)**  
**Richmond area only: (804) 692-2394**

**Child Nutrition Inc. (CNI)**

9 North Third Street, Suite 100  
Warrenton, Virginia 20186-3404

**Contact:** Beth Witussen, bethw@cni-usda.org;  
Sheila Jock, sheilaj@cni-usda.org  
Phone: (540) 347-3767  
Fax: (540) 347-2225

**Counties:** Augusta, Clarke, Culpeper, Fauquier, Frederick, Loudoun, Madison, Orange, Page, Prince William, Rappahannock, Rockbridge, Rockingham, Shenandoah, Stafford, Warren

**Cities:** Ashburn, Berryville, Culpeper, Dale City, Dumfries, Front Royal, Harrisonburg, Haymarket, Leesburg, Luray, Manassas, Manassas Park, Occoquan, Quantico, Staunton, Sterling, South Riding, Unionville, Warrenton, Waynesboro, Winchester, Woodstock

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**DOLP-West**

Virginia Department of Social Services  
Division of Licensing Programs – Voluntary Registration  
801 East Main Street, 9th Floor  
Richmond, Virginia 23219-2901

**Contact:** Margie Irby, margie.irby@dss.virginia.gov  
Phone: (804) 726-7170, 1-800-543-7545 (voice mail only)  
Fax: (804) 726-7132

**Counties:** Alleghany, Amherst, Appomattox, Bath, Bedford, Bland, Botetourt, Buchanan, Buckingham, Campbell, Carroll, Charlotte, Craig, Cumberland, Dickenson, Floyd, Franklin, Giles, Grayson, Halifax, Henry, Highland, Lee, Montgomery, Patrick, Pittsylvania, Prince Edward, Pulaski, Roanoke, Russell, Scott, Smyth, Tazewell, Washington, Wise, Wythe

**Cities:** Abingdon, Appomattox, Bedford, Blacksburg, Bluefield, Bristol, Buena Vista, Christiansburg, Clifton Forge, Collinsville, Covington, Danville, Farmville, Galax, Lexington, Lynchburg, Madison Heights, Marion, Martinsville, Norton, Radford, Roanoke, Rose Hill, Salem, South Boston, Tazewell, Wytheville

**Children, Youth & Family Services, Inc. (CYFS)**

ATTN: C.C.Q.,  
1000 East High Street  
Charlottesville, Virginia 22902-4848

**Contact:** Mary-Margaret Gardiner, mmgardiner@cyfs.org  
Sharon Churchman, Schurchman@cyfs.org  
Phone: (434) 296-4118, ext. 228 – Mary-Margaret, ext. 241 – Sharon  
Fax: (434) 295-2638

**Counties:** Albemarle, Fluvanna, Greene, Louisa, Nelson  
**Cities:** Charlottesville

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**Memorial Child Guidance Clinic (MCGC)**

200 North 22nd Street, Richmond, Virginia 23223-7020

**Contact:** Brenda Cubero, bcubero@childsavers.org  
Phone: (804) 644-9590 ext. 3039  
Fax: (804) 343-2708

**Counties:** Amelia, Charles City, Chesterfield, Cumberland, Dinwiddie, Goochland, Hanover, Henrico, New Kent, Nottoway, Powhatan, Prince George, Surry

**Cities:** Blackstone, Charles City, Chester, Colonial Heights, Glen Allen, Hopewell, Petersburg, Richmond

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**The Planning Council (TPC)**

Robin Hood Road, Suite 700  
Norfolk, Virginia, 23513-2406

**Contact:** Lytisha Spencer,  
lspencer@theplanningcouncil.org  
Phone: (757) 622-9268 ext. 3051  
Fax: (757) 623-3051

**Counties:** Accomack, Brunswick, Caroline, Essex, Gloucester, Greenville, Isle of Wight, James City, King George, King Williams, Lancaster, Mathews, Middlesex, Northumberland, Northampton, Richmond, Southampton, Spotsylvania, Sussex, York

**Cities:** Chesapeake, Emporia, Franklin, Fredericksburg, Hampton, Newport News, Norfolk, Portsmouth, Suffolk, Virginia Beach, Williamsburg

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**DOLP-EAST**

Virginia Department of Social Services  
Division of Licensing Programs – Voluntary Registration  
801 East Main Street, 9th Floor  
Richmond, Virginia 23219-2901

**Contact:** Margie Irby, margie.irby@dss.virginia.gov  
Phone: (804) 726-7170, 1-800-543-7545 (voice mail only)  
Fax: (804) 726-7132

**Counties:** Clark, Halifax, King and Queen, Lunenburg, Mecklenburg, Westmoreland

# Program Philosophy, Goals and Objectives

When a family enrolls their child in a family child care program, it is important for the provider to orient the family to the program by communicating information like philosophy, goals, and objectives. Sharing this information is a good way to introduce your program to enrolling families. Knowing a program's philosophy, goals and objectives can help a family choose a family child care provider that has goals similar to their own.

## Philosophy

Your philosophy includes the underlying values, general beliefs, concepts, and attitudes, which direct your program. It also includes your day-to-day responses to problems and the interactions between adults and children. Philosophy is the centering point of your program. It can be lengthy or short, general, or quite specific. The following are sample philosophy statements. Your statement will reflect your own values, goals, and priorities.<sup>2</sup>

### SAMPLE Philosophy Statement #1

*My philosophy is that all children must be treated with respect. All children have the right to safe, healthy, loving care and opportunities for developmental activities according to their ages, special needs, talents, and interest.*

*In order to help children grow to their fullest potential, I believe children should be provided with materials and activities which meet their developmental needs. The furniture and other equipment in my home are designed to help children gain independence in motor skills and self-help skills. The responsibilities of my program include making sure the children are safe, assisting them when they need help, providing appropriate toys and activities, maintaining a flexible but predictable routine each day, providing them with gentle positive discipline and guidance, and most importantly giving them loving and nurturing care.<sup>2</sup>*

*It is important that children learn to become self disciplined. A child armed with self discipline has a tremendous asset for addressing life's challenges. Children learn self discipline through consequences and choices. By teaching children to become self disciplined I am helping them develop a quality that will enable them to be successful in life.*

### SAMPLE Philosophy Statement #2

*We offer a nurturing, educational program for infants to school aged children. We believe that each child is a unique and special individual who has the right to safe, stimulating, and educational child care regardless of race, gender, color, religion, ability, economic background, national origin, culture, or ancestry. We know how hard it is to leave your child in the care of another, but please rest assured that your child will be cherished and kept safe while you are away. Our goal is to provide high quality child care by creating a safe, healthy, and caring environment that promotes the physical, social, emotional, and cognitive development of your child, as well responding to the needs of your family. We partner with parents; working together to help our children grow happy, healthy, and strong, and building a relationship of mutual trust and respect.<sup>3</sup>*



## Goals

Your program goals are tied directly to your own particular philosophy. Differences in philosophies create differences in program goals. A goal is a statement with a long term view of expected outcomes. By definition, goals should be broad in nature and represent something that will be continuous and ongoing over a long period of time. Your program goals should provide the "WHAT"

and the “WHY” of your activities for children. There will be some differences in goals, curricula, and values related to differing philosophies. However, there are many common goals across all philosophies which are connected to the developmental tasks of the child.

What is a developmental task? Developmental tasks are common to most children at a particular age, and usually occur in sequence. Developmental tasks must be mastered by the child before moving to the next set of developmental tasks, e.g. toilet training, walking, going up and down steps, language use. We divide those tasks into five broad areas:

- Cognitive or mental
- Social
- Emotional
- Physical
- Creative

The goals established by a provider guide the daily schedule, activities, and the sequence of skill development.<sup>2</sup>

### **SAMPLE Goal Statement**

*In my family child care home, each child is viewed as an individual.*

*The goals for the children enrolled in my program are:*

- 1. To encourage positive self-esteem and self concept.*
- 2. To promote a self-confident, learner for life.*
- 3. To promote positive social skills.*
- 4. To promote fine and gross motor skills.*
- 5. To promote cognitive and creative skills in the areas of literacy, math, science, music, art, and language development.*

- 6. To promote independence, self-reliance, and self-discipline.*
- 7. To promote the appreciation of cultural diversity in community.*

### **Objectives**

Objectives are the practical steps needed to help you achieve your goals. Objectives help break down goals into smaller, achievable steps. Objectives are clear and geared towards philosophies and curriculum. The goals and objectives that are established guide the daily schedule, the activities, and the sequence of skill development. Each objective should define a specific, intended measurable accomplishment. Unlike goal statements, objectives typically are limited in time. One goal may produce several objective outcomes.<sup>2</sup>

### **SAMPLE Objective Statement #1**

**Goal:** *To grow in independence.*

**Daily objectives:**

- *to hang up own coat*
- *to set the table at snack and lunch*
- *to choose from a small group of activities*
- *to clean up activities and spills<sup>2</sup>*

### **SAMPLE Objective Statement #2**

**Goal:** *To begin to understand the physical world.*

**Daily objectives:**

- *to observe ice melting*
- *to search for ants to start an ant colony*
- *to start seedlings*
- *to compare rocks<sup>2</sup>*

## **Provider Records and Responsibilities**

The type of records you are required to keep may depend on whether you are licensed, regulated, or unregulated; however, your licensing status does not change the responsibilities you have for operating a family child care business.

### **Provider Records**

Licensed, regulated, and unregulated providers should maintain personnel records that include a variety of information. Personal information, reference checks, background record checks and health screenings help ensure that caregivers and the adults that the children come in contact with are of good character. At the end of this section

of the toolkit, you will find a variety of checklists, sample forms and information that can assist you with compiling personnel records. The checklists and sample forms provided meet or exceed the regulations for Licensed Family Day Homes, effective July 1, 2010; however, you should contact your regulatory authority to verify that you are complying with those regulations.

## To operate a quality program, it's important to understand the qualifications and responsibilities involved. Provider responsibilities include:

- Ensuring that the home's activities, services, and facilities are conducive to the welfare of children in care.
- Meeting the requirements and complying with child care regulations based on operating guidelines set by the State or local ordinances.
- Maintaining child/adult ratios that support quality supervision and care.
- Maintaining a healthy and safe atmosphere for children.
- Developing and implementing a developmentally appropriate environment for children, including activities that contribute to the care, growth and development, and individual needs of each child.
- Maintaining knowledge of first aid and injury procedures.
- Working with parents and children to develop effective relationships.
- Keeping a written record of children in attendance each day.
- Maintaining an up-to-date record at the family child care home for each enrolled child, including immunizations, physicals and parent contact information.
- Ensuring that the information in a child's record is privileged and confidential. The provider shall not distribute or release information in a child's record to any unauthorized person without the written consent of the child's parent.
- Providing the parents with written information on the policies and procedures of the family child care home before the child's first day of attendance (*see Chapter 2: Policies and Procedures for more information*).
- Scheduling regular conferences with families to discuss the child's development and setting goals that support future growth in the domains of learning found in Virginia's Milestones of Child Development; e.g., Social and Emotional Development, Approaches to Learning, Language and Literacy, Cognition and General Knowledge, Fine Arts and Physical Development and Health. The complete Milestones of Child Development published by the Office of Early Childhood Development, can be found online at [www.dss.virginia.gov/family/cc/professionals\\_resources.cgi](http://www.dss.virginia.gov/family/cc/professionals_resources.cgi).
- Scheduling regular meetings with other caregivers to review daily routines, discuss children's development and plan activities.
- Maintaining caregiver records, including background checks, professional development activities and TB screening.
- Directing, guiding and modeling good practices in early childhood, e.g., maintaining confidentiality, using positive discipline, promoting school readiness.
- Providing all caregivers working in the home with an orientation to the program. Some items reviewed in the orientation may need to be reviewed annually and as policies and procedures change.
- Conducting evaluations on substitutes and assistants and providing written feedback on job performance and professional development planning. Refer to Virginia's Competencies for Early Childhood Professionals, published by the Office of Early Childhood Development, which can be found online at [www.dss.virginia.gov/family/cc/professionals\\_resources.cgi](http://www.dss.virginia.gov/family/cc/professionals_resources.cgi) to help develop future professional planning.
- Preparing and maintaining a budget including personnel costs, equipment, food, supplies and training.
- Ensuring proper business practices including fiscal management, marketing, taxes and labor laws.
- Working with the community to establish a variety of relationships with resources and services for providers and families.
- Ensuring that any advertising is not misleading or deceptive.
- Attending training, seminars, conferences and other professional development opportunities to keep current on quality child care practices.
- Joining and participating in early childhood associations in order to become connected to other professionals and to learn ways to be an advocate for children and families.





# Professional Development

Research indicates that there is a strong relationship between on-going professional development and quality in a child care program. Professional development is defined as the process of obtaining the skills, qualifications, and experience that allow you to make progress in your career. Professional development is much more than attending workshops to satisfy annual training hours.

In this section, providers will learn more about professional competencies for early childhood professionals, professional development plans, and where to find professional development opportunities. Active involvement in professional development activities enhances professionalism, allows providers to network and find support, increases knowledge and understanding, and helps to prevent burnout.

## Competencies for Early Childhood Professionals

Virginia's *Competencies for Early Childhood Professionals* is a best practice guide for adults supporting the growth and development of children from birth to kindergarten entry. The *Competencies for Early Childhood Professionals* illustrates what early childhood professionals should know and be able to do to provide quality care and education

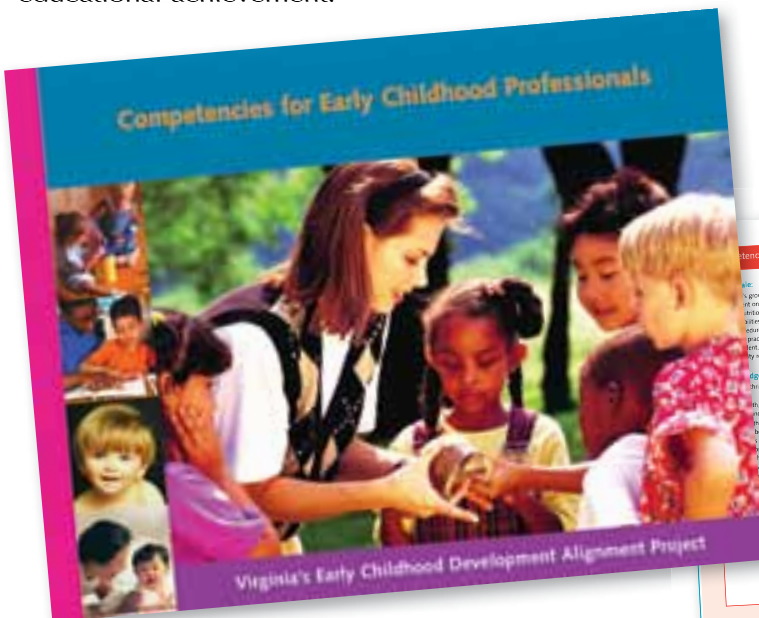
Family child care providers can use the *Competencies for Early Childhood Professionals* to track professional development activities and to identify specific areas of need for future professional development (e.g., training/education) for both themselves and any employees. Family child care providers may also want to use the *Competencies for Early Childhood Professionals* to specify training/education requirements for job descriptions, to develop professional development plans and policies, and to establish a salary scale based on educational achievement.

There are eight competency areas which detail specific competencies needed to deliver quality care and education in programs for children.

- Health, Safety, and Nutrition Practices
- Understanding Child Growth and Development
- Appropriate Child Observation and Assessment
- Partnering with Families and Community
- Learning Environment
- Effective Interactions
- Program Management
- Teacher Qualifications and Professional Development

Each of the eight competency areas includes:

- An explanation or rationale.
- The related knowledge base outlining the key research-based indicators in which the competency area is grounded.
- A set of practices based on knowledge to provide specific approaches and strategies to foster children's healthy growth and development.







performance part of the Plan. The Staff Observation Form can help guide you on what to look for when observing employees. Comments from families and anecdotes on contributions over the evaluation period will also help the provider provide clear examples of performance. The Performance and Development Plan also allows the provider, assistants, and/or substitutes to work together to identify goals and follow-up activities that support the assistants' and substitutes' future professional development. The provider, assistants, and

substitutes can use the Competencies and Lattice to help guide professional goals and future training needs as they complete the development part of the Plan.

The Professional Development/Training Log will assist the provider, assistants, and substitutes as they document annual training hours determined by the person's professional goals and/or regulations. The log is used to determine if the follow-up activities described in the Performance and Development Plan have been met.

## Finding Professional Development Activities

### *Colleges, Universities, and Continuing Education*

A wide range of certificates, associate and baccalaureate degrees, graduate work, short courses, continuing education credits, and extension courses in child care and early childhood development are available in Virginia, but not equally to all parts of the state. For a list of the institutions in Virginia visit, [www.schev.edu/Students/PublicCollegeList.asp](http://www.schev.edu/Students/PublicCollegeList.asp).

Financial aid is often available either through grants, loans, or work/study.

### *Virginia Child Care Provider Scholarship Program*

The Virginia Child Care Provider Scholarship Program provides tuition assistance to those employed in child care and those who plan to enter the field of child care and want to attend courses in child care, child development, or child care administration taught at Virginia's institutions of higher learning. The purpose of the scholarship program is to provide child care providers with a foundation in child care. The scholarship program is funded through the Child Care and Development Fund, which is financed through federal funding. Approved courses may be used toward obtaining such achievements as a Career Studies Certificate in Early Childhood Education, a Career Studies Certificate in School-Age Child Care Education, a Career Studies Certificate in Child Care Management, an Advanced Career Studies Certificate in Early Childhood Education, an Associate Degree in Early Childhood Education, and a Bachelor Degree in Early Childhood Education.

An application can be obtained by: (1) calling the Scholarship Program Hotline at 1-866-636-1608 or

(2) using the Department of Social Services' (VDSS) website, [www.dss.virginia.gov/family/cc/scholarship.cgi](http://www.dss.virginia.gov/family/cc/scholarship.cgi).

### *Virginia Department of Social Services (VDSS) Sponsored Classes*

The Virginia Department of Social Services Division of Child Care and Development provides child care professional development classes in the Professional Development Catalog published bi-annually. These classes are offered regionally and provide a wide selection of classes on topics for professionals that work with children from infants to school-age.

VDSS also provides other opportunities such as Read-A-Book and two video-based training programs, The Whole Child - A Caregiver's Guide to the First Five Years (TWC) and The Program for Infant/Toddler Caregivers (PITC). These opportunities are self-paced and require the professional to complete materials that are mailed to VDSS and reviewed for appropriate training credit.

The Professional Development Catalog and other professional development opportunities and resources offered by VDSS can be accessed online at, [www.dss.virginia.gov/family/cc/professionals\\_resources.cgi](http://www.dss.virginia.gov/family/cc/professionals_resources.cgi).

### *Other Agencies, Organizations and Associations for Professional Development*

There are a variety of statewide, regional, and national organizations, committed to the interests of young children. These organizations and their publications, conferences, membership activities, and journals offer rich opportunities for improving your own professional development.



### ***Virginia Child Care Resource and Referral Network***

Virginia Child Care Resource and Referral Network (VACCRRN) agencies provide important resources for the professional growth of child care providers across the state. The network is made up of 15 local child care resource and referral (CCR&R) agencies that assist providers with their training and business needs. VACCRRN works to improve the quality of child care services by supporting child care providers and encouraging more people to join the child care workforce. To learn more about VACCRRN or to find an agency near you visit [www.vachildcare.org](http://www.vachildcare.org).

### ***Virginia Infant & Toddler Specialist Network***

The Virginia Infant & Toddler Specialist Network strives to achieve excellence in early care by increasing the educational level and skills of those who care for infants and toddlers, whether in family homes or in centers. Specialists provide resources, training, conference calls and quality improvement services that support quality programs for infants and toddler. The Network serves to link existing community resources that support healthy, safe, and nurturing care for infants and toddlers. To learn more about The Virginia Infant and Toddler Specialist Network or to contact a specialist serving your region visit, [www.va-itsnetwork.org](http://www.va-itsnetwork.org).

### ***Virginia Alliance of Family Child Care Associations***

Virginia Alliance of Family Child Care Associations (VAFCCA) exists to support the Family Child Care Profession and Providers' professional development. VAFCCA promotes the professional development of Family Child Care Providers in the areas of child care training and early childhood education; areas that have an impact on the delivery of quality child care services. VAFCCA board is made up of 12 to 16 members from their 21 local associations across the state. Providers can participate in training and network with other family child care providers. The Alliance provides advocates for state child care issues that affect children, families, and family child care providers. To learn more about VAFCCA visit, [www.vafcca.org](http://www.vafcca.org).

### ***Virginia Association for Early Childhood Education***

The Virginia Association for Early Childhood Education (VAECE) is the state affiliate organization of the National Association for the Education of Young Children (NAEYC). VAECE is made up of professionals that work with children from birth through 3rd grade and people interested in the education and welfare of young children and their families. VAECE offers an annual state conference and the affiliate organizations to VAECE throughout the state provide local professional development workshops and activities through the year. To learn more about VAECE visit, [www.vaece.org](http://www.vaece.org).

### ***National Association for Family Child Care***

The National Association for Family Child Care (NAFCC) is a non-profit organization dedicated to promoting quality child care by strengthening the profession of family child care. NAFCC works to:

- strengthen state and local associations
- promote a professional accreditation program
- represent family child care providers by advocating for their needs and collaborating with other organizations
- promote the diversity of the family child care profession through training, state and local associations, public education, and Board membership and
- help to deliver effective programs through strong organizational management.

To learn about NAFCC visit, [www.nafcc.org](http://www.nafcc.org).

### ***National Association for Early Childhood Education***

National Association for Early Childhood Education (NAEYC) members are organized in a vibrant network of local, state, and regional Affiliate Groups. These Affiliate Groups are local, state, and regional early childhood associations that share NAEYC goals in working on behalf of young children and the early childhood profession. NAEYC annual conferences bring together early childhood educators representing many roles — teaching staff, program administrators, family child care providers, students, researchers and teacher educators — to discuss the latest ideas and learn from one another. To learn more about NAEYC visit [www.naeyc.org](http://www.naeyc.org).

# Financial Budget

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Do you know what it costs to run your family child care business? Do you know what your profit for the year might be or what last year's profit was? Predicting your earnings and expenses accurately will help you make sound financial decisions that can help your family child care stay profitable. There are many unique recordkeeping and tax rules for family child care, so finding a tax professional that specializes in family child care business is important.

## *Developing an Operating Budget*

Family child care is a business. Best practices encourage businesses to complete a yearly operating budget. The easiest way for a family child care business to create an operating budget is to review last year's income tax report.

Operating budgets are important because they can help you see where the largest part of your income is going and help you see where you are spending more than you should on certain expenses. It may also help you determine if you need to raise rates because you are not making enough to cover your expenses.

To create an operating budget, you should start by estimating (or using last year's income tax report) what the costs will be to operate your family child care. Typical expenses may include:

- Advertising
- Association Dues, e.g. NAEYC, NAFCC
- Bank service charges
- Food served to children
- Furniture and equipment
- Liability insurance
- License fees
- Office supplies
- Other supplies, e.g. books, art materials
- Professional services such as attorney and/or accountant fees
- Professional development, e.g. conferences, workshops
- Professional resources, e.g. curriculum books, reference books
- Repairs, i.e. child care specific repairs
- Salaries and wages
- Special events such as family conferences
- Taxes
- Utilities, e.g. a second phone line

- Field trips (instead of building the cost of field trips into your regular expenses, you may want to consider setting a separate field trip fee)
- Zoning costs and local business license

One simple way to start the budget process is to create a spreadsheet. In the beginning your operating budget will be an estimate of the expenses, but as each month goes by, you will start to see the actual expenses. By subtracting your expenses from your income, you can determine the profit of your business.

## *Recordkeeping*

Keeping good business records enables you to see the progress of your business. Providers do not need to be an accountant to keep good records. There are many books, computer software, and other tools to help you stay organized. See Chapter 5 of this toolkit for more information on resources.

## *Expenses*

Business expenses are expenses that are incurred as a direct result of your business. In other words, if you did not have the business you would not have the expenses. Business expenses are claimed on income tax reports. Providers have both direct and indirect expenses.

Direct expenses are the costs incurred from your business. Direct expenses are 100% deductible.

Direct expenses may include:

- Advertising
- Food served to the children
- Furniture and equipment
- Office supplies
- Other supplies, e.g. books, art materials
- Professional development, e.g. conferences, workshops

Indirect Expenses are expenses that are shared between your family and your business. Because family child care is a home-based business, there will always be some indirect expenses. Examples of indirect expenses include home repairs, real estate taxes, and shared cleaning supplies. Family child care providers are allowed to deduct a percentage of these expenses. This percentage is determined by the time-space percentage. The time-space percentage is determined using the time-space formula.

Keeping track of business expenses is an important part of being a business owner. Taking the time to accurately track your expenses could help you avoid paying unnecessary taxes.

### Business Hours

It is important for you to track the number of hours spent on the family child care business. These hours are used to calculate the time-space percentage for tax reporting. Business hours are not just the hours you spend with the children. You may also account for the hours spent on activities like cleaning, interviewing potential staff, planning activities, and preparing meal; however, you cannot claim hours more than once even if you were doing multiple activities like caring for children while preparing a meal. You also cannot claim the hours spent on business that is conducted away from the home like transporting children or grocery shopping. When tracking business hours, you should include the date, the time, and the activity completed.

## Time-Space Formula

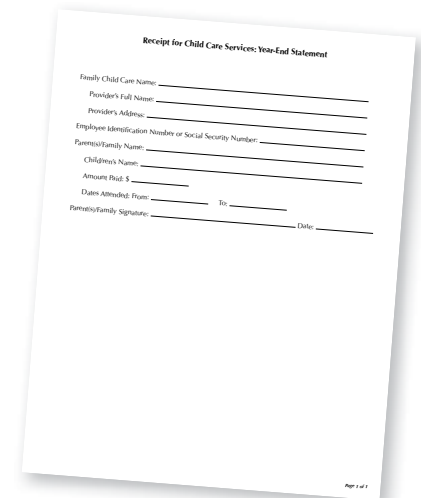
$$\text{Time Percent} \times \text{Space Percent} = \text{Time-Space Percentage}$$

*time percent* = number of hours home is used for business (total number of hours in a year)

*space percent* = number of square feet in the home used for business (total number of square feet in home)

### Year-End Statement for Families

Families are allowed to claim their child care expenses as a deduction on their taxes. This is called the Child and Dependent Care Credit. Although providers are not required to give families a year end statement, they are required to provide families with their employee identification number (EIN) or social security number. By taking the extra step of giving families a signed receipt for child care services for the year and keeping a copy for yourself with their signature, you will ensure you are prepared for any questions that may arise during tax time.



Receipt for Child Care Services Year-End Statement

Family Child Care Name: \_\_\_\_\_

Provider's Full Name: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Employee Identification Number or Social Security Number: \_\_\_\_\_

Parent/Family Name: \_\_\_\_\_

Children's Name: \_\_\_\_\_

Amount Paid: \$ \_\_\_\_\_

Dates Attended From \_\_\_\_\_ To \_\_\_\_\_

Parent/Family Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Sample Forms and Materials for Chapter 1

Checklist for Adult Household Member Record  
Checklist for Household Member Record  
Sworn Statement or Affirmation for Child Day Programs  
Criminal History Record Name Search Request  
Criminal History Record/Sex Offender and Crimes Against Minors Registry Search  
Virginia Department of Social Services/Child Protective Services Central Registry Release of Information  
Report of Tuberculosis Screening - Children's Programs  
Provider Record Checklist  
Assistant/Substitute Provider Record  
Caregiver Reference  
Documentation of Assistant and Substitute Provider Orientation Training  
Confidentiality Policy for Caregivers  
Career Lattice  
Professional Development Plan  
Performance and Development Plan  
Record of Annual Training  
Staff Observation Form  
Receipt for Child Care Services

The most recent versions of the Virginia Department of Social Services Model Forms for Family Day Homes (VDSS Model Form – FDH) are available online, visit: [www.dss.virginia.gov/facility/child\\_care/licensed/fdh/](http://www.dss.virginia.gov/facility/child_care/licensed/fdh/)  
Before using one of these forms, check the website to be sure it is the most recent version.

The entire toolkit, including all sample forms and materials, is available online and can be printed as needed, visit: [www.smartbeginnings.org/Home/StarQualityInitiative/ForEarlyChildhoodProfessionals.aspx](http://www.smartbeginnings.org/Home/StarQualityInitiative/ForEarlyChildhoodProfessionals.aspx)



## CHECKLIST FOR ADULT HOUSEHOLD MEMBERS

FULL NAME OF HOUSEHOLD MEMBER: \_\_\_\_\_

ORIGINAL BACKGROUND CHECKS (Renewed every three years) \_\_\_\_\_  
Expiration Date

*SWORN DISCLOSURE STATEMENT INDICATING NO BARRIER CRIME*

*CRIMINAL RECORD REPORT INDICATING NO BARRIER CRIME*

*CHILD PROTECTIVE SERVICES REGISTRY REPORT INDICATING NO FOUNDED COMPLAINT*  
*(Also required for household members aged 14 and above)*

REPORT OF TUBERCULOSIS SCREENING (Obtained every two years) \_\_\_\_\_  
Expiration Date

032-05-0603-00-eng



## Checklist for Household Member Record

(To be completed on all household members over 14 years.)

\_\_\_\_\_  
Name of household member Household member is:  Over 14 years old  Over 18 years old

### Household members over 14 years old will obtain a Child Protective Services Central Registry Check.

- Child Protective Services Central Registry Check (CPS Check)** indicating NO founded complaint.

\_\_\_\_\_  
(date mailed) (date received) (date updated) (date updated) (date updated)

\*The provider will fill out the *Child Protective Services Central Registry Check* and send it to the Virginia Department of Social Services. Virginia Department of Social Services will search their data base and then return it.

\*The *Child Protective Services Central Registry Check* is updated every three years.

### Household members over 18 years old will request/complete three separate Criminal Background Checks.

- Sworn Disclosure Statement or Affirmation for Child Day Programs** indicating NO barrier crime.

\_\_\_\_\_  
(date received) (date updated) (date updated) (date updated)

\*The provider completes the *Sworn Disclosure Statement or Affirmation* and places the completed form in their record.

\*The *Sworn Disclosure Statement or Affirmation* is updated every three years.

- Criminal History Record Check (State Police Report)** indicating NO barrier crime.

\_\_\_\_\_  
(date mailed) (date received) (date updated) (date updated) (date updated)

\*The provider will fill out the *Criminal History Record Check* and then send it to the Virginia State Police. The Virginia State Police will search their data base and then return it. You may also request this check online at <https://apps.vsp.virginia.gov/ncjis/publicforms.do>, select SP-230. If returned with a crime/conviction listed, the provider must review the barrier crimes list to verify the offense is not a barrier crime.

\*The *Criminal History Record Check* is updated every three years.

- Child Protective Services Central Registry Check (CPS Check)** indicating NO founded complaint.

\_\_\_\_\_  
(date mailed) (date received) (date updated) (date updated) (date updated)

\*The provider will fill out the *Child Protective Services Central Registry Check* and send it to the Virginia Department of Social Services. Virginia Department of Social Services will search their data base and then return it.

\*The *Child Protective Services Central Registry Check* is updated every three years.

### Household members over 18 years old will obtain a Tuberculosis screening.

- Report of Tuberculosis Screening Children's Program (TB Test).**

\_\_\_\_\_  
(date received) (date updated) (date updated) (date updated) (date updated)

\*Report of Tuberculosis Screening is updated every two years.

**SWORN STATEMENT OR AFFIRMATION FOR CHILD DAY PROGRAMS**  
Please Print

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<b>Last Name</b>	<b>First</b>	<b>Middle</b>	<b>Maiden</b>	<b>Social Security Number</b>
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<b>Current Mailing Address</b>	<b>Street, P.O. Box #, Apt. #</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
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<b>Name of Licensed/Registered Approved Facility/Provider</b>	<b>Street, P.O. Box #, Apt. #</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
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*Please respond to all four (4) questions below:*

1. Have you ever been convicted of or are you the subject of pending charges of any crime within the Commonwealth of Virginia?     Yes (convicted in Virginia)     Yes (pending in Virginia)     No

If yes to convicted or pending, specify crime(s): \_\_\_\_\_

\_\_\_\_\_

2. Have you ever been convicted of or are you the subject of pending charges of any crime outside the Commonwealth of Virginia?     Yes (convicted outside Virginia)     Yes (pending outside Virginia)     No

If yes to convicted or pending, specify crime(s) and state, or other location: \_\_\_\_\_

\_\_\_\_\_

3. Have you ever been the subject of a founded complaint of child abuse or neglect within the Commonwealth of Virginia?     Yes (in Virginia)     No (in Virginia)

4. Have you ever been the subject of a founded complaint of child abuse or neglect outside the Commonwealth of Virginia?     Yes (outside Virginia)     No (outside Virginia)

If yes, specify state, or other location: \_\_\_\_\_

**I hereby affirm that the information provided on this form is true and complete. I understand that the information is subject to verification and that making a materially false statement or affirmation is a Class I misdemeanor.**

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Signature	Date
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## Explanation of Sworn Statement or Affirmation

**Requirement:** Sections 63.2-1704, 63.2-1720, 63.2-1721, 63.2-1722, 63.2-1724 and 63.2-1725 of the *Code of Virginia* (Code) require individuals to provide a sworn statement or affirmation to a licensing, approving or hiring authority, facility, or agency prior to licensure, registration, approval, employment, or provision of volunteer services. A sworn disclosure or affirmation is a statement completed by a person attesting to whether he has ever been: (i) convicted of or the subject of pending charges of any crime within the Commonwealth or equivalent offense outside the Commonwealth, or (ii) the subject of a founded complaint of child abuse or neglect within or outside the Commonwealth. Additionally for family day homes, the person affirms if he, or if he knows that any person who resides in the home, has a sex offense conviction or is the subject of a founded complaint of child abuse or neglect within or outside the Commonwealth. The statement or affirmation must be made available to the Department of Social Services' representative.

**Who must comply:** These individuals must provide sworn statements or affirmations:

- Applicant upon application for licensure or registration as a child welfare agency, and any subsequent person designated as applicant, licensee, or registrant;
- Agent at the time of application who is or will be involved in the day-to-day operation of the child welfare agency or who is or will be alone with, in control of, or supervising one or more of the children and any subsequent person designated as agent who will be involved in the day-to-day operation or will be alone with, in control of, or supervising one or more of the children;
- Any other adult living in the home of an applicant for licensure or registration or approval as a family day home, or any existing employee or volunteer, and subsequent employee or volunteer or other adult living in the home;
- Operator of family day home requesting approval by family day system;
- Person who signs the statement of intent to operate a religiously exempt child day center;
- Any person who will be expected to be alone with one or more children enrolled in a religious exempt child day center; and
- Any employee or volunteer of a licensed, registered, or approved facility who is involved in the day-to-day operations or who is alone with, in control of, or supervising one or more children.

Note: Any other child day center or family day home that has not otherwise met these requirements, and applies to enter into a contract with a local department to provide child care services to clients of a local department, must also submit a sworn statement or affirmation.

Exception: A parent-volunteer is not required to provide a sworn statement or affirmation. A parent-volunteer is a person supervising, without pay, a group of children that includes the parent-volunteer's own child in a program that operates no more than four hours per day, provided that the parent-volunteer works under the direct supervision of a person who has received satisfactory background checks as provided for in the Code.

Any person making a materially false statement regarding any such offense is guilty of a Class 1 misdemeanor.

Further dissemination of the sworn statement information is prohibited other than to the Commissioner's representative or a federal or state authority or court in order to comply with an express requirement in the law for that dissemination.

**Consequence:** If a person required to submit a sworn statement or affirmation (i) fails to submit a sworn statement or affirmation, or (ii) has been convicted of a barrier crime (specified below), or (iii) has been convicted of any other felony in the last five years, or (iv) has been the subject of a founded complaint of child abuse or neglect, and the facility refuses to separate that person from employment or service:

- Licensure, registration or approval of a child day program is prohibited;
- Licensure, registration or approval will be revoked and renewal of a license or registration or religiously exempt status will be denied;
- Religiously exempt status will be revoked; and
- The child welfare agency will not be permitted to receive federal, state or local child care funds.

Exception: A person who wants to operate or to volunteer or work at a facility covered by this regulation, but who is disqualified because of a criminal conviction, or a criminal conviction in the background check of any other adult living in a family day home governed by this regulation may apply for a waiver if: 1) a non-barrier crime felony conviction occurred less than five years ago, or 2) any other adult living in the home of a state regulated family day home applicant or provider has been convicted of not more than one misdemeanor offense of assault and battery or assault and battery against a family or household member. This other adult may not be an assistant or substitute provider.



**DO NOT USE THIS FORM. OBTAIN ORIGINAL FORM FROM THE VIRGINIA STATE POLICE.**

S.P. 167 (Rev. 11-01-2010)

**CRIMINAL HISTORY RECORD NAME SEARCH REQUEST**

<b>PURPOSE OF THIS REQUEST (Check only one):</b>			
<input type="checkbox"/> ADOPTION-DOMESTIC	<input type="checkbox"/> ADOPTION-INTERNATIONAL COUNTRY: _____		
<input type="checkbox"/> VISA (INTERNATIONAL TRAVEL)	<input type="checkbox"/> OTHER (please specify): _____		
<b>NAME INFORMATION TO BE SEARCHED:</b>			
<u>LAST NAME</u>	<u>FIRST NAME</u>	<u>MIDDLE NAME</u>	<u>MAIDEN NAME</u>
<u>RACE</u>	<u>SEX</u>	<u>DATE OF BIRTH</u> / / (MM/DD/YYYY)	<u>SOCIAL SECURITY NUMBER</u>
<b>AFFIDAVIT FOR RELEASE OF INFORMATION:</b>			
I hereby give consent and authorize the Virginia State Police to search the files of the Central Criminal Records Exchange for a criminal history record and report the results of such search to the agent or individual authorized in this document to receive same.			
			_____ Signature of Person
State of _____; County/City of _____, to wit: Subscribed and sworn to before me this _____ day of _____, 20 ____.			
My Commission expires _____, 20 ____ My registration # is: _____			
			_____ Signature of Notary Public
<b>SIGNATURE OF PERSON MAKING REQUEST:</b>			
As provided in Section 19.2-389, <u>Code of Virginia</u> , I hereby request the criminal history record of the individual named in Section 1 and swear or affirm I have the consent of the individual to obtain their record and will not further disseminate the information received, except as provided by law.			
			_____ Signature of Person Making Request
State of _____; County/City of _____, to wit: Subscribed and sworn to before me this _____ day of _____, 20 ____.			
My Commission expires _____, 20 ____ My registration # is: _____			
			_____ Signature of Notary Public
<b>NAME AND MAILING ADDRESS OF AGENCY, INDIVIDUAL OR AUTHORIZED AGENT MAKING REQUEST:</b>			
Mail Reply To:			
<u>NAME</u>			
<u>ATTENTION</u>			
<u>ADDRESS</u>			
<u>CITY</u>	<u>STATE</u>	<u>ZIP CODE</u>	
<b>FEES FOR SERVICE:</b>			
FEES:		* FEES For Volunteers with Non-Profit Organizations:	
<input type="checkbox"/> \$15.00 CRIMINAL HISTORY SEARCH	<input type="checkbox"/> \$20.00 COMBINATION CRIMINAL HISTORY & SEX OFFENDER SEARCH	<input type="checkbox"/> \$8.00 CRIMINAL HISTORY SEARCH	<input type="checkbox"/> \$16.00 COMBINATION CRIMINAL HISTORY & SEX OFFENDER SEARCH
* To be entitled to reduced price, services must be on volunteer basis for a non-profit organization with a tax exempt number Attach documentation to form which supports volunteering status and include organization's name, address, and your tax exempt identification number			
<b>METHOD OF PAYMENT: (Note: Personal Checks <u>Not</u> Accepted)</b>		<b>Mail Request To:</b>	
<input type="checkbox"/> Business or Certified Check or Money Order (payable to Virginia State Police)		Virginia State Police Central Criminal Records Exchange - NF P.O. Box 85076 Richmond, Virginia 23261-5076  ATTN: NEW FORM	
<input type="checkbox"/> Charge Card <input type="checkbox"/> MasterCard  OR <input type="checkbox"/> Visa			
Account Number: _____			
Expiration Date: ____/____/____			
Signature of Cardholder: _____			
<input type="checkbox"/> Virginia State Police Charge Account Number: _____			
<b>FOR STATE POLICE USE ONLY – DO NOT WRITE BELOW THIS LINE</b>			
Response based on comparison of name information submitted in request against a master name index maintained in the Central Criminal Records Exchange only.			
<input type="checkbox"/> No Conviction Data – Does Not Preclude the Existence of an Arrest Record		Purpose code: <input type="checkbox"/> C	
<input type="checkbox"/> No Criminal Record – Name Search Only		<input type="checkbox"/> N	
<input type="checkbox"/> No Sex Offender Registration Record		<input type="checkbox"/> O	
<input type="checkbox"/> No Criminal Record – Fingerprint Search			
<input type="checkbox"/> Criminal Record Attached			
Date _____ By CCRE/ _____			



**CRIMINAL HISTORY RECORD NAME SEARCH REQUEST**

**INSTRUCTIONS FOR COMPLETING THE CRIMINAL HISTORY RECORD NAME SEARCH REQUEST FORM**

Pay By: Certified Check/Money Order or Business Check made payable to "Virginia State Police"  
**OR we accept VISA and Mastercard**  
Personal Checks Not Accepted

Effective November 1, 2010, the public is hereby placed upon notice that returned checks or dishonored money orders and/or credit card payment denials will incur a handling fee of \$50 in addition to the amount of the original payment. Requesting goods or services will be deemed to be acceptance of these terms.  
Code of Virginia §2.2-4805.

Discard these Instructions Prior to Submitting to State Police

Refer to Page 2 of these Form Instructions for Pricing Structure and Types of Name Searches Available

If you are interested in obtaining a name search of the "Sex Offender and Crimes Against Minors Registry," refer to the instructions on page 2 of this form.

The Form Must be **TYPED OR NEATLY HAND-PRINTED.**  
Complete the Criminal History Record Request by following these instructions:

\*\*\*

- PURPOSE OF THIS REQUEST:** Primary reason for request.
- NAME INFORMATION TO BE SEARCHED:** Name, race, sex, date of birth, and social security number on whom the criminal record name search is to be conducted. Providing the social security number is voluntary; however, it is a screening tool that is used for this request to be processed in a more timely manner. Failure to provide this number may result in an inability to process this request due to multiple records with similar names and demographics. Without this additional identifier, the form may be returned to the requestor unprocessed, and the applicant will be required to submit a set of fingerprints along with this request form to determine if this applicant has a criminal record. Numbers provided will be used to help identify the proper record and will be used for no other purpose.
- AFFIDAVIT FOR RELEASE OF INFORMATION:** Individual's signature on which the search is to be conducted. The signature indicating consent must be notarized for the search to be conducted and mailed to the individual or authorized agent (if applicable).
- SIGNATURE OF PERSON MAKING REQUEST:** Affidavit must be signed by authorized agent and notarized to receive the search results.
- NAME AND MAILING ADDRESS OF AGENCY, INDIVIDUAL OR AGENT MAKING REQUEST:** Name and complete mailing address of the individual, agency or authorized agent to receive processed criminal record search must be completed.
- FEES FOR SERVICE:** Indicate fee that is submitted, based upon type of request. Fees for volunteer of non-profit organizations must be accompanied with their tax exempt number.
- METHOD OF PAYMENT:** Indicate method of payment.

Mail the Completed S.P. 167 "Criminal History Record Request" to:

Virginia State Police  
Central Criminal Records Exchange – NF  
P.O. Box 85076  
Richmond, Virginia 23261-5076





**Instructions For Requesting a Search of the “Sex Offender and Crimes Against Minors Registry”**

In accordance with Section 9.1-900 – 9.1-918, Code of Virginia, the Central Criminal Records Exchange of the Virginia Department of State Police is responsible for maintaining the above captioned Registry containing name, personal descriptive/conviction information and photographs of individuals convicted of specific sex offenses. The law also provides for the dissemination of sex offender registrations for the following purpose: Child/adult care, child minding, public/child protection, daycare services, volunteering services or employment. To request an inquiry of the Registry, S.P. 266 “Sex Offender and Crimes Against Minors Registry” name search forms may be obtained by downloading from the State Police’s web site: <http://www.vsp.virginia.gov>.

There are two classifications of sex offenders: the sex offender and violent sex offender. A single name search can be conducted to determine if a person is convicted of a violent or sex offense by completing and S.P 266 form. Violent sex offenders can be searched on the Virginia State Police web site: Virginia State Police Sex Offender and Crimes Against Minors Registry <http://sex-offender.vsp.virginia.gov/sor/>.

**Cost Structure and Types of Records Searches Available**

\*\*\*

CRIMINAL HISTORY RECORD	\$15.00 per search of Criminal History Name File.
COMBINATION CRIMINAL HISTORY/SEX OFFENDER REGISTRY	\$20.00 for a COMBINATION criminal history record name search conducted and a Sex Offender and Crimes Against Minors name search.
COMPLETE SEX OFFENDER REGISTRY	\$15.00 per search of the Sex Offender Registry only through the submission of an S.P. 266 “Sex Offender and Crimes Against Minors” name search request form.
VIOLENT SEX OFFENDERS	No Charge for searches conducted of violent offender registrations ONLY through the Virginia State Police web site: Virginia State Police Sex Offender and Crimes Against Minors Registry <a href="http://sex-offender.vsp.virginia.gov/sor/">http://sex-offender.vsp.virginia.gov/sor/</a> .
NON-PROFIT ORGANIZATION COMBINATION CRIMINAL HISTORY/SEX OFFENDER REGISTRY	\$16.00 for a COMBINATION criminal history record name search conducted for a “Criminal History Record Name Search” and “Sex Offender and Crimes Against Minors.” The purpose of this search is for volunteering services for a non-profit organization. The S.P. 167 must be submitted attached to documentation explaining the purpose of the search is for volunteering services for a non-profit organization. The documentation must include the name of the organization, address and the tax-exempt identification number of the organization.
NON-PROFIT ORGANIZATION COMPLETE SEX OFFENDER	\$8.00 for each name search of the Sex Offender Registry conducted for individuals volunteering for a non-profit organization. The S.P. 167 must be submitted attached to documentation explaining the purpose of the search is for volunteering services for a non-profit organization. The documentation must include the name of the organization, address and the tax-exempt identification number of the organization.





**Instructions for completing the Criminal History Record/Sex Offender and Crimes Against Minors Registry Request Form**  
**(Please read the following General Instructions)**

<b>PURPOSE OF THIS REQUEST:</b>	Check type of name search(es) requested for Criminal History Search. Dissemination of criminal history records are processed in accordance with Section 19.2-389, <u>Code of Virginia</u> , governing the program for which the search is requested.
<b>NAME TO BE SEARCHED:</b>	Type the full name (last, first middle [no initials] and maiden name (if applicable), sex, race, date of birth, and completed address of person whose name is to be searched against the master criminal name file and/or the Sex Offender and Crimes Against Minors Registry. <b>Note: Signature of person making request is required.</b>  Providing the social security number is voluntary; however, it is a screening tool that is used for this request to be processed in a more timely manner. Failure to provide this number may result in an inability to process this request due to multiple records with similar names and demographics. Without this additional identifier, the form may be returned to the requestor unprocessed, and the applicant will be required to submit a set of fingerprints along with this request form to determine if this applicant has a criminal record. Numbers provided will be used to help identify the proper record and will be used for no other purpose.
<b>NAME AND MAILING ADDRESS OF AGENCY, INDIVIDUAL OR AUTHORIZED AGENT MAKING REQUEST:</b>	Agency, Individual or Authorized Agent Making Request: Your agency identification serves as the mailing label for the State Police to return the search results. This information is also reviewed to ensure requestor is statutorily entitled to use this form to request a criminal name search.
<b>FEES FOR SERVICE:</b>	Indicate the fee for the service requested.
<b>METHOD OF PAYMENT:</b>	Method of Payment: Certified Check, Money Order, Company/Business check, MasterCard or Visa. For charge account: record charge account number issued by State Police.  Effective November 1, 2010, the public is hereby placed upon notice that returned checks or dishonored money orders and/or credit card payment denials will incur a handling fee of \$50 in addition to the amount of the original payment. Requesting goods or services will be deemed to be acceptance of these terms. <u>Code of Virginia §2.2-4805.</u>

**Mailing Instructions:**

Mail to: Virginia State Police  
CCRE – Attention: New Form  
P.O. Box 85076  
Richmond, Virginia 23261-5076



Virginia Department of Social Services/Child Protective Services  
Central Registry Release of Information Form

**Part III: CERTIFICATION AND CONSENT FOR RELEASE OF INFORMATION**

I hereby certify that the information contained on this form is true, correct and complete to the best of my knowledge. Pursuant to Section 2.2-3806 of the *Code of Virginia*, I authorize the release of personal information regarding me which as been maintained by either the Virginia Department of Social Services or any local department of social services which is related to any disposition of founded child abuse/neglect in which I am identified as responsible for such abuse/neglect. I have provided proof of my identity to the Notary Public prior to signing this in his/her presence.

Signature of Person to Be Searched \_\_\_\_\_ Parents' Signature (Needed if child is 17 years old or younger) \_\_\_\_\_

**Part IV: CERTIFICATE OF ACKNOWLEDGEMENT OF INDIVIDUAL**

City/County of \_\_\_\_\_

Commonwealth/State of \_\_\_\_\_

Acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Notary Public Signature \_\_\_\_\_

Notary Number \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

Do not write below this line.

**Part V: Findings - To be completed by OBI Central Registry staff only.**

**CENTRAL REGISTRY FINDINGS**

1. We are unable to determine at this time if the individual for whom a search has been requested is listed in the Central Registry. Please answer the following questions and return to Central Registry Unit in order for us to make a determination:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Worker: \_\_\_\_\_ Date: \_\_\_\_\_

2. \_\_\_\_\_ Based on information provided by the Local Department of Social Services, we have determined that \_\_\_\_\_ is listed in the Child Abuse/Neglect Central Registry with a founded disposition of child abuse/neglect. For more detailed information, contact the

\_\_\_\_\_ Dept.of Social Services in reference to referral \_\_\_\_\_ phone# \_\_\_\_\_

\_\_\_\_\_ Dept.of Social Services in reference to referral \_\_\_\_\_ phone# \_\_\_\_\_

3 \_\_\_\_\_ As of this date, based on the information provided, the individual whose name was being searched is **NOT** identified in the Central Registry Child Abuse/Neglect.

Signature of worker completing search: \_\_\_\_\_ Date: \_\_\_\_\_  
OBI staff only



## Report of Tuberculosis Screening Children's Programs

Standards and child care policy require certain individuals to submit a report indicating the absence of tuberculosis in a communicable form when involved with (i) children's facilities regulated by the Department of Social Services or (ii) legally operating child care programs, excluding care by relatives, that receive Child Care and Development Funds. Each report must be dated and signed by the examining physician, the physician's designee, or an official of a local health department. When signed by the physician's designee, the form must also identify the physician/physician practice with which the physician – designated screener is affiliated.

---

**Name**


---

**Date of Birth**


---

**Address (Street, City, State Zip)**


---

1.)  A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

---

2.) Tuberculin Skin Test (PPD):    Date given: \_\_\_\_\_    Date read: \_\_\_\_\_  
 Results: \_\_\_\_\_mm    Positive: \_\_\_\_\_    Negative: \_\_\_\_\_

---

3.)  The individual has a history of a positive tuberculin skin test (latent infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

---

4.)  The individual either is currently receiving or has completed medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

---

5.)  The individual had a chest x-ray on \_\_\_\_\_ (date) at \_\_\_\_\_ (location) that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

**Based on the available information, the individual can be considered free of tuberculosis in a communicable form.**

---

 Signature/Title (MD/designee or Health Department Official)

---

 Date

---

 Print Name/Title

---

 Telephone Number

---

 Address (Including name of practice, if appropriate)



## PROVIDER RECORD CHECKLIST

- ORIGINAL BACKGROUND CHECKS (Renewed every three years)** \_\_\_\_\_  
Expiration Date
- SWORN DISCLOSURE STATEMENT INDICATING NO BARRIER CRIME**
  - CRIMINAL RECORD REPORT INDICATING NO BARRIER CRIME**
  - CHILD PROTECTIVE SERVICES REGISTRY REPORT INDICATING NO FOUNDED COMPLAINT**
  
  - REPORT OF TUBERCULOSIS SCREENING (Obtained every two years)** \_\_\_\_\_  
Expiration Date
  
  - DOCUMENTATION OF ANNUAL TRAINING** \_\_\_\_\_  
Anniversary Date
  
  - Current CPR certification** \_\_\_\_\_  
Expiration Date
  
  - Current First Aid certification** \_\_\_\_\_  
Expiration Date
  
  - Current MAT certification** \_\_\_\_\_  
Expiration Date

## ASSISTANT/SUBSTITUTE PROVIDER RECORD

FULL NAME OF CAREGIVER: _____ <input type="checkbox"/> ASSISTANT <input type="checkbox"/> SUBSTITUTE	
Street: _____	City: _____ State: _____ ZIP: _____
TELEPHONE NUMBER: _____	AGE: _____ (Attach Verification)
SPOUSE, PARENT, SIBLING OR CHILD OF THE PROVIDER <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>PERSON TO BE CONTACTED IN CASE OF EMERGENCY:</b>	
Name: _____	Telephone Number: _____
Street: _____	City: _____ State: _____ ZIP: _____
<b>EDUCATION (For substitute provider):</b>  (Attach Verification)	
<b>PROGRAMMATIC EXPERIENCE (For substitute provider):</b>  (Attach Verification)	
DATE OF EMPLOYMENT/VOLUNTEERING: _____	
TERMINATION DATE: _____	

**ADDITIONAL REQUIREMENTS:**

- TWO WRITTEN REFERENCES OR NOTATIONS OF VERBAL REFERENCES.** (Obtained prior to employment for an assistant or substitute provider who is not the spouse, parent, sibling or child of the provider)
  
- ORIGINAL BACKGROUND CHECKS (Renewed every three years)** \_\_\_\_\_ **Expiration Date**
  - SWORN DISCLOSURE STATEMENT INDICATING NO BARRIER CRIME (In caregiver record by the first day of employment)*
  - CRIMINAL RECORD REPORT INDICATING NO BARRIER CRIME (In the caregiver record by the 30<sup>th</sup> day of employment)*
  - CHILD PROTECTIVE SERVICES REGISTRY REPORT INDICATING NO FOUNDED COMPLAINT (In the caregiver record by the 30<sup>th</sup> day of employment)*
  
- REPORT OF TUBERCULOSIS SCREENING (Obtained every two years)** \_\_\_\_\_ **Expiration Date**
- DOCUMENTATION OF ORIENTATION TRAINING**
- DOCUMENTATION OF ANNUAL TRAINING (including annual emergency response training)**
- Current CPR certification (Renewed every two-three years)** \_\_\_\_\_ **Expiration Date**
- Current First Aid certification (Renewed every three years)** \_\_\_\_\_ (or documentation of licensure to administer prescription medications) **Expiration Date**
- Current MAT certification (Renewed every three years)** \_\_\_\_\_ (or documentation of licensure to administer prescription medications) **Expiration Date**
- FOR SUBSTITUTES, DOCUMENTATION OF TIME OF ARRIVALS AND DEPARTURES**
- FOR CAREGIVERS PROVIDING TRANSPORTATION, VALID DRIVER'S LICENSE**

032-05-0601-00-eng



## ASSISTANT/SUBSTITUTE PROVIDER RECORD

FULL NAME OF CAREGIVER: _____ <input type="checkbox"/> ASSISTANT <input type="checkbox"/> SUBSTITUTE	
Street: _____	City: _____ State: _____ ZIP: _____
TELEPHONE NUMBER: _____	AGE: _____ (Attach Verification)
SPOUSE, PARENT, SIBLING OR CHILD OF THE PROVIDER <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>PERSON TO BE CONTACTED IN CASE OF EMERGENCY:</b>	
Name: _____	Telephone Number: _____
Street: _____	City: _____ State: _____ ZIP: _____
<b>EDUCATION (For substitute provider):</b>  (Attach Verification)	
<b>PROGRAMMATIC EXPERIENCE (For substitute provider):</b>  (Attach Verification)	
DATE OF EMPLOYMENT/VOLUNTEERING: _____	
TERMINATION DATE: _____	

**ADDITIONAL REQUIREMENTS:**

- TWO WRITTEN REFERENCES OR NOTATIONS OF VERBAL REFERENCES.** (Obtained prior to employment for an assistant or substitute provider who is not the spouse, parent, sibling or child of the provider)
- ORIGINAL BACKGROUND CHECKS (Renewed every three years)** \_\_\_\_\_ **Expiration Date**
  - SWORN DISCLOSURE STATEMENT INDICATING NO BARRIER CRIME (In caregiver record by the first day of employment)*
  - CRIMINAL RECORD REPORT INDICATING NO BARRIER CRIME (In the caregiver record by the 30<sup>th</sup> day of employment)*
  - CHILD PROTECTIVE SERVICES REGISTRY REPORT INDICATING NO FOUNDED COMPLAINT (In the caregiver record by the 30<sup>th</sup> day of employment)*
- REPORT OF TUBERCULOSIS SCREENING (Obtained every two years)** \_\_\_\_\_ **Expiration Date**
- DOCUMENTATION OF ORIENTATION TRAINING**
- DOCUMENTATION OF ANNUAL TRAINING (including annual emergency response training)**
- Current CPR certification (Renewed every two-three years)** \_\_\_\_\_ **Expiration Date**
- Current First Aid certification (Renewed every three years)** \_\_\_\_\_ (or documentation of licensure to administer prescription medications) **Expiration Date**
- Current MAT certification (Renewed every three years)** \_\_\_\_\_ (or documentation of licensure to administer prescription medications) **Expiration Date**
- FOR SUBSTITUTES, DOCUMENTATION OF TIME OF ARRIVALS AND DEPARTURES**
- FOR CAREGIVERS PROVIDING TRANSPORTATION, VALID DRIVER'S LICENSE**

032-05-0601-00-eng



**CAREGIVER REFERENCE**

\_\_\_\_\_

(Name of Applicant)

\_\_\_\_\_

(Name/Address of Family Day Home)

has applied for a position providing child care to children at the above family day home. Please answer the following questions to help determine the eligibility of the applicant for employment.

1. How long have you known the applicant? \_\_\_\_\_

2. How have you known the applicant?  
\_\_\_\_\_ Friend \_\_\_\_\_ Neighbor \_\_\_\_\_ Other: \_\_\_\_\_

(In answering the following questions, please provide comments or examples).

3. Does the applicant demonstrate:

(a) An ability to relate to children with courtesy, respect, patience, and affection?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(b) An ability to understand and respect the families of children in care?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(c) An ability to speak, read, and write in English well enough to carry out assigned job responsibilities and communicate effectively with emergency responders?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Do you believe the applicant to be physically and mentally capable of carrying out assigned responsibilities?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**DOCUMENTATION OF ASSISTANT AND SUBSTITUTE PROVIDER ORIENTATION TRAINING**

**Assistants and substitute providers shall receive the following training by the end of their first week of assuming job responsibilities (Standards for Licensed Family Day Homes 22 VAC 40-111-200:**

- \_\_\_ 1. Job responsibilities
- \_\_\_ 2. Requirements for parental notifications in § 650 of the Standards for Licensed Family Day Homes:

Parent must be notified:

- Daily about the child's health, development, behavior, adjustment, or needs
- When persistent behavioral problems are identified and such notification shall include any disciplinary steps taken in response.
- Immediately when the child:
  - Has a head injury or any serious injury that requires emergency medical or dental treatment;
  - Has an adverse reaction to medication administered;
  - Has been administered medication incorrectly;
  - Is lost or missing; or
  - Has died.
- The same day whenever first aid is administered to the child.
- Within 24 hours or the next business day of the home's having been informed, unless forbidden by law, when a child has been exposed to a communicable disease listed in the Department of Health's current communicable disease chart. Life-threatening diseases must be reported to parents immediately. The provider shall consult the local health department if there is a question about the communicability of a disease.
- Whenever the child will be taken off the premises of the family day home, before such occasion (except in emergency evacuation or relocation situations) and the provider will have written parental permission
- As soon as possible of the child's whereabouts if an emergency evacuation or relocation is necessary.

- \_\_\_ 3. The requirements of the Standards for Licensed Family Day Homes that relate to the substitute provider's or assistant's responsibilities
- \_\_\_ 4. Emergency evacuation, relocation, and shelter-in-place procedures
- \_\_\_ 5. Location of emergency numbers, first aid kit, and emergency supplies
- \_\_\_ 6. Confidential treatment of personal information about children in care and their families
- \_\_\_ 7. Requirement for paid caregivers to immediately report suspected child abuse and neglect to the local department of social services or the Child Abuse and Neglect Hotline

**I, \_\_\_\_\_, have received the orientation training listed above.  
Substitute or Assistant's Printed Name**

\_\_\_\_\_  
Substitute or Assistant's Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
Provider's Signature \_\_\_\_\_  
Date



## Confidentiality Policy for Caregivers

Providers and caregivers will request and obtain information from parents about their child to ensure that the program can provide high quality child care services to each family. Personally, each of us has our own lifestyle and values, which should not be imposed upon the families and children in our program. Children and families should not be criticized, belittled, manipulated, or labeled. Our program is committed to fostering a healthy social emotional competence /self-concept in the children we care for, which starts with a mutual level of respect. We model this by talking positively and objectively in front of a child to other children, parents and caregivers. We teach children to accept their feelings as valid and meaningful and to respect others feelings and their differences. As professionals, we are committed to respecting the rights and privacy of the children, their families and the caregivers in our program.

It is our policy that all caregivers maintain confidentiality of verbal information and written records. Any information given to caregivers verbally or in writing by parents is to be respected and remain private.

To protect the rights of each child, the provider and caregivers will not share the name of someone else's child to a parent when involved in an accident or incident. This includes stating the other child's name verbally, written in accident reports or communicated in any way to another parent.

The provider and caregivers will refrain from discussing a child's negative or concerning behavior in front of other children or parents. The provider and caregivers will also refrain from discussing sensitive family issues in front of a child, other children or other parents. Instead, the provider will find a private space to discuss sensitive issues or schedule a call or conference with the parent.

To ensure confidentiality and professionalism, caregivers may not post information or photographs about or of children, families or other caregivers to social media websites such as Facebook, My Space or on personal cell phones or Twitter at anytime.

All child records are kept confidential and stored in a manner that will not allow access by an unauthorized person. This includes caregivers sharing information from records without the expressed permission of the parent, provider or delegated authority.

Any concerns relating to a child's personal safety are kept in a secure, confidential file and are only shared with people on a "need-to-know" basis.

Furthermore, only the provider will be responsible for approving and providing any requests for confidential information revealed in cases of professional necessity such suspected child abuse or neglect, developmental records or special family circumstances.

The provider will ensure that each child and caregiver record is complete and open to inspection from regulatory agencies to determine compliance with local and state child care regulations and laws.

**Agreement:** I have read, understand and agree to respect the confidentiality policy for the program.

\_\_\_\_\_  
Signature Caregiver

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature Provider

\_\_\_\_\_  
Date

## Early Childhood and Child Care Professional Development Career Lattice

The Career Lattice details steps of career development based on training, education, and experience in the field. The Lattice provides guidance for any individual developing a plan for professional advancement in early childhood education and child care based on Virginia Department of Social Services (VDSS) Licensing Standards.

ENTRY LEVEL		STEP I	STEP II	STEP III
AIDE ENTRY LEVEL	FAMILY DAY HOME PROVIDER (FDH) ENTRY LEVEL	PROGRAM LEADER/TEACHER (PL) ENTRY LEVEL	VDSS EARLY CHILDHOOD ENDORSEMENT	120-CLOCK-HOUR CHILD DEVT. CREDENTIAL [PROGRAM DIRECTOR (PD) ENTRY LEVEL]
LICENSING REQUIREMENTS:	<b>LICENSING REQUIREMENTS:</b> <ul style="list-style-type: none"> <li>• Current TB Screening</li> <li>• Satisfactory Sworn Statement</li> <li>• Clear Criminal History Record Report</li> <li>• Clear Child Protective Services Central Registry Check</li> <li>• Demonstrated proficiency in English</li> </ul>	<b>A. LICENSING REQUIREMENTS:</b> <ul style="list-style-type: none"> <li>• Minimum 18 yrs of age</li> <li>• High school program completion or equivalent</li> <li>• Current TB Screening</li> <li>• Satisfactory Sworn Statement</li> <li>• Clear Criminal History Record Report</li> <li>• Clear Child Protective Services Central Registry Check</li> <li>• Ability to communicate with emergency personnel</li> </ul>	<b>LICENSING REQUIREMENTS:</b> <ul style="list-style-type: none"> <li>• FDH – Meets FDH Entry Level</li> <li>• PL – Meets Step I A &amp; B</li> </ul>	<b>LICENSING REQUIREMENTS:</b> <ul style="list-style-type: none"> <li>• FDH – Meets FDH Entry Level</li> <li>• PL - Meets Step I A</li> <li>• Program Director (PD) – Meets Step I A and minimum 21 years of age</li> <li>• PD without mgmt. experience<sup>1</sup> must have 10 clock hrs. of mgmt. training OR one child care mgmt. course OR one college course in business-related field</li> </ul>
TRAINING	<ul style="list-style-type: none"> <li>• Provider – Minimum 18 yrs of age</li> <li>• If employed after 6/30/10, high school program completion or equivalent</li> <li>• First Aid and Cardiopulmonary Resuscitation (CPR)</li> </ul>	<b>HIGH SCHOOL EDUCATION OPTION:</b> <ul style="list-style-type: none"> <li>• Within six months prior to or one month after assuming Program Leader (PL) position: Completion of Virginia Department of Education High School Early Childhood Education I &amp; II with National Occupational Competency Testing Institute (NOCTI) Certification</li> </ul>	<b>OR:</b>	<b>OR:</b>
EDUCATION	<ul style="list-style-type: none"> <li>• Assistant – Minimum 16 yrs. of age</li> <li>• If assistant 18 yrs. or older and left alone with children – First Aid and Cardiopulmonary Resuscitation (CPR)</li> </ul>	<b>EDUCATION:</b> <ul style="list-style-type: none"> <li>• CHD 166 – Infant and Toddler Programs (College course consisting of at least 3 credits)</li> <li>• CHD 120 - Introduction to Early Childhood Education (College course consisting of at least 3 credits)</li> </ul>	<b>OR:</b>	<b>EDUCATION:</b> <ul style="list-style-type: none"> <li>• College courses equivalent to or exceeding 120 clock hours of training requirement as determined by credentialing organization<sup>2</sup> and VA Standards for Licensed CDCs</li> </ul>
EXPERIENCE	<ul style="list-style-type: none"> <li>• None required at this level</li> </ul>	<ul style="list-style-type: none"> <li>• Provider - If employed after 6/30/10, 3 months of programmatic experience</li> </ul>	<ul style="list-style-type: none"> <li>• PL – 6 months supervised programmatic experience</li> </ul>	<ul style="list-style-type: none"> <li>• PL – 6 months supervised programmatic experience</li> </ul>
EXPERIENCE	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• PL – 3 months</li> <li>• PD – 2 years w/1 year supervisory</li> </ul>
CREDENTIAL	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• VDSS Infant &amp; Toddler Endorsement</li> <li>• VDSS Preschool Endorsement</li> </ul>
CREDENTIAL	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• 120-Clock-Hour Child Development Credential [e.g., Child Development Associate (CDA)]</li> </ul>

<sup>1</sup> Mgmt. experience is defined as at least six months of on-the-job training in an administrative position that requires supervising, orienting, training, and scheduling staff.  
<sup>2</sup> International or national credentialing organization that meets requirements as stated in 22 VAC 15-30-230 A 4 b of Virginia Standards for Licensed Child Day Centers.  
<sup>3</sup> Child-related field such as, but not limited to, child care administration, early childhood administration, child development, early childhood development, early childhood education (ECE), human development, early childhood special education, child care, and elementary education (Early Childhood, PK-3, NK-3).

## Early Childhood and Child Care Professional Development Career Lattice

The lattice indicates the **minimum licensing requirements** for professionals employed by organizations regulated by VDSS. For those individuals who wish to pursue a position that is regulated by another federal or state authority, a higher level of qualification may be required. For example, Head Start requires 50% of teachers to have an Associate degree (Step VI) or higher, 100% to have a minimum of a 120-clock-hour credential (Step III). Also, some employers may require a higher level of qualification, e.g., 98% of teachers employed by the Virginia Preschool Initiative program hold a Bachelor degree (Step VII) or higher.

STEP IV	STEP V	STEP VI	STEP VII	STEP VIII	STEP IX	
<b>12-CREDIT COMMUNITY COLLEGE CERTIFICATE</b>	<b>ONE-YEAR COMMUNITY COLLEGE CERTIFICATE</b>	<b>ASSOCIATE DEGREE</b>	<b>BACHELOR DEGREE</b>	<b>MASTER DEGREE</b>	<b>DOCTORATE DEGREE</b>	
<b>LICENSING REQUIREMENTS:</b> <ul style="list-style-type: none"> <li>FDH – Meets FDH Entry Level</li> <li>PL – Meets Step I A</li> <li>PD – Meets Steps I A &amp; III</li> </ul> <b>EDUCATION:</b> <ul style="list-style-type: none"> <li>Community College Certificate in approved course of study in child-related field<sup>3</sup> w/minimum of 12 total credits</li> </ul>	<b>LICENSING REQUIREMENTS:</b> <ul style="list-style-type: none"> <li>FDH – Meets FDH Entry Level</li> <li>PL - Meets Step I A</li> <li>PD - Meets Steps I A &amp; III</li> </ul> <b>EDUCATION:</b> <ul style="list-style-type: none"> <li>One-year community college certificate in approved course of study in child-related field<sup>3</sup> w/minimum of 30 total credits</li> </ul>	<b>LICENSING REQUIREMENTS:</b> <ul style="list-style-type: none"> <li>FDH – Meets FDH Entry Level</li> <li>PL - Meets Step I A</li> <li>PD – Meets Steps I A &amp; III</li> </ul> <b>EDUCATION:</b> <ul style="list-style-type: none"> <li>Approved course of study in child-related field<sup>3</sup></li> </ul>	<b>LICENSING REQUIREMENTS:</b> <ul style="list-style-type: none"> <li>FDH-Meets FDH Entry Level</li> <li>PL-Meets Step I A</li> <li>PD-Meets Steps I A &amp; III</li> </ul> <b>EDUCATION:</b> <ul style="list-style-type: none"> <li>Approved course of study in child-related field<sup>3</sup> or with child-related Licensure or Endorsement</li> </ul>	<b>LICENSING REQUIREMENTS:</b> <ul style="list-style-type: none"> <li>FDH-Meets FDH Entry Level</li> <li>PL-Meets Step I A</li> <li>PD-Meets Steps I A &amp; III</li> </ul> <b>EDUCATION:</b> <ul style="list-style-type: none"> <li>Approved course of study in child-related field<sup>3</sup></li> </ul>	<b>LICENSING REQUIREMENTS:</b> <ul style="list-style-type: none"> <li>FDH-Meets FDH Entry Level</li> <li>PL-Meets Step I A</li> <li>PD-Meets Steps I A &amp; III</li> </ul> <b>EDUCATION:</b> <ul style="list-style-type: none"> <li>Approved course of study in child-related field<sup>3</sup></li> </ul>	LICENSING REQUIREMENTS TRAINING EDUCATION
<ul style="list-style-type: none"> <li>PL – 3 months</li> <li>PD – 2 years w/1 year supervisory</li> </ul>	<ul style="list-style-type: none"> <li>PL – 3 months</li> <li>PD – 2 years w/1 year supervisory</li> </ul>	<ul style="list-style-type: none"> <li>PL – 3 months</li> <li>PD – 1 year</li> </ul>	<ul style="list-style-type: none"> <li>PD – 1 year</li> </ul>	<ul style="list-style-type: none"> <li>PD – 6 months</li> </ul>	<ul style="list-style-type: none"> <li>PD – 6 months</li> </ul>	EXPERIENCE
<ul style="list-style-type: none"> <li>Community College Certificate in child-related field<sup>3</sup> w/minimum 12 total credits</li> </ul>	<ul style="list-style-type: none"> <li>One-year Community College Certificate in child-related field<sup>3</sup> w/minimum 30 total credits</li> </ul>	<ul style="list-style-type: none"> <li>Associate in Applied Science</li> <li>Associate of Science</li> <li>Associate of Arts</li> </ul>	<ul style="list-style-type: none"> <li>Bachelor of Science</li> <li>Bachelor of Arts</li> </ul>	<ul style="list-style-type: none"> <li>Master of Science</li> <li>Master of Arts</li> <li>Master of Education</li> <li>Master of Teaching</li> </ul>	<ul style="list-style-type: none"> <li>Doctor of Philosophy (Ph.D.)</li> <li>Doctor of Education (Ed.D.)</li> </ul>	CREDENTIAL

**KEY:** FDH – Family Day Home Provider PL – Program Leader/Teacher PD – Program Director

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## Professional Development Plan

Name \_\_\_\_\_ Date \_\_\_\_\_

**Required Training and Dates:**

Training Type:	Date Completed	Expiration Date
CPR		
First Aid		
MAT		

**Trainings completed within 20 \_\_\_\_\_**

Content Area	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours
Health, Safety & Nutrition										
Child Growth & Development										
Observation & Assessment										
Families & Community										
Learning Environment										
Interactions										
Program Management										

**Health, Safety and Nutrition Practices**

- Policies, Practices, and Procedures: health preventing injuries, communication with families
- Personal and Routine Care (hand washing, diaper/toileting, nap/rest)
- Child Abuse and neglect
- Nutrition and Dietary Practices
- Emergency Preparedness
- Indoor and outdoor Safety, Playground safety, Field trips/Transporting Children





**Child Development:**

- Basic child development
- Relationships and interaction
- Infant toddler development
- Preschool development
- School-age development
- Developmentally appropriate practices
- Special needs, inclusion, early intervention
- Behavior
- Cognitive development
- Social and emotional development
- School readiness
- Theories and philosophies

**Appropriate Child Observation and Assessment:**

- Methods of observing children
- Assessment tools (ASQ; Ages and Stages, PALS, Phonological Awareness Literacy Screening)
- Assessment planning and procedures

**Partnering with Families and Community:**

- Positive relationships
- Parent - provider communication
- Supporting parents
- Community resources

**Learning Environment:**

- Learning strategies
- Room arrangement
- Curriculum
- Child directed
- Effective teaching strategies
- Exploration of play, stages of play, principles of play
- Interactions
- Cultural awareness, diversity
- Literacy
- Math
- Science and nature
- Social studies, community
- Fine motor
- Gross motor

**Program Management:**

- Regulations
- Contracts and Policies
- Fiscal Management and budget
- Marketing and public relations
- Record keeping and taxes
- Risk Management
- Provider as employer



**Professional Organizations:**

Check the professional organization you are a member of:

- NAEYC - National Association for the Education of Young Children
- RECA - Richmond Early Childhood Association
- VAECE - Virginia Association for the Education of Young Children
- NAFCC - National Association for Family Child Care
- VAFCCA - Virginia Alliance of Family Child Care Association
- Local association \_\_\_\_\_
- Other: \_\_\_\_\_

Program/business goals:

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---

Professional development goals:

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## Performance and Development Plan

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Name of Staff

Date of Evaluation

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Evaluation Period

Type of Evaluation (Probationary or Annual)

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Position

**Summary of Performance:** *(Check the One Category That Best Describes the Staff's Overall Performance)*

- Exceeds Expectations** – Staff's performance consistently meets and frequently exceeds all established goals/expectations for the position.
- Meets Expectations** – Staff's performance consistently meets established goals/expectations for the position.
- Needs Improvement** – Staff member's performance meets some, but not all, established goals/expectations for the position and improvement in specific areas is required.

**Other comments:** *(Include positive comments about the staff's performance, team work, attitude, positive attributes about the staff person)*

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**Feedback on accomplishing goals for this evaluation period:** *(List identified goals and provide supporting feedback on staff's performance results)*

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**Feedback on demonstration of competencies identified as vital to position and/or professional development:** *(Give supporting feedback on how staff demonstrated competency in their position and ways to enhance competency, if applicable)*

Examples: Think of this section as the staff's portfolio

- Positive comments from children, families and team members throughout the evaluation period
- Pictures of successful class activities or family events
- Pictures of the staff with the children and families
- Picture of the staff helping other staff members or participating in program events
- Anecdotes from Provider and/or co-workers about the staff about helping other team members, working as a team, great customer service to a family, observations about child or family relationships
- Examples of lesson plans, assessments, family boards, classroom evaluation forms, family letters

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**Competencies to be further developed during the next evaluation cycle:** (List 3 – 5 competencies to be developed and/or demonstrated during the coming cycle; using the Competencies for Early Childhood Professionals and the Quarterly Employee Classroom Evaluation form)

Use **E** for exceeds expectations; **M** for meets expectations and **NI** for needs improvements for each area.

**Health, Safety and Nutrition Practices**

- \_\_\_ correcting or reporting health and safety concerns
- \_\_\_ following hand washing, diapering and sanitation procedures
- \_\_\_ injury prevention, and documenting and reporting injuries
- \_\_\_ following food safety and nutrition policies
- \_\_\_ knowledge of emergency procedures

Comments:

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\_\_\_ Overall rating

**Understanding Child Growth and Development**

- \_\_\_ knowledge of child development, include milestones and developmental domains (e.g., physical, cognitive, linguistic, social, emotional)
- \_\_\_ recognizing atypical development including referring families to appropriate outside services
- \_\_\_ integrating IFSP's or IEP's into daily activities and routines
- \_\_\_ understands the influences of family, culture, play, other children and adults on development

Comments:

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\_\_\_ Overall rating

**Appropriate Child Observation and Assessment**

- \_\_\_ following the process and the procedures for child assessments
- \_\_\_ learning, learning from and including families in assessments
- \_\_\_ learning plans and goals
- \_\_\_ using IFSP's and IEP's to help set goals for children and families
- \_\_\_ nurturing families as advocates
- \_\_\_ maintaining child and family confidentiality and respect
- \_\_\_ always put the child before the disability

Comments:

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\_\_\_ Overall rating



**Partnering with Families and Community**

- \_\_\_ demonstrates mutual respect for children and all families
- \_\_\_ provides a welcome and positive environment including taking opportunities to include families into classroom activities and events
- \_\_\_ able to effectively communicate with family including child's activities, progress and any concerns
- \_\_\_ linking children and families to the community for services, resources and events
- \_\_\_ helping children and families with transitions to school

Comments:

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\_\_\_ Overall rating

**Learning Environment**

- \_\_\_ knowledge and application of appropriate and responsive teaching including effective learning strategies
- \_\_\_ provides an environment for participation, curiosity, exploration and play
- \_\_\_ provides a curriculum framework that includes predictable and flexible schedules and transitions
- \_\_\_ the physical environment, materials and supplies are age and ability appropriate and easily assessable to all children
- \_\_\_ the learning environment is culturally diverse and sensitive
- \_\_\_ planned lesson plans/activities

Comments:

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\_\_\_ Overall rating

**Effective Interaction (Staff/child and child/child)**

- \_\_\_ staff builds respectful, positive, trusting, predictable, accepting relationships with and among children
- \_\_\_ staff provides many opportunities for children to work individually and collaboratively in small and large group activities
- \_\_\_ staff demonstrates and fosters appropriate communication skills
- \_\_\_ provides guidance with respect, appropriate expectations and uses logical consequences, pro-social behavior to prevent behavioral problems

Comments:

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\_\_\_ Overall rating





**Staff Qualifications and Professional Development**

\_\_\_ list annual training hours obtained for evaluation period

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\_\_\_ list professional organizations or groups (NAEYC, RECA, VAECE, NACCP, NAFCC, Directors Group, child advocacy (Voices)

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\_\_\_ professional attitude, supports programs philosophy and goals

\_\_\_ followings programs policies

\_\_\_ professional ethics for communications, interactions and confidently for children and families

\_\_\_ works as a team member

\_\_\_ seeks and demonstrates positive communication and respect for co-workers

Comments:

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\_\_\_ Overall rating

**Goals established for next evaluation cycle:**

**Personal:** (being on time, positive attitude, following the dress code, requesting time off per policy)

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**Classroom Improvements:** (changing or adding learning centers, provide more opportunities to include families in the program including adding a family board, more individualized lesson/ activities plan including parents when setting goals)

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**Professional Development Activities:** (moving from an assistant staff to a lead staff, joining a professional association, presenting at a conference, mentoring other staff, attending specific training sessions)

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**Required training or health updates:** (CPR, First Aid, MAT, Health Screening, TB tests, Health Checks)

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**Follow-up activities:**

Performance will be reviewed again on: \_\_\_\_\_ (date)

Staff is eligible for a pay increase next evaluation period?  Yes  No



**Signatures:**

\_\_\_\_\_  
\*Staff's Signature

\_\_\_\_\_  
Date

***\*My signature indicates that the Performance Evaluation has been reviewed with me and I have received a copy.***

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date

Staff's comments (Optional): The staff may submit written comments on any aspect of the performance evaluation process. If the staff wishes to provide comments, s/he should check the following box. [ ]

\*Note areas of Competencies correlate with Virginia's Competencies for Early Childhood Professionals, [www.dss.virginia.gov/family/cc/professionals\\_resources.cgi](http://www.dss.virginia.gov/family/cc/professionals_resources.cgi).

\*The notation to staff in the Plan and in the Competencies is interchangeable with provider, staff or substitute.

**RECORD OF ANNUAL TRAINING**  
Standards for Licensed Family Day Homes 22-VAC 40-111-230)

CAREGIVER'S NAME: \_\_\_\_\_ JOB TITLE: \_\_\_\_\_

NAME OF TRAINING SESSION	NAME OF TRAINER	NUMBER OF HOURS	DATE(S) ATTENDED	NAME OF ORGANIZATION THAT SPONSORED TRAINING <small>*Attach Copy of Training Certificate</small>
<ul style="list-style-type: none"> <li>• <i>First Aid and CPR training do NOT count toward caregivers' annual training requirements;</i></li> <li>• <i>Caregivers must receive annual training on emergency preparedness and response</i></li> <li>• <i>On the caregiver's anniversary date that falls between July 1, 2010 and June 30, 2011, the caregiver must have had 8 clock hours of annual training;</i></li> <li>• <i>On the caregiver's anniversary date that falls between July 1, 2011 and June 30, 2012, the caregiver must have had 12 clock hours of annual training;</i></li> <li>• <i>On the caregiver's anniversary date that falls between July 1, 2012 and June 30, 2013, the caregiver must have had 14 clock hours of annual training;</i></li> <li>• <i>On each of the caregiver's anniversary dates that fall after July 1, 2013, the caregiver must have had 16 clock hours of training.</i></li> </ul>				



# Staff Observation Form

Staff Person Observed: \_\_\_\_\_

Date: \_\_\_\_\_

<b>Health and Safety</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
Staff follows procedures for sanitizing tables, sinks, toys, mats/cots, and cribs to help reduce the spread of germs.			
Staff and children use proper hand washing and diaper changing procedures.			
Staff and children wash their hands: <ul style="list-style-type: none"> <li>• Upon entering, before touching toys and materials.</li> <li>• Before handling and preparing food.</li> <li>• Before and after eating.</li> <li>• After coming in from outdoors.</li> <li>• After messy play (i.e. art, sand).</li> <li>• After handling pets and animals.</li> <li>• After toileting/diapering.</li> <li>• After handling bodily fluids.</li> </ul>			
Staff attention is on the children.			
Staff attention is on the children.			
<b>Interactions and Relationships</b>			
Staff greets each child and family member with a friendly, personal greeting upon arrival and departure.			
Staff helps children say good bye to parents and transition into the activities after parents leave.			
Staff is observed down on the floor or down on the child's level listening and interacting with them.			
Staff spends time interacting with the children individually, and in small groups			
Staff addresses the children by name when speaking to them.			
Staff participates in meaningful conversations with the children.			

Staff helps children expand on their ideas and play by asking open-ended questions; why how, when, what, and where.			
Staff encourages children to have conversations, positive interactions, and relationships with their peers.			
Staff encourage and models problem-solving skills when addressing conflicts, including validating the children’s feelings.			
Staff uses calm voices and tones when interacting with the children and guiding or redirecting children.			
Staff demonstrates enthusiasm for their job.			
Staff shares concerns about development with provider.			
All children are not required to participate in the activities if they are not interested.			
<b>Curriculum and Planning</b>			
Staff plans developmentally appropriate activities for children.			
Staff is prepared for activities each day.			
Staff plans curriculum in advance.			
<b><i>Summary and action plan:</i></b>			



## Receipt for Child Care Services: Year-End Statement

Family Child Care Name: \_\_\_\_\_

Provider's Full Name: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Employee Identification Number or Social Security Number: \_\_\_\_\_

Parent(s)/Family Name: \_\_\_\_\_

Child/ren's Name: \_\_\_\_\_

Amount Paid: \$ \_\_\_\_\_

Dates Attended: From: \_\_\_\_\_ To: \_\_\_\_\_

Parent(s)/Family Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Chapter 2

# Policies and Procedures



# Chapter 2: Policies and Procedures

What are policies and procedures? Why do we need to have policies and procedures? Why don't we do just what seems best to do at the time? Does it matter how we do things? What difference does it make? Just imagine the kind of chaos that would result if caregivers did not respond in a consistent manner to children. What if children never knew what to expect when they came in each day?<sup>2</sup>

Policies and procedures are established for good reasons. Policies and procedures: save time, provide consistency and enhance professionalism. There is less opportunity for confusion and misunderstanding when policies and procedures are written down. Clearly defined policies and procedures are simple to understand and carry out.<sup>2</sup>

## Procedures

Procedures should answer the questions: how, who, and where. Procedures outline the process and the responsibility for carrying out the family child care home's policies. The procedure is the action to be taken in implementing the policy in the day-to-day operation. Procedures detail who is responsible, which steps or methods are to be followed and which records must be kept and by whom. Well-written procedures are useful in both daily happenings and in rare happenings. Written procedures, if followed faithfully, also ensure that legal responsibilities are met.<sup>2</sup>

Policies and procedures must be clear to everyone (staff, parents, and family members) to be effective. Family child care providers should not create policies that will not be enforced or that they do not believe in. This only causes confusion for families and gives the idea that the policies are optional. Using policies and procedures from another family child care provider because you think they sound good doesn't mean that they are right for your program. Every family child care provider's business is different in some way. Some providers may decide they only need a few policies and procedures, while others may feel the more policies they have, the better. You will have to decide what works best for your family child care home.

## Policies

Policies should answer the questions: what, when, and why. Policies are those principles which we set up to govern actions within the family child care home, especially for situations that occur frequently in the family child care home. Policies come from:

- the philosophy, goals, and objectives of the family child care home;
- decisions made by the family child care provider, either alone or with staff, parents, and family members; and
- operating regulations either from licensing, public health, or local ordinances.<sup>2</sup>





Below is a list of topics you may want to address. This is not an all inclusive list. Your family child care home's special character and way of doing things will determine your own policy statements.

1. arrival and departure
2. illness
3. communication
4. meals
5. confidentiality
6. medications
7. curriculum
8. parent involvement/volunteering
9. daily activities/schedule
10. parent/non-parent visit, calling, or picking up children
11. disaster preparedness
12. parent/provider conferences
13. discipline
14. pets
15. enrollment
16. reporting suspected child abuse/neglect
17. fees
18. termination
19. field trips
20. toys from home
21. holiday schedule
22. transportation

### ***Risk Management Policies***

Creating a safe and friendly environment for children is part of owning a child related business. Safe environments don't just happen, they require planning and commitment. While you may already have some risk management policies such as fire evacuation there are many areas of health and safety to think about. You may want to have policies related to child abuse and neglect, fieldtrips, health checks, open door policy, and/or universal precautions (dealing with body fluids). The health and safety section of the toolkit can help you create risk management policies.

It is important that family child care providers keep a written record of children attending each day, so that the children in care can be accounted for at any time in the day. This is particularly important in the

case of an emergency where the provider may be separated from the children.

### ***Culturally Responsive Care***

As our world continues to grow more diverse, we are more aware of raising our children in an environment that shows cultural differences are valued and respected. Being able to work with diverse families will not only expand your business potential, but will help you create better relationships with the children and families enrolled in your program. You can become culturally responsive to those you care for, educate yourself about their beliefs and culture and learn greetings and key phrases in their home language.



### ***Parent Handbook***

A parent handbook is a guide to the way you run your business and will help you share that information with families. When meeting with a family interested in enrolling their child in your program, review the handbook with them so they will know what to expect.

Items in the parent handbook may include:

- A welcome letter that lets families know the benefits of choosing not only family child care but your program, why you chose family child care for your profession, your background, and a little about you and your family
- A program description, philosophy, goals, and objectives
- Enrollment requirements
- Policies and procedures
- A copy of your holiday/vacation calendar, daily schedule, and any other information you would like to share

Providers should have parents read and sign verification that they understand the information included in the parent handbook. The provider should also review policies and procedures annually to ensure they are still needed or to update or add policies.

## Communication

Positive relationships between parents and providers are created by open communication. Communication is an important part of the provider-parent relationship. The word communication covers many areas of the provider-parent relationship, information about the child, what your program is about, what the parent can expect from the provider and the program, and what the provider expects from the parents.

A successful partnership between parents and providers will have some of the following qualities:

- Parents and providers communicate on a daily or other regular basis
- Parents trust and feel at ease with the provider and child care program
- Providers offer many opportunities for parents to be involved in the family child care home
- Providers ask parents for input and feedback on the program (e.g. an annual family survey)
- Children are successful and happy at the family child care home

The image shows two overlapping forms. The top form is the 'Infant/Toddler Daily Report' which includes fields for child's name, date, AM snack, lunch, and PM snack. It features a 'Diapers' table with columns for Time, Conditions, and Cnt. Below the table are sections for 'My nap was from...', 'Daily activities/developmental milestones', 'Notes', and 'We need: Diapers, Wipes, Other'. The bottom form is the 'Family Child Care Program Parent Survey', which is an annual survey asking parents to rate various aspects of the program on a scale from 'Agree' to 'Not Sure'. It includes a section for 'Please share any suggestions, concerns or questions you have about this program.' and signature lines for the parent and provider.

## Daily Communication

Daily communication with parents is an important part of a high quality program. Talking with parents about their child's day, progress, or any concerns you have is an ongoing process.

Communication can be done in many ways:

- Face to face communication
- Regular emails or notes sent between parents and providers
- Daily notes that inform parents of the day's events
- Regularly scheduled parent-provider meetings/conferences to discuss the child's progress and development in the program
- A daily notebook that goes back and forth from home to the program in which providers and parents write notes to each other about the child or any other issues or concerns
- Telephone calls that are made when concerns arise or when there is an immediate issue that needs addressing

Communication between a provider and parents comes with clear policies and expectations.<sup>6</sup>

## Annual Survey

Asking families to complete an annual survey will help you keep a pulse on your family child care home. A family survey shows that you are committed to the quality of the program and are interested in receiving feedback from the families you serve. You can create your own family survey by asking questions that are important to you and your program. Questions may include:

- What do you like best about my program?
- What would you suggest I do to improve my services?
- Is there something about my program you would like me to change?
- Is there something you would like me to add to my program?
- Would you recommend my program to other parents? Why or why not?



## Daily Schedule

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The daily schedule can be thought of as both policy and procedure. The basic framework and routine should provide a stable sequence of events. This stability gives children a sense of security and order.

The change in activities from day to day allows for learning, for improving skills, and for enjoying the great range of sensory, social, language, and other experiences that stimulate children's growth. A good schedule meets the needs of all children in care and includes well-planned times for personal care needs such as washing, toileting, snacks, drinks of water, rest, and mealtimes. A good schedule has a balance between active and quiet activities and between indoor and outdoor play. A good schedule also provides the opportunity to take advantage of events of the day and of the interests of children.<sup>2</sup>

### **Sample Daily Schedule #1:**

8:00 AM	Children Arrive/Free Play
8:30 AM	Breakfast
9:00 AM	Music Time
9:30 AM	Circle Time
10:00 AM	Free Choice Play
10:30 AM	Art or Project Time
11:00 AM	Outside Time
12:00 PM	Lunch is Served
12:30 PM	Free Choice Play
1:00 PM	Naptime
3:30 PM	Snack is Served
4:00 – 5:30PM	Free Play/Outdoor Time/Departure

- During free choice play children have many activities to choose from including books, music, art, fine motor activities and exploring the learning centers.
- Clean up is done during, in-between, and after playing.
- Hand washing is done whenever necessary and always upon arrival, before meals, after messy play, and after bathroom use.

### **Sample Daily Schedule #2:**

7:00 a.m. – 9:00 a.m.	Arrival Time/Self-Initiated Play
9:00 a.m. – 9:15 a.m.	Clean-up Time
9:15 a.m. – 9:45 a.m.	Breakfast
9:45 a.m. – 10:15 a.m.	Circle Time
10:15 a.m. – 11:15 a.m.	Outdoor Play
11:15 a.m. – 12:00 p.m.	Self-Initiated Play
12:00 p.m. – 12:30 p.m.	Lunch
12:30 p.m. – 1:00 p.m.	Story Time
1:00 p.m. – 3:00 p.m.	Nap Time
3:00 p.m. – 3:30 p.m.	Afternoon Snack
3:30 p.m. – 4:00 p.m.	Group Play
4:00 p.m. – 4:30 p.m.	Afternoon
4:00 p.m. – 4:30 p.m.	Snack for School-Age Children/Self-Initiated Play for Younger Children
4:30 p.m. – 6:00 p.m.	Outdoor Play

We try to follow the schedule, but are also flexible in order to meet children's needs. Activities are spread throughout the day so all children have the opportunity to participate.

## Children's Records

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When a family enrolls their child in a family child care home, providers should request a variety of information about the child and the family. This may include personal information, emergency contacts, medical records, and developmental information that allows the provider to learn more about the child's individual needs. These records should be treated confidentially and stored in a secure and private location. Records should not be accessible to other families or other people unless the person is responsible for caring for the child, e.g., assistants and substitutes. The provider should allow the parent/guardian access to this record at anytime. Records should be updated regularly including when there is a change in address, change in employment for parents and when the child visits a health care provider for regular check-ups.



**Records may include:**

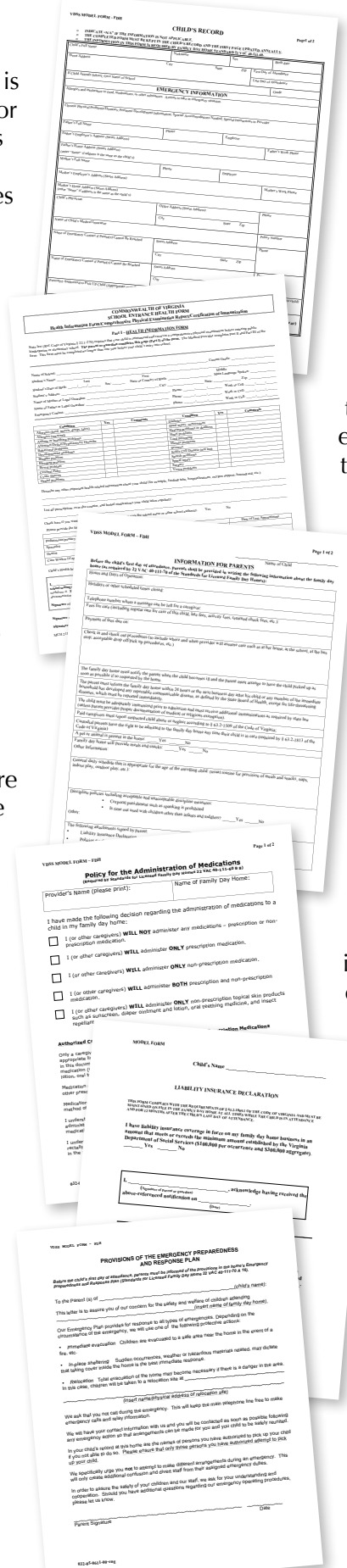
**Child's Enrollment Record** – this form is completed by the parent(s)/guardians for each child enrolled. This form includes information about the child and family including name, date of birth, addresses and parent and emergency contacts in case of emergencies. It should be updated as needed, but at least annually.

**Pre-Enrollment Information** – this form is completed by the parent(s)/guardian for each child enrolled. This form gives the provider more information about the child upon enrollment including the child's development, routines and family members. It should be updated as needed, but at least annually.

**School Entrance Health Form (Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization, Form MCH 213G)** – this form is completed by the child's pediatrician or health care professional. This form ensures that the child has had routine health exams and has been properly immunized. It should be updated based on scheduled physical exams and immunizations, normally determined by the child's age.

**Information for Parents** – this form is completed by the provider and signed by the parent. This form includes operating information like days the program operates and holidays, illness policies, termination policies and procedures for children's records and food service. It should be updated when policies or procedures in the program change.

**Policy for the Administration of Medication** – this form is completed by the provider and signed by the parent. This form is used to communicate to the parents whether the provider will administer non-prescription or prescription. It should be updated if/when the policy changes.



**Liability Insurance Declaration** – this form is completed by the provider and signed by the parent. This form communicates if the provider has liability insurance coverage on the family child care program. It should be updated if/when the policy changes.

**Provisions of the Home's Emergency Preparedness and Response Plan** – this form is completed by the provider and signed by the parent. This form provides general information about the actions the provider might take in case of an emergency. It should be updated if/when the policy changes.

**Staffing Recommendations for a Child with Special Needs** – this form is completed by the provider and parent when a child with special needs enrolls. This form helps the provider and parent mutually determine a recommendation for the appropriate level of staffing necessary to accommodate a child with special needs. It should be updated if/when the child's needs change.

**Individual Health Care Plan for a Child with Special Health Care Needs** – this form is completed by the parent and health care provider. This form details information on a child's special health care needs, like an allergy or medical condition. It gives guidance to the provider on how to handle the child's needs including any training or procedures necessary to ensure the safety of the child being enrolled. It should be updated if/when the child's needs change.

**All of these forms meet or exceed the regulations for Licensed Family Day Home regulations effective July 1, 2010. Family Child Care programs that are not licensed can use this information as they compile children's records.**





## Sample Forms and Materials for Chapter 2

Record of Daily Attendance  
Infant/Toddler Daily Report  
Family Child Care Program Parent Survey  
Child's Record  
Pre-Enrollment Information  
Commonwealth of Virginia School Entrance Health Form  
Information for Parents  
Policy for the Administration of Medications  
Liability Insurance Declaration  
Provisions of the Emergency Preparedness & Response Plan  
Staffing Recommendations for Child with Special Needs  
Individual Health Care Plan for Child with Special Health Care Needs

The most recent versions of the Virginia Department of Social Services Model Forms for Family Day Homes (VDSS Model Form – FDH) are available online, visit: [www.dss.virginia.gov/facility/child\\_care/licensed/fdh/](http://www.dss.virginia.gov/facility/child_care/licensed/fdh/)  
Before using one of these forms, check the website to be sure it is the most recent version.

The entire toolkit, including all sample forms and materials, is available online and can be printed as needed, visit: [www.smartbeginnings.org/Home/StarQualityInitiative/ForEarlyChildhoodProfessionals.aspx](http://www.smartbeginnings.org/Home/StarQualityInitiative/ForEarlyChildhoodProfessionals.aspx)



# Infant/Toddler Daily Report

Child's name: \_\_\_\_\_ Date: \_\_\_\_\_

AM snack: \_\_\_\_\_

Lunch: \_\_\_\_\_

\_\_\_\_\_

PM snack: \_\_\_\_\_

Diapers		
Time	Conditions	Comments

My nap was from \_\_\_\_\_ to \_\_\_\_\_ & \_\_\_\_\_ to \_\_\_\_\_

Daily activities/developmental milestones: \_\_\_\_\_

\_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

We need: \_\_\_ Diapers \_\_\_ Wipes \_\_\_Other \_\_\_\_\_

Special instructions from parents: \_\_\_\_\_

\_\_\_\_\_

⋮



## Family Child Care Program Parent Survey

Below is an annual family child care survey. Your honest opinion and observations only make the program better. Please return this survey to me, in the envelope provided, by \_\_\_\_\_.

\_\_\_\_\_  
Child's Name Date of enrollment

Answer the following, indicating whether you agree, disagree, or are not sure.

1. The operating policies and procedures for the child care program are clear.  Agree  Disagree  Not Sure
2. The child care home is clean and has adequate supplies for the number of children enrolled.  Agree  Disagree  Not Sure
3. Provider displays genuine affection and joy for working with children.  Agree  Disagree  Not Sure
4. Provider gives my child one on one attention.  Agree  Disagree  Not Sure
5. Provider gives me feedback daily about my child's day, development and participation in activities.  Agree  Disagree  Not Sure
6. Provider is knowledgeable about child development and child care.  Agree  Disagree  Not Sure
7. Provider communicates and works with us to set goals for our child's growth and development.  Agree  Disagree  Not Sure
8. Provider works to accommodate specific needs of my child, e.g, special dietary restrictions, food allergies, cultural needs.  Agree  Disagree  Not Sure
9. Other caregivers, assistants or substitutes, are friendly, helpful and take good care of my child.  Agree  Disagree  Not Sure
10. I would recommend this program to my friends, family and neighbors.  Agree  Disagree  Not Sure

Please share what you like most or find positive about this program.

\_\_\_\_\_  
\_\_\_\_\_

Please share any suggestions, concerns or question you have about this program.

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent's Signature Date Completed

\_\_\_\_\_  
Provider's Signature Date Received



### CHILD'S RECORD

- o INDICATE "N/A" IF THE INFORMATION IS NOT APPLICABLE.
- o THE COMPLETED FORM MUST BE KEPT IN THE CHILD'S RECORD AND THE FIRST PAGE UPDATED ANNUALLY.
- o THE INFORMATION IN THIS FORM IS REQUIRED BY FAMILY DAY HOME STANDARD 22 VAC 40-111-60.

Child's Full Name		Nickname	Sex	Birth date
Street Address		City	State	Zip
				First Day of Attendance
				Last Day of Attendance
If Child Attends School, Give Name of School				Grade
<b>EMERGENCY INFORMATION</b>				
Allergies and intolerance to food, medications, or other substances. Actions to take in emergency situation.				
Chronic Physical Problems/Diseases; Pertinent Development Information; Special Accommodations Needed; Special Instructions to Provider				
Father's Full Name		Phone	Employer	
Father's Employer's Address (Street Address)				Father's Work Phone
Father's Home Address (Street Address) (enter "Same" if address is the same as the child's)				
Mother's Full Name		Phone	Employer	
Mother's Employer's Address (Street Address)				Mother's Work Phone
Mother's Home Address (Street Address) (enter "Same" if address is the same as the child's)				
Child's Physician		Office Address (Street Address)		Phone
		City	State	Zip
Name of Child's Medical Insurance				Policy Number
Name of Emergency Contact if Parent(s) Cannot Be Reached		Street Address		Phone
		City	State	Zip
Name of Emergency Contact if Parent(s) Cannot Be Reached		Street Address		Phone
		City	State	Zip
Person(s) Authorized to Pick Up Child (Appropriate custodial paperwork (custody order or other court order) shall be attached if a parent is not allowed to pick up the child)				
Parent Signature _____				Date _____ <b>(Valid for One Year)</b>

032-05-0011-06- eng





## Pre-Enrollment Information Form

Please take a moment to complete this information form so we can learn more about your child.

\_\_\_\_\_ Date

Sex:  Male  Female

\_\_\_\_\_ Child's Full Name

\_\_\_\_\_ Preferred Name (First, Middle or Nickname)

\_\_\_\_\_ Father's Full Name

\_\_\_\_\_ Occupation

\_\_\_\_\_ Mother's Full Name

\_\_\_\_\_ Occupation

Is father living? \_\_\_\_\_ Is mother living? \_\_\_\_\_ Separated? \_\_\_\_\_ Divorced? \_\_\_\_\_

Sibling, extended family or friends who attend program:

Name	Age	Relationship	Indicate Name Used by Child
------	-----	--------------	-----------------------------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other members of the family (brothers, sisters, grandparents, etc.) living at home:

Name	Age	Relationship	Indicate Name Used by Child
------	-----	--------------	-----------------------------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child had any previous child care or school experience? \_\_\_\_\_



### Pre-Enrollment Information Form

If so, please give name and type of school? \_\_\_\_\_  
\_\_\_\_\_ Length of attendance: \_\_\_\_\_

Does your child take a nap?  Yes,  Morning  Afternoon  
 No

How many hours does your child sleep at night? (Approximately) \_\_\_\_\_

Is your child toilet trained?  Yes  No

Does your child use any special word for toileting?  Yes  No

If so, please state: \_\_\_\_\_

Describe your child's appetite:

- always hungry     never hungry     snacks     snacks all day
- eats at mealtime     has to be coaxed to eat

Are there any foods your child may not or cannot eat? (due to allergies, religious customs, etc.) \_\_\_\_\_

If so, please list: \_\_\_\_\_

Are there any foods your child dislikes? \_\_\_\_\_

If so, please list: \_\_\_\_\_

Child's special interests:

- singing     painting     stories     trucks
- pets     music     outside play     coloring
- other \_\_\_\_\_

Is your child generally:

- cooperative     shy     competitive     happy
- aggressive     sensitive     submissive     angry

Your child usually does what is asked of him/her? \_\_\_\_\_

Your child seldom does what is asked of him/her? \_\_\_\_\_ whines? \_\_\_\_\_

List other behavior characteristics of your child: \_\_\_\_\_

Please list any other information of concerns that you think we should know about in order to provide the best care for your child.

\_\_\_\_\_  
\_\_\_\_\_

Resource: Adapted from Pre-Admission Background Information Form, The Director's Toolbox, Division of Child Care and Development, Commonwealth of Virginia, 2007.



**COMMONWEALTH OF VIRGINIA  
SCHOOL ENTRANCE HEALTH FORM  
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization**

**Part I – HEALTH INFORMATION FORM**

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: \_\_\_\_\_ Current Grade: \_\_\_\_\_  
 Student's Name: \_\_\_\_\_  
 Student's Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Sex: \_\_\_\_\_ State or Country of Birth: \_\_\_\_\_ Middle Main Language Spoken: \_\_\_\_\_  
 Student's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Name of Mother or Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work or Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Name of Father or Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work or Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work or Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example, feeding tube, hospitalizations, oxygen support, hearing aid, etc.):  
 \_\_\_\_\_  
 \_\_\_\_\_

List all prescription, over-the-counter, and herbal medications your child takes regularly:  
 \_\_\_\_\_  
 \_\_\_\_\_

Check here if you want to discuss confidential information with the school nurse or other school authority.  Yes  No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance:  None  FAMIS Plus (Medicaid)  FAMIS  Private/Commercial/Employer sponsored

I, \_\_\_\_\_ (do ) (do not ) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. *This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Signature of person completing this form: \_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Signature of Interpreter: \_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_







Student's Name: \_\_\_\_\_ Date of Birth: |\_\_|\_|\_|\_|\_|

**Section II**  
**Conditional Enrollment and Exemptions**

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

**MEDICAL EXEMPTION:** As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

\_\_\_\_\_

\_\_\_\_\_

DTP/DTaP/Tdap:[\_\_]; DT/Td:[\_\_]; OPV/IPV:[\_\_]; Hib:[\_\_]; Pneum:[\_\_]; Measles:[\_\_]; Rubella:[\_\_]; Mumps:[\_\_]; HBV:[\_\_]; Varicella:[\_\_]

This contraindication is permanent: [\_\_], or temporary [\_\_] and expected to preclude immunizations until: Date (Mo., Day, Yr.): |\_\_|\_|\_|\_|.

**Signature of Medical Provider or Health Department Official:** \_\_\_\_\_ **Date (Mo., Day, Yr.):** |\_\_|\_|\_|

**RELIGIOUS EXEMPTION:** The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

**CONDITIONAL ENROLLMENT:** As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on \_\_\_\_\_.

**Signature of Medical Provider or Health Department Official:** \_\_\_\_\_ **Date (Mo., Day, Yr.):** |\_\_|\_|\_|

**Section III**  
**Requirements**

**For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at <http://www.vdh.virginia.gov/epidemiology/immunization>**

**Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)). (requirements are subject to change.)**

**Certification of Immunization 10/2010**



**Part III – COMPREHENSIVE PHYSICAL EXAMINATION REPORT**

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at [www.vahealth.org/schoolhealth](http://www.vahealth.org/schoolhealth)

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F

<b>Health Assessment</b>	<b>Date of Assessment:</b> ____/____/____ Weight: ____ lbs. Height: ____ ft. ____ in. Body Mass Index (BMI): _____ BP _____ <input type="checkbox"/> Age / gender appropriate history completed <input type="checkbox"/> Anticipatory guidance provided <b>TB Risk Assessment:</b> <input type="checkbox"/> No Risk <input type="checkbox"/> Positive/Referred Mantoux results: _____ mm	<b>Physical Examination</b> 1 = Within normal    2 = Abnormal finding    3 = Referred for evaluation or treatment <table style="width:100%; border:none;"> <tr> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> </tr> <tr> <td>HEENT</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Neurological</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Skin</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Abdomen</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Genital</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Heart</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Extremities</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Urinary</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> </table>		1	2	3		1	2	3		1	2	3	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<b>EPSDT Screens <u>Required</u> for Head Start – include specific results and date:</b> Blood Lead: _____ Hct/Hgb _____																																																		

<b>Developmental Screen</b>	<b>Assessed for:</b>	<b>Assessment Method:</b>	<i>Within normal</i>	<i>Concern identified:</i>	<i>Referred for Evaluation</i>
	Emotional/Social				
	Problem Solving				
	Language/Communication				
	Fine Motor Skills				
	Gross Motor Skills				

<b>Hearing Screen</b>	<input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.				<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> <b>Unable to test – needs rescreen</b> <input type="checkbox"/> Permanent Hearing Loss Previously identified: ___ Left ___ Right <input type="checkbox"/> Hearing aid or other assistive device
		1000	2000	4000	
	R				
L					
<input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Refer					

<b>Vision Screen</b>	<input type="checkbox"/> With Corrective Lenses (check if yes)				
	Stereopsis	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Not tested	
	Distance	Both	R	L	Test used:
		20/	20/	20/	
<input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> <b>Unable to test – needs rescreen</b>					

<b>Dental Screen</b>	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care
----------------------	--

<b>Recommendations to (Pre) School, Child Care, or Early Intervention Personnel</b>	<b>Summary of Findings (check one):</b> <input type="checkbox"/> Well child; no conditions identified of concern to school program activities <input type="checkbox"/> Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here): _____ _____ _____ _____	
	Allergy <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____ Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction    Response required: <input type="checkbox"/> none <input type="checkbox"/> epi pen <input type="checkbox"/> other: _____	
	<input type="checkbox"/> <b>Individualized Health Care Plan needed</b> (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)	
	<input type="checkbox"/> <b>Restricted Activity</b> Specify: _____	
	<input type="checkbox"/> <b>Developmental Evaluation</b> <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____	
	<input type="checkbox"/> <b>Medication.</b> Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school.	
	<input type="checkbox"/> <b>Special Diet</b> Specify: _____	
	<input type="checkbox"/> <b>Special Needs</b> Specify: _____	
	<input type="checkbox"/> <b>Other Comments:</b> _____	

<b>Health Care Professional's Certification</b> (Write legibly or stamp):	
Name : _____	Signature: _____ Date: ____/____/____
Practice/Clinic Name: _____	Address: _____
Phone: _____ - _____ - _____	Fax: _____ - _____ - _____ Email: _____



\_\_\_\_\_  
Name of Child

**INFORMATION FOR PARENTS**

**Before the child's first day of attendance, parents shall be provided in writing the following information about the family day home (as required by 22 VAC 40-111-70 of the Standards for Licensed Family Day Homes):**

Hours and Days of Operation:
Holidays or other scheduled times closed:
Telephone number where a message can be left for a caregiver:
Fees for care (including regular rate for care of this child, late fees, activity fees, returned check fees, etc.):
Payment of fees due on:
Check in and check out procedures (to include where and when provider will assume care such as at her home, at the school, at the bus stop; acceptable drop off/pick up procedures, etc.)
The family day home must notify the parent when the child becomes ill and the parent must arrange to have the child picked up as soon as possible if so requested by the home.
The parent must inform the family day home within 24 hours or the next business day after his child or any member of the immediate household has developed any reportable communicable disease, as defined by the State Board of Health, except for life-threatening diseases, which must be reported immediately.
The child must be adequately immunized prior to admission and must receive additional immunizations as required by state law (unless parent provides proper documentation of medical or religious exemption).
Paid caregivers must report suspected child abuse or neglect according to § 63.2-1509 of the Code of Virginia;
Custodial parents have the right to be admitted to the family day home any time their child is in care (required by § 63.2-1813 of the Code of Virginia)
A pet or animal is present in the home: <input type="checkbox"/> Yes <input type="checkbox"/> No
Family day home will provide meals and snacks: <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Information:
General daily schedule that is appropriate for the age of the enrolling child: (usual routine for provision of meals and snacks, naps, indoor play, outdoor play, etc.):
Discipline policies including acceptable and unacceptable discipline measures: <ul style="list-style-type: none"> <li>• Corporal punishment such as spanking is prohibited</li> <li>• Is time out used with children other than infants and toddlers? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> Other:
The following attachments signed by parent: <ul style="list-style-type: none"> <li>• Liability Insurance Declaration</li> <li>• Policies for the Administration of Medication</li> <li>• Provisions of the Emergency Preparedness and Response Plan</li> </ul>



**INFORMATION FOR PARENTS**

Amount of time per week that an adult assistant or substitute provider instead of the provider is regularly scheduled to care for the child (such as when provider leaves each day to transport children): \_\_\_\_\_

Name of the adult assistant or substitute provider: \_\_\_\_\_

Policies for termination of care (to include any requirements for prior notice; fees if prior notice is not given by parents; general reasons for termination such as non-payment of fees, age of child, behavior of child, etc.):

A copy of the regulation, *Standards for Licensed Family Day Homes*, and additional information about the family day home, including compliance history that includes information after July 1, 2003 may be obtained from the following website:  
<http://www.dss.virginia.gov/facility/search/licensed.cgi>

**Providers must notify parents (required by 22 VAC 40-111-650):**

- In writing, within 10 business days after the effective date of the change when there is no longer liability insurance in force on the family day home operation (may use Liability Insurance Declaration Form);
- Daily about the child's health, development, behavior, adjustment, or needs
- Prior to when a substitute provider will be caring for the children (for provider’s vacation, appointments, etc.)
- When persistent behavioral problems are identified and such notification shall include any disciplinary steps taken in response.
- Immediately when the child:
  - Has a head injury or any serious injury that requires emergency medical or dental treatment;
  - Has an adverse reaction to medication administered;
  - Has been administered medication incorrectly;
  - Is lost or missing; or
  - Has died.
- The same day whenever first aid is administered to the child.
- Within 24 hours or the next business day of the home's having been informed, unless forbidden by law, when a child has been exposed to a communicable disease listed in the Department of Health's current communicable disease chart. Life-threatening diseases must be reported to parents immediately. The provider shall consult the local health department if there is a question about the communicability of a disease.
- In writing, whenever there are changes in the home's emergency preparedness and response plan (that is, any changes to the Provisions of the Emergency Preparedness and Response Plan given to parents prior to the child’s first day of attendance.
- Whenever the child will be taken off the premises of the family day home, before such occasion (except in emergency evacuation or relocation situations) and the provider will have written parental permission
- As soon as possible of the child's whereabouts if an emergency evacuation or relocation is necessary.

\_\_\_\_\_  
 Parent Signature

\_\_\_\_\_  
 Date

032-05-0609-00-eng



**Policy for the Administration of Medications**  
(Required by Standards for Licensed Family Day Homes 22 VAC 40-111-60 B 8)

Provider’s Name (please print):	Name of Family Day Home:
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I have made the following decision regarding the administration of medications to a child in my family day home:

- I (or other caregivers) **WILL NOT** administer any medications – prescription or non-prescription medication.
- I (or other caregivers) **WILL** administer **ONLY** prescription medication.
- I (or other caregivers) **WILL** administer **ONLY** non-prescription medication.
- I (or other caregivers) **WILL** administer **BOTH** prescription and non-prescription medication.
- I (or other caregivers) **WILL** administer **ONLY** non-prescription topical skin products such as sunscreen, diaper ointment and lotion, oral teething medicine, and insect repellent.

**Authorized Caregivers to Administer Prescription and Non-Prescription Medications**

Only a caregiver who has a current Medication Administration Training (MAT) certificate or has appropriate licensure to administer prescription medications and is listed as a medication administrator in this document will be permitted to administer prescription medications and non-prescription medication (except non-prescription topical skin products such as sunscreen, diaper ointment and lotion, oral teething medicine, and insect repellent) in my family day home.

Medication administrators will administer prescription medications in accordance with the physician’s or other prescriber’s instructions and in accordance with the standards of practice in the MAT training.

Medication administrators will administer non-prescription medications at the dose, duration, and method of administration specified on the manufacturer’s label for the age or weight of the child.

I understand that any individual listed in this section as a medication administrator is approved to administer prescription medications using the following routes: topical, oral, inhaled, eye, and ear, medication patches and epinephrine using an auto-injector device.

I understand that if a child in my family day home requires prescription medication to be administered rectally, vaginally, by injection or by another route not listed above, I will follow the procedures outlined in the MAT training for children with special health care needs.





**Medication Administrator(s)**

Current MAT certificates (or documentation of licensure to administer prescription medications), current age-appropriate first aid certificates, and current CPR certificates for the caregivers listed below will be kept in the caregivers’ records and be available upon request.

Caregiver Name: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_

**Confidentiality Statement**

Information about any child in my family day home is confidential and will not be given to anyone except VDSS’ designees or other persons authorized by law unless the child’s parent gives written permission. Information about a child in my family day home will be given to the local department of social services if I receive a day care subsidy for the child or if the child has been named in a report of suspected child abuse or neglect or as otherwise allowed by law.

**ADA Statement**

I understand the provisions of the Americans with Disabilities Act. If any child enrolled in my family day home now or in the future is identified as having a disability covered under the Americans with Disabilities Act, I will assess the ability of the family day home to meet the needs of the child (for further information on ADA seek legal counsel and/or go to the following website: [www.usdoj.gov/crt/ada/chcaflyr.htm](http://www.usdoj.gov/crt/ada/chcaflyr.htm)). If my family day home can meet the needs of the child without making a fundamental alteration to the program and the child will need regular or emergency medication, I will ensure that I have a caregiver in my family day home who has a current Medication Administration Training (MAT) certificate or has appropriate licensure to administer prescription medications.

**Provider Statement**

I understand that it is my responsibility to follow my *POLICY FOR THE ADMINISTRATION OF MEDICATION* and all health and infection control regulations applicable to my family day home.

I will verify and document the credentials for all new caregivers before the caregiver is allowed to administer prescription or non-prescription medications (except non-prescription topical skin products) to any child in my family day home.

My *POLICY FOR THE ADMINISTRATION OF MEDICATION* will be made available to parents at enrollment, whenever changes are made and upon request.

**Provider and the parent of each enrolled child must sign below. The provider must maintain a copy of this form in each child’s individual record.**

Provider’s Signature:	Date:
Parent’s Signature:	Date:

032-05-0147-01-eng



Child's Name \_\_\_\_\_

**LIABILITY INSURANCE DECLARATION**

THIS FORM COMPLIES WITH THE REQUIREMENTS OF § 63.2-1809.1 OF THE CODE OF VIRGINIA AND MUST BE MAINTAINED ON FILE IN THE FAMILY DAY HOME AT ALL TIMES WHILE THE CHILD IS IN ATTENDANCE AND FOR 12 MONTHS AFTER THE CHILD'S LAST DAY OF ATTENDANCE.

**I have liability insurance coverage in force on my family day home business in an amount that meets or exceeds the minimum amount established by the Virginia Department of Social Services (\$100,000 per occurrence and \$300,000 aggregate).**  
\_\_\_\_\_ Yes \_\_\_\_\_ No

I, \_\_\_\_\_, acknowledge having received the  
(Signature of parent or guardian)  
above-referenced notification on \_\_\_\_\_.  
(Date)

I no longer have liability insurance coverage in force on my family day home business in an amount that meets or exceeds the minimum amount established by the Virginia Department of Social Services effective \_\_\_\_\_.  
(Date)

I, \_\_\_\_\_, acknowledge having received the  
(Signature of parent or guardian)  
above-referenced notification on \_\_\_\_\_.  
(Date)

## PROVISIONS OF THE EMERGENCY PREPAREDNESS AND RESPONSE PLAN

***Before the child's first day of attendance, parents must be informed of the provisions in the home's Emergency Preparedness and Response Plan (Standards for Licensed Family Day Home 22 VAC 40-111-70 A 16).***

To the Parent (s) of \_\_\_\_\_ (child's name):

This letter is to assure you of our concern for the safety and welfare of children attending  
\_\_\_\_\_ (insert name of family day home).

Our Emergency Plan provides for response to all types of emergencies. Depending on the circumstance of the emergency, we will use one of the following protective actions:

- *Immediate evacuation* Children are evacuated to a safe area near the home in the event of a fire, etc.
- *In-place sheltering* Sudden occurrences, weather or hazardous materials related, may dictate that taking cover inside the home is the best immediate response.
- *Relocation* Total evacuation of the home may become necessary if there is a danger in the area. In this case, children will be taken to a relocation site at \_\_\_\_\_

\_\_\_\_\_ (insert name/physical address of relocation site)

We ask that you not call during the emergency. This will keep the main telephone line free to make emergency calls and relay information.

We will have your contact information with us and you will be contacted as soon as possible following any emergency action so that arrangements can be made for you and you child to be safely reunited.

In your child's record at this home are the names of persons you have authorized to pick up your child if you not able to do so. Please ensure that only those persons you have authorized attempt to pick up your child.

We specifically urge you **not** to attempt to make different arrangements during an emergency. This will only create additional confusion and divert staff from their assigned emergency duties.

In order to assure the safety of your children and our staff, we ask for your understanding and cooperation. Should you have additional questions regarding our emergency operating procedures, please let us know.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

032-05-0611-00-eng



**STAFFING RECOMMENDATIONS FOR CHILD WITH SPECIAL NEEDS**  
(22 VAC 40-111-620)

Child's Name: \_\_\_\_\_ Child's Age: \_\_\_\_\_

Type(s) of Disability/Special Needs: \_\_\_\_\_

Degree of Disability: Mild \_\_\_\_ Moderate \_\_\_\_ Severe \_\_\_\_ N/A \_\_\_\_

Family Day Home Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

**\* Please follow the instructions on the back of form:** (Check only one)

1. The family day home's capacity or points do not need to be adjusted.

Explain: \_\_\_\_\_

\_\_\_\_\_

2. The family day home's capacity needs to be reduced by  one child or  two children.

Explain: \_\_\_\_\_

\_\_\_\_\_

3. In determining the need for an additional caregiver, this child needs to be assigned points of a child in a younger age group (applies only to a child older than 15 months).

Explain: \_\_\_\_\_

\_\_\_\_\_

Parent (s) Name (s) \_\_\_\_\_

Parent (s) Signature (s) \_\_\_\_\_

Date \_\_\_\_\_

Provider's Name \_\_\_\_\_

Provider's Signature \_\_\_\_\_

Date \_\_\_\_\_

Licensing Representative \_\_\_\_\_

Representative's Signature \_\_\_\_\_

Date \_\_\_\_\_

032-05-0212-01-eng

INSTRUCTIONS:

The child’s parent(s) and the provider are to mutually determine a recommendation for the appropriate level of staffing they think is necessary to accommodate a child with special needs. The completed form is to be signed by the parent, provider, and Licensing representative.

Please check only one of the recommendations on this form and explain your reason for selecting the recommendation as follows:

1. If block #1 is checked: explain how the child will be integrated into the family day home or any necessary adjustments that need to be made to accommodate the child.
2. If block #2 is checked: explain any functional limitations of the child that may require the provider to care for one or two fewer children (refer to the Interpretation at 22 VAC 40 C 2 in the Standards for Licensed Family Day Homes).
3. If block #3 is checked: explain any functional limitations of the child that demand a similar amount of care, attention, and supervision as required for a child in a younger age group, and specify the younger age group this child needs to be counted in (refer to 22 VAC 40-111-570. Determining need for additional caregiver).

The completed form is to be sent by the provider to the family day home’s regional licensing representative. After considering the recommendation, the licensing representative will notify the provider of a final determination for staffing requirements or for any capacity limitations determined as necessary to adequately meet the needs of all children in care.

The recommendation for staffing shall be reviewed annually by all involved parties to consider any changes in the child’s level of functioning.

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ADDITIONAL COMMENTS RELATED TO STAFFING RECOMMENDATION





**Describe any additional training, procedures or competencies the staff identified will need to carry out the health care plan for the child with special health care needs as identified by the child’s parent and/or the child’s health care provider. This should include information completed on the Medical Statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.**


**Signature of Authorized Program Representative:**

I understand that it is my responsibility to follow the above plan and all health and infection control day care regulations related to the modality of care I provide. This plan was developed in close collaboration with the child’s parent and the child’s health care provider. \*I understand that it is my responsibility to see that those staff identified to provide all treatments and administer medication to the child listed in the specialized health care plan have a valid MAT certificate, CPR and first aid certifications or have a license that exempts them from training; and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Provider/Facility Name:	Facility address:	Facility Telephone Number:
Authorized child care provider’s name (please print)		Date:
Authorized child care provider’s signature:		

**Signature of Parent or Guardian:**

	Date:
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**Signature of Health Care Provider:**

	Date:
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Chapter 3

# Health and Safety



# Chapter 3: Health and Safety

One of the first steps in providing quality child care is ensuring your environment protects the health and safety of the children in your care. Families depend on their child care provider to keep their children healthy and safe.

This chapter addresses best practices for family child care providers in the areas of health and safety. Included at the end of this chapter are sample forms and materials for you to copy, post, and share with assistants, substitutes, and the families you serve as reminders of good health and safety routines.

Licensing Standards provide excellent guidelines for ensuring children's health and safety. Compliance with these guidelines can assist you in developing policies and procedures for your program. It is important that everyone who comes in contact with the children—assistants, substitute providers, and household members—learn the policies and procedures that ensure the health and safety of the children in care.

**Note:** *As you develop your policies, refer to the appropriate regulatory agencies or authorities to ensure that your policy meets those regulations.*

## Promoting Wellness

Young children are in the process of building their immune systems. It is almost impossible to avoid a sick child. Even when a provider maintains basic sanitary conditions and follows suggested health practices, children are exposed to a variety of germs that can be spread from the child's home to the child care home. Following some basic procedures will help reduce the spread of germs.

### *Morning Inspection<sup>2</sup>*

Each morning as the children arrive, you should ask parents how the night and the morning were for their children, e.g., how they slept, did they eat breakfast. During this greeting it is a good time to look over the child to determine if he/she is well enough to attend. A morning health check of each child is an important way to help keep illnesses from spreading. Even though this list may seem lengthy, the morning health check will only take a few minutes. The check is easy to remember if you start at the top and go from head to toe and then from front to back.



### Check the following:

1. **Scalp** - Itching, sores, cleanliness, lice. Children are excluded from school if lice are present and have not yet been properly treated
2. **Face** - General appearance, expression, unusual color
3. **Eyes** - Redness of eyelid lining, irritation, puffiness, squinting, frequent rubbing, styes, sensitivity to light, yellowish color
4. **Ears** - Drainage, earache (There are other observations for hearing impairment.)
5. **Nose** - Runny nose, sneezing, frequent rubbing
6. **Mouth** - Inside of mouth for redness, spots, sores
7. **Throat** - Enlarged, red, or irritated tonsils with or without white spots
8. **Chest** - Frequent or severe coughing, wheezing, rattles (raspy breathing)
  - Child gets red or blue in the face.
  - Child makes high-pitched croupy or whooping sound after he coughs.
9. **Skin** - Yellowish skin or eyes, unusual spots, rash, bumps, bruises, unusual injuries; crusty, bright yellow dry or gummy areas of body. Check both front and back of body.
10. **Fever** - Feverish appearance with changes in behavior
  - Child is cranky or less active than usual.
  - Child cries more than usual.
  - Child appears unwell or generally uncomfortable.
  - Fever greater than 101°F.

# Hand Washing Procedures<sup>7, 8</sup>

Practicing good hand washing techniques is the most effective way to reduce the spread of infection. Hand washing is not only a basic component of personal hygiene but very important to preventing disease in children. Providers should make hand washing a habit that is established from infancy and a part of the normal daily routine. Modeling good hand washing techniques provides the best example of healthy practices for children. Posting easy to follow hand washing posters near sinks used by children and caregivers are helpful reminders.

## Hands should be washed...

- Upon arrival at the home, when re-entering the home after outdoor play.
- Immediately after toileting and/or diapering and before touching other objects in the room.
- Before preparing meals or handling food.
- Before and after meals.
- Before shared water play and after mess, sand, or water play.
- After dealing with bodily fluids (e.g. running noses, vomit, blood, soil clothing) or making significant skin contact when open sores exist.

Hand washing at the sink should be conducted individually. For example, each child should wash hands, not having to share the sink and water, and the provider should not consider that her hands have been washed because she washes the hands of a child. The provider, as well as the child, should independently wash hands using the following procedure:

1. Moisten hands with warm water and use liquid soap.
2. Rub hands together for 20 seconds (slowly sing the Alphabet Song).
3. Rinse hands free of soap under running water.
4. Dry hands with a clean disposable paper towel or air dry with a blower.
5. Turn off water using a paper towel.
6. Throw the used paper towel into trash can.

**Note: Wearing gloves never replaces washing hands. All posters are included at the end of this chapter.**



# Diapering/Toileting Procedures<sup>8</sup>

More often than not in a family child care home the family bathroom is used for diapering and toileting. It is important to follow basic sanitary procedures to not only keep the children in your care healthy but also your family.

Supervising children who are toilet trained to ensure they are flushing and washing their hands and emptying and sanitizing potty chairs immediately after they are used will help cut down on gastrointestinal illnesses.

## Preparing for Diapering

To minimize contamination outside of the diaper changing area, prepare for a diaper change before bringing the child to the changing area by having:

- Enough wipes out for the diaper change (including cleaning the child's bottom and the child's and provider's hands after removing the soiled clothing).



- A clean diaper, a plastic bag for soiled clothes, and clean clothes (if soiled clothing is anticipated).
- Non-porous gloves, if they will be used, and a dab of diaper cream on a disposable paper towel if cream is being used. It is recommended that gloves be worn when diapering.

Supplies should be removed from their containers and placed near, but not directly on, the diapering surface before starting the diaper change.

### Diapering Procedures

1. Prepare for diapering as indicated above.
2. Place the child on the diapering table. Remove clothing to access diaper. If soiled, place clothes into a plastic bag. Soiled clothing should be sealed in a plastic bag without being rinsed and sent home.
3. Remove soiled diaper and place into a lined, hands-free trash container.
4. Use wipes to clean child's bottom from front to back.
5. Use a wipe to remove soil from your hands.
6. Use another wipe to remove soil from child's hands.
7. Throw soiled wipes into a lined, hands-free trash container.
8. Put on clean diaper and re-dress the child.
9. Place the child at the sink and wash hands following the proper hand washing procedures.
10. Clean the diapering surface by spraying it with a soap and water solution and drying the surface with a disposable (paper) towel.
11. Sanitize the diapering surface by spraying it with a bleach-water solution and waiting at least two minutes before wiping with disposable towel or allowing it to air-dry. The surface should not be sprayed and immediately wiped.
12. Wash your hands using the proper hand washing procedures without contaminating any other surfaces.



## Nap and Rest Time Routines

An important part of a child's health and an area that is often overlooked is adequate rest. Although you can't control how much sleep a child gets at home, you can provide that child with the best sleeping conditions when they are in your care.

There are many different approaches to nap and rest time in the family child care home since most family child care providers care for mixed age groups.

Nap and rest may not be the same time for all children in care. Infants often need more sleep and have more than one nap, while older children tend to lie down together at the same time each day.

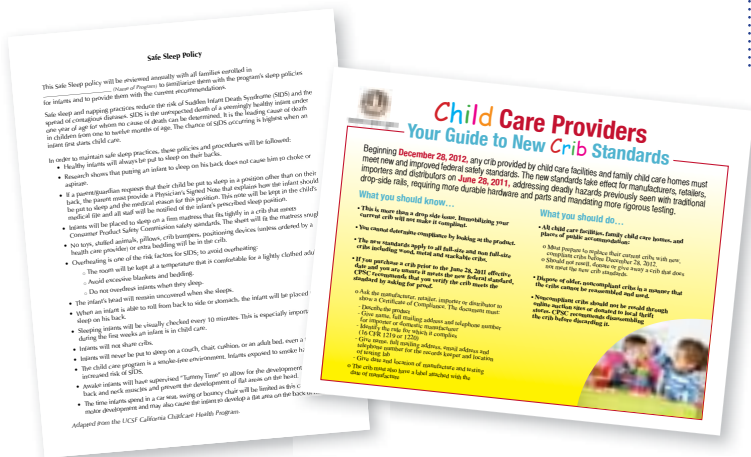
Family child care providers may have different sleeping arrangements for children in their care. Some children sleep on cots or mats specific for this purpose and others may sleep on furniture used for other purposes in the provider's house, like the provider's own bed or couch. None of the these examples are incorrect; however, there are steps you

will want to take to make sure whatever method you chose is sanitary and healthy for the children and your family.



## Infants

- Cribs should meet the Consumer Product Safety Commission (CPSC) guidelines, and beginning December 28, 2012 all cribs used in family child care homes must meet new federal safety standards. Check the CPSC website ([www.cpsc.gov](http://www.cpsc.gov)) for the most up to date standards.
- If you care for more than one infant, when possible place cribs 36 inches apart from each other to help control airborne infections.
- Crib linen should be washed weekly or as needed.
- The best way to supervise a sleeping infant is to have the infant within sight and sound. If that is not possible checking on the sleeping infant every 10 minutes is recommended.



## Toddler, preschooler, and school-age children

- Each child should have his own cot, mat, or bed and should not be switched unless all surfaces are first cleaned and sanitized.
- Cots and mats should be kept clean and stored so that sleeping surfaces do not touch each other.
- Children should have their own individual sheets and blankets.
- Children's stored clothing or bedding should not touch.
- When possible, have children nap or rest 36 inches apart from each other to help control airborne infections. If there are solid barriers that separate the children 36 inches is not needed.

Nap or rest time is often a time for family child care providers to catch up on the dishes, eat their lunch, or relax for a few minutes. This is also a time of day when providers may be located in different

area of the home from the children; however, it is just as important to supervise toddler, preschooler, and school-age children as it is to supervise infants during nap or rest time. You should always be at least within sound of the children in your care and should check on children every 15 minutes.

## Sudden Infant Death Syndrome (SIDS)

Sudden infant death syndrome (SIDS) is the unexpected, sudden death of a child under age 1 in which an autopsy does not show an explainable cause of death. Approximately 20% of SIDS deaths occur in regulated child care, with most of those deaths happening in family child care homes. Some family child care providers may be unaware that infants should be put to sleep on their backs. There are many misconceptions about the risk of SIDS and many parents request that providers put their infant to sleep on the infant's tummy.

You can lower the risk of SIDS while children are in your care by doing the following things:

- Use a firm mattress in a safety-approved crib covered by a tight-fitted sheet.
- Always place the infant on his or her back to sleep for nap. Require a physician's note for a non-back sleeper that explains why the infant should not use a back-sleeping position.
- Do not use pillows, blankets, sheepskins, bumper pads, soft toys or stuffed animals in the crib.
- Do not let anyone smoke in the home.
- Talk with assistants, substitutes, and families about the importance of sleep positioning and encourage them to follow these guidelines at home.

The good news is the number of infants who die from SIDS has decreased every year since the "Back to Sleep" campaign began in 1995 nationally. Family child care providers can continue to help that number decrease by educating parents on the importance of placing an infant to sleep on his/her back and by creating a safe sleep policy. More information regarding SIDS can be found at [www.sids.org](http://www.sids.org) and [www.vasids.org](http://www.vasids.org).



# Nutrition

Children’s eating habits are formed during the early childhood years and may last a lifetime. Good eating habits do not just happen, they are learned. Offering children a variety of nutritious foods can help them learn to make nutritionally sound food choices. Children may need to be exposed to a food 10 to 15 times before they are even willing to try it. Making sure mealtimes are relaxing and social will help children feel comfortable when new foods are introduced.

Drinking water is an essential part of a healthy diet. Water should be offered to children throughout the day between meals and snacks. Water can also be offered in addition to milk with the planned meal or snack.<sup>9</sup>

Milk provides nutrients that help children grow healthy and strong.

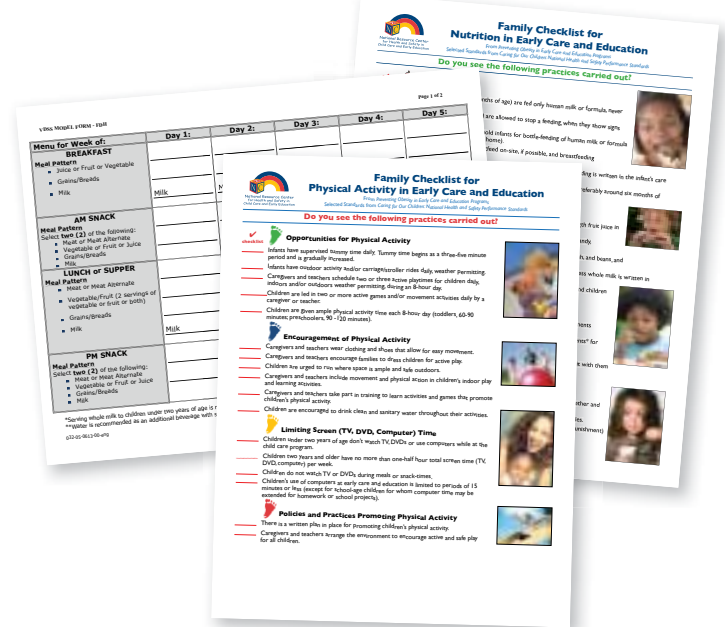
- Calcium and vitamin D for growing bones and teeth. These same nutrients help your bones stay healthy.
- Protein for building a growing body. It also keeps your body in good repair.
- Vitamin A for healthy eyes and skin.

For children less than 2 years old, offer whole milk after discontinuing breast milk or formula. Infants and toddlers need fat from milk to grow properly. Starting at age 2, most children can switch to drinking milk that has a lower fat content like 2% or 1%.<sup>10</sup>

For more information on meal planning and nutrition, visit [www.cnpp.usda.gov/fgp4children.htm](http://www.cnpp.usda.gov/fgp4children.htm).

## Child & Adult Care Food Program

The Child & Adult Care Food Program (CACFP) is a federal program that provides nutrition training and financial reimbursement for approved meals and snacks served in regulated child care homes. The primary objective of the CACFP is to ensure that



children 12 years of age and younger enrolled in child care homes receive well-balanced, nutritious meals. The program helps child care providers meet this goal through nutrition education, program training, and financial reimbursement.

There are a variety of benefits to participating and there is no cost.

- **Provider:** A regulated child care provider can receive (1) monthly reimbursements for serving nutritional meals to their child care children and (2) nutrition education.
- **Child:** A child receives nutritional meals that meet USDA requirements as well as learns positive eating habits for the future.
- **Parent:** A parent receives reassurance that their child is getting their nutritional needs met without extra cost.
- **Community:** Improvement and quality care of children in the community by meeting their nutritional needs.

For more information on this program contact one of the sponsor agencies.<sup>11</sup>



## Virginia TSA Member CACFP Sponsors

### Child Care Resources

203 Hull Street Suite A  
Richmond, Virginia 23224  
804-339-2022  
www.ChildCareResourcesVA.org

### Child Nutrition Inc.

9 N. 3rd St. Ste. 100  
Warrenton, Virginia 20186  
(540) 347-3767  
www.cni-usda.org

### ChildSavers

200 N 22 St  
Richmond, Virginia 23223  
(804) 591 3924

### Children's Harbor

702 London Street  
Portsmouth, Virginia 23704  
(757) 397-2984

### Council of Community Services

502 Campbell Ave., SW  
Roanoke, Virginia 24004  
(540) 985-0131  
www.councilofcommunityservices.org

### Mid-Atlantic Child Dev Prog

2112 Amphibious Dr. JEB 750  
Bldg.3624  
Virginia Beach, Virginia 23459  
(757) 462-8362

### THE CHILDCARE NETWORK

410 Westwood Office Park  
Fredericksburg, Virginia 22401  
(540) 373-3275  
www.thechildcarenetwork.org

## Food Allergies

A food allergy is when the body reacts as though that particular food is harmful. As a result, the body's immune system creates antibodies to fight the food allergen, the substance in the food that triggers the allergy. The next time a person comes in contact with that food, the body releases chemicals to "protect" itself. These chemicals trigger allergic symptoms that can affect the respiratory system, gastrointestinal tract, skin, or cardiovascular system. These symptoms might include a runny nose, an itchy skin rash, a tingling in the tongue, lips, or throat, swelling, abdominal pain, or wheezing.

- More than 12 million Americans have food allergies. That's one in 25, or 4% of the population.
- The incidence of food allergy is highest in young children – one in 17 among those under age 3.
- About 3 million children in the U.S. have food allergies.
- Eight foods account for 90% of all food-allergic reactions in the U.S.: milk, eggs, peanuts, tree nuts (e.g., walnuts, almonds, cashews, pistachios, pecans), wheat, soy, fish, and shellfish.

Have a list of children's names with the food allergies they have next to them available, so all caregivers are aware a child has food allergies. Including a photo of the child on the list will help when substitutes provide care or if you have new staff. To maintain children's confidentiality the list

should not be posted in a public place where any visitor can see it.

Family child care homes should have a written policy for food allergies that specifically defines the responsibilities of the child's family and the family child care home in managing the food allergy. The family's responsibilities might include providing documentation of the food allergies from the child's physician, providing instructions that need to be taken for avoiding the allergic foods, and supplying the physician's order for medication administration if necessary.

The specifics of a child's food allergies, along with up-to-date documentation, should be maintained in the child's records. Any forms and correspondence between the child care program, the child's family, and the child's health care provider should be included along with any other relevant information.

## Table Sanitizing

To sanitize an eating surface, spray the table with a bleach-water solution and wait more than 10 seconds before wiping with a disposable towel or allow to air dry. It should be noted that the recommended practice is to wait for 2 minutes to allow the solution to kill germs. However, if there is a delay of more than 10 seconds before the solution is wiped from the surface, this is considered adequate. The surface cannot be sprayed and immediately wiped.<sup>8</sup>



### Additional Precautions

- Sponges should not be used for sanitizing tables because they soak bacteria away from the surface of the sponge, which then cannot be easily reached in the interior of the sponge by the sanitizing agent.
- If wet cloths are used, a separate cloth is suggested for each table, and cloths cannot be returned to soak in a bleach-water solution.

- Food should not be put directly on the table or highchair trays because eating surfaces are more likely to be contaminated than disposable plates or washed and sanitized dishes.
- If highchair trays are used as eating surfaces, the trays should be washed and sanitized in the same way as plates and other food service utensils.
- Sanitizing solution should not be sprayed while children are seated at the table.

## Common Illness

Because children are in the process of learning good hygiene habits they are more susceptible to germs that cause common illness. A child's world is filled with germs and they are exploring that world with their senses. Children are more likely to become sick and to share those germs with others.

There is no perfect solution. In order for an immune system to develop, it has to be challenged by germs. And there is no test to determine if a child is contagious. It all comes down to using good judgment when excluding children from care.

There are 3 illnesses that are the most common to children in group settings, like a family child care home:

- **The common cold:** excluding children when they have the common cold is not necessary. Children typically have anywhere from six to ten colds each year with more severe and long lasting symptoms than adults. Symptoms typically improve for a child within a week. If you work with children, you are going to have runny noses to deal with.

- **Ear infections:** An inner ear infection is most common for children between the ages of 4 months and 5 years old. An ear infection is caused by bacteria or viruses and is not contagious. When these germs make their way to the inner ear it fills with fluid causing pressure which can hurt. Some children run a fever with an ear infection, and should be excluded from care until they are "fever free."
- **Stomach virus:** None of us like to get the stomach flu and it is the second most common childhood illness. It is always important to watch children when they have the stomach flu for signs of dehydration. Most providers will exclude a child with a stomach virus until they are free of symptoms.

Providers will want to develop a variety of policies to share with families so they know what to do if their child is sick.



## Common Childhood Illness Chart<sup>12</sup>

Disease	Incubation Period*	Transmission	Common Symptoms	Recommendations
<b>Common cold</b>	Range 1-5 day, Commonly 2 days	Respiratory Transmission	Runny nose, watery eyes, fatigue, coughing, and sneezing.	Teach importance of washing hands and covering mouth when coughing or sneezing. <i>Covering Your Cough Posters</i> are included in this section. Colds are caused by viruses; antibiotics are not indicated.
<b>Coxsackie Virus Diseases</b>  (Hand, Foot & Mouth disease)	Commonly 3-5 days	Fecal-Oral Transmission (touching feces or objects contaminated with feces then touching your mouth)	Blisters on the hands (palms and fingers) and feet (soles and in between toes), and ulcers or blisters in the mouth appear 1-2 days after the first symptoms and may last for 2 – 7 days. Because of the sore mouth, the child may refuse to eat/drink.	Not unless person has a fever, then exclude. Exclude until the child has no fever for at least 24 hours after they no longer have fever or do not have signs of fever, without using fever-reducing drugs and can tolerate normal activities. Consult a physician for treatment.  Children often are infectious before symptoms appear. Excluding children with colds or other respiratory illnesses will probably NOT decrease transmission.
<b>Influenza (flu)</b>	Commonly 1-3 days	Spread mainly from person to person through coughs or sneezes of infected individuals or by touching something with flu virus on it and then touching mouth, nose, or eyes.	Symptoms include fever (usually high), headache, extreme tiredness, dry cough, sore throat, runny or stuffy nose, and muscle aches. Nausea, vomiting, and diarrhea also can occur.	Exclude for fever over 101 degrees and/or if child not well enough to participate in group setting. Consult a physician for treatment.
<b>MRSA</b> (Methicillin-resistant Staphylococcus aureus).	Variable		Mild infections may look like a pimple or boil and can be red, swollen, painful, or have pus or other drainage.  More serious infections may cause pneumonia, bloodstream infections, or surgical wound infections.	Suspected outbreaks of staph infections should be reported to the local health department. Health department staff may be able to provide additional guidance in identifying causes of transmission, and recommendations for reducing the risk to children and staff.
<b>Pinworms</b>	Variable, 2 weeks- 2 months or longer	Fecal-Oral Transmission (touching feces or objects contaminated with feces then touching your mouth)	Itching of the anal area especially at night is the most common sign. The child may have insomnia or nightmares and may lose his/her appetite.	Consult your physician if you suspect pinworms. Other members of the family should also be observed and treated. Teach importance of hand washing.
<b>Sinus Infection</b>	Variable	A sinus infection is typically the result of other conditions in the body. If the infection is the result of a common cold, the cold may be contagious, but the sinus infection is not.	Fever, headache, greenish to yellowish mucus for more than one week.	Exclude at least 24 hours <b>after</b> they no longer have fever or do not have signs of fever, without using fever-reducing drugs.  Antibiotics are only indicated for long-lasting or severe sinus infections.
<b>RSV</b> (respiratory syncytial virus)	RSV infection usually lasts between 7 and 14 days.	Highly contagious. The virus is transmitted by physical contact with infectious secretions through hand contamination and by coughing and sneezing.	Children often are infectious before symptoms appear. Early symptoms include low grade fever (under 102 degrees in infants), runny nose, cough and decreased appetite.	Excluding children with colds or other respiratory illnesses will probably NOT decrease transmission. You should exclude until the child has no fever and can tolerate normal activities. Consult physician for treatment.

## Creating an Illness Policy

The American Academy of Pediatrics (AAP) recommends that a child be kept home if any of the following conditions exist:

- Signs of severe illness, including fever, irritability, difficulty breathing, crying that doesn't stop with the usual comforting, or extreme sleepiness.
- Diarrhea or stools that contain blood or mucus.
- Vomiting two or more times in 24 hours, unless a physician feels the cause of vomiting is not an infectious disease and the child is in no danger of becoming dehydrated.
- Mouth sores and drooling until a physician or the health authority does not feel the condition is infectious.
- Fever or rash or a change in behavior until a physician has determined that the problem is not caused by an infectious disease.<sup>7</sup>

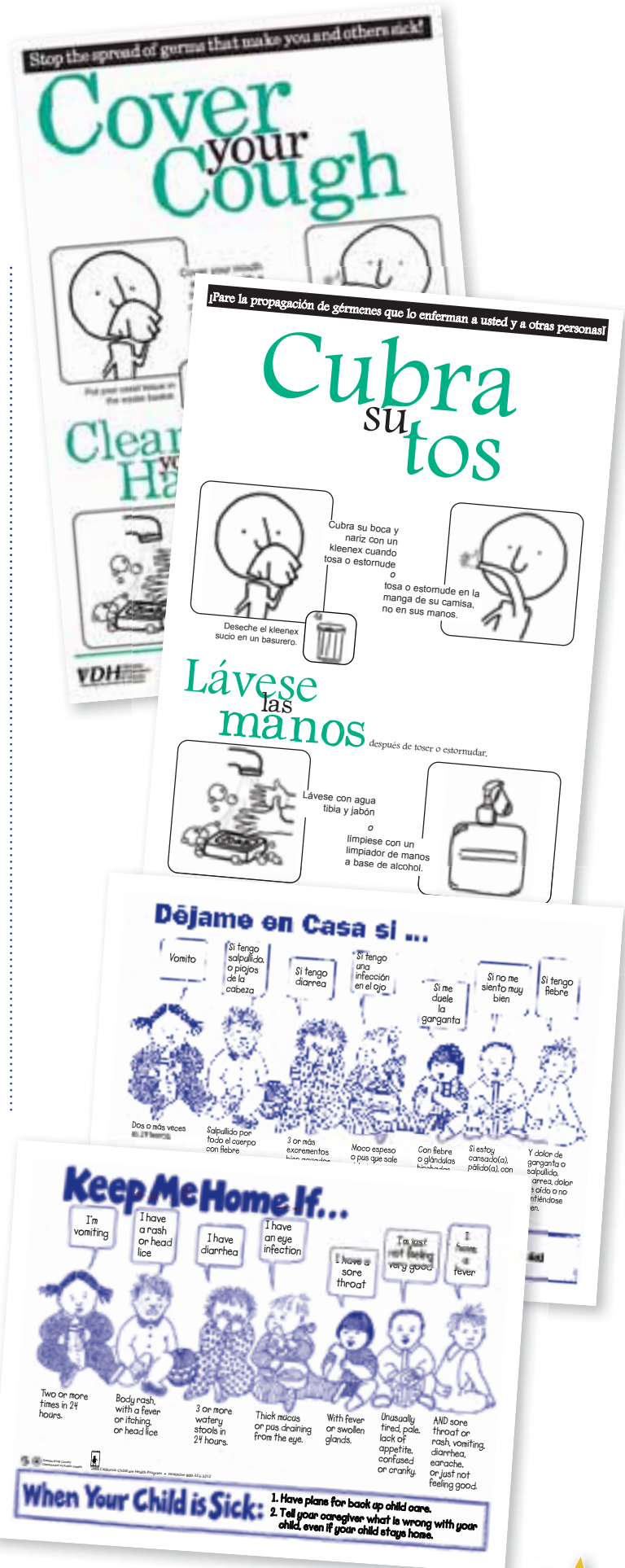
Family child care providers should develop their own illness policy and share it with families. Although most illnesses do not require excluding a child from care, providers need to determine if the illness prevents the child from participating comfortably in activities; results in a need for care that is greater than the caregiver can provide without compromising the health and safety of other children; or poses a risk of spreading the illness to others.

## Communicable Diseases

A communicable disease is a disease that can be communicated from one person to another. Diseases or illnesses can be transmitted by direct contact, respiratory transmission, fecal-oral transmission or blood transmission as detailed in the chart on the following page.

## When to Report a Disease to the Health Department

Most child care providers know they must report certain communicable diseases to the Virginia Department of Health. Few realize they should also report any cluster of cases of illness — even if the condition is not specifically listed by name as a reportable disease. An example of this would be three or four young children in the same classroom or child care home with significant diarrhea.



## How Some Infectious Diseases Are Spread<sup>13</sup>

### Method of Transmission

<b>Contact</b> (touching infected person's skin, body fluid or a contaminated surface)	<b>Respiratory Transmission</b> (passing from the lungs, throat, or nose of one person to another through the air)	<b>Fecal-Oral Transmission</b> (touching feces or objects contaminated with feces then touching your mouth)	<b>Blood Transmission</b> (direct contact with blood)
Chickenpox*	Chickenpox*	Campylobacter**	Cytomegalovirus
Cold sores	Common Cold	E. coli 0157:H7	Hepatitis B*
Conjunctivitis	Diphtheria	Enterovirus	Hepatitis C
Head Lice	Fifth Disease	Giardia	HIV infection
Impetigo	Bacterial Meningitis*	Hand-Foot-Mouth Disease	
Ringworm	Hand-Foot-Mouth Disease	Hepatitis A*	
Scabies	Impetigo	Infectious Diarrhea	
Influenza*	Measles*	Pinworms	
Hepatitis B*	Mumps*	Polio*	
Pertussis*	Rubella*	Salmonella**	
Pneumonia	Influenza*	Shigella	
		Cryptosporidiosis	

\*Vaccines are available for preventing these diseases

\*\*Often transmitted from infected animals through foods or direct contact

Another example of a disease that needs to be reported to the Health Department is an outbreak of chickenpox in a child care program. Children who have not had chicken pox disease, who were born on and after January 1, 1997, are entering 4-year-old child care programs in September 2011 and kindergarten in 2012 will be required to have received at least one dose of chicken pox vaccine. Even if children who have been immunized against chickenpox develop symptoms of the disease, their illnesses should be mild. When an outbreak occurs among children who have been immunized, health authorities must investigate promptly to be sure that the vaccine was not weakened by improper storage or that some other problem occurred.

A reportable disease in Virginia is defined in two ways: 1) as a "communicable disease declared reportable by regulation" and 2) as an unusual or group expression of illness the Department

of Health may determine to be a public health emergency. Child care providers must alert health authorities about any outbreak or suspected outbreak of any type of illness.

The Regulations for Disease Reporting and Control details what diseases must be reported to the health department and the methods to use to report. For the complete Regulations for Disease Reporting and Control, July 2008 document, visit [www.vdh.virginia.gov/Epidemiology/documents/pdf/reggs.pdf](http://www.vdh.virginia.gov/Epidemiology/documents/pdf/reggs.pdf).

The Communicable Disease Reference Chart from the Virginia Department of Health provides information and guidance on communicable diseases including incubation periods, how they are transmitted, common symptoms and recommendations on when to exclude a child from care. The recommendations in the Communicable Disease Reference Chart for School Personnel apply to school-aged children, but can be useful information for younger children. Contact your local health department or pediatrician to ensure that the recommendations are appropriate for children 5 years of age and younger.

The Communicable Disease Reference Chart for School Personnel and Common Childhood Illness Charts are divided into sections that breakdown the information making it easier to understand and share with parents. As you review the following charts, here is a short explanation of the terms used as column headings.

- **Disease** – any change from or interruption of the normal structure or function of any body part, organ, or system that is manifested by a characteristic set of symptoms and signs.
- **Incubation period** – the time from the moment of exposure to an infectious agent until signs and symptoms of the disease appear.
- **Transmission** – the passing of a communicable disease from an infected host individual or group to a nonspecific individual or group.
- **Common symptoms** – usual signs or qualities associated with a particular illness or disease.
- **Recommendations** – guidance on if the child needs to be excluded from care, how long and any other steps that need to be taken.



## Communicable Disease Reference Chart for School Personnel

Disease	Incubation Period*	Transmission	Common Symptoms	Recommendations
Chickenpox** (Varicella)	From 2-3 weeks, usually 14-16 days.	By direct contact with vesicular fluid or by airborne spread from respiratory tract secretions.	Sudden onset with slight fever and itchy eruptions which become vesicular (small blisters) within a few hours. Lesions commonly occur in successive crops, with several stages of maturity present at the same time. Communicable for as long as 5 days (usually 1-2 days) before eruption of vesicles and until all lesions are crusted (usually 5 days). Communicability may be prolonged in immunocompromised people.	CASE: Exclude from school for at least 5 days after eruptions first appear or until vesicles become dry. Avoid exposure to women in early pregnancy who have not had chickenpox and/or varicella vaccine.  CONTACTS: On appearance of symptoms, exclude from school.
Conjunctivitis, Acute Bacterial (Pink Eye)	Usually 24-72 hours.	By contact with discharges from the conjunctivae or contaminated articles.	Pink or red eyeball with swelling of the eyelids and eye discharge. Eyelids may be matted shut after sleep. May involve one or both eyes.	CASE: Exclude from school while symptomatic or until 24 hours of antibiotic treatment has been completed.  CONTACTS: School exclusion not indicated.
Diarrheal Diseases** (Campylobacteriosis,  E. coli O157:H7, Giardiasis, Salmonellosis, Shigellosis, etc.)	<b>Campylobacteriosis:</b> From 1-10 days, usually 2-5 days.  <b>E. coli O157:H7:</b> From 2-10 days, usually 3-4 days.  <b>Giardiasis:</b> From 3-25 days, usually 7-10 days.  <b>Salmonellosis:</b> From 6-72 hours, usually 12-36 hours.  <b>Shigellosis:</b> From 12-96 hours, usually 1-3 days.	By the fecal-oral route through direct contact or ingestion of contaminated food or water.	Ranges from sudden onset of fever, abdominal pain, diarrhea, nausea, and sometimes vomiting in salmonellosis, to cramps and bloody stools in severe cases of shigellosis and E. coli O157:H7. Dangerous dehydration may occur in younger children. In giardiasis, persons may be asymptomatic or have decreased appetite and weight loss.	CASE: Exclude from school until cessation of acute diarrhea. Stress importance of proper handwashing.  CONTACTS: School exclusion and stool cultures not indicated in absence of symptoms. Consult with your local health department for advice during suspected school outbreaks.
Fifth Disease (Erythema Infectiosum)	From 4-20 days.	Primarily through contact with respiratory secretions.	Rash characterized by a vivid reddening of the skin, especially of the face, which fades and recurs; classically, described as a "slapped face appearance." Mild symptoms of fever, body aches, and headache may occur 7-10 days before rash.	CASE: Exclusion from school not indicated.  CONTACTS: School exclusion not indicated. Pregnant women and immunocompromised persons should seek medical advice.

Disease	Incubation Period*	Transmission	Common Symptoms	Recommendations
Hepatitis A**	From 15-50 days, usually 28-30 days.	By the fecal-oral route through direct contact or ingestion of contaminated food or water.	Fever, loss of appetite, nausea, abdominal discomfort and weakness followed by jaundice. Many unrecognized mild cases without jaundice occur, especially in children. Communicability greatest from 7 days before to several days after onset of jaundice.	<p>CASE: Exclude from school until physician advises return. Convalescence may be prolonged.</p> <p>CONTACTS: School exclusion not indicated. Stress importance of proper hand-washing.</p>
Hepatitis B**	From 45-180 days, usually 60-90 days.	By direct contact with infected blood or body fluids. Transmission occurs when the hepatitis B virus enters the body through broken skin or mucous membranes.	Only a small proportion of acute infections have clinical symptoms. Symptoms are similar to those of hepatitis A.	<p>CASE: Follow advice of child's physician and/or your local health department.</p> <p>CONTACTS: School exclusion not indicated.</p>
HIV Infection** and AIDS**	Variable	By direct contact with infected blood or body fluids. Transmission occurs when the human immunodeficiency virus enters the body through broken skin or mucous membranes.	A broad range of disease manifestations affecting multiple organ systems. Many children remain asymptomatic.	<p>CASE: Follow advice of child's physician and/or your local health department.</p> <p>CONTACTS: School exclusion not indicated.</p>
Measles** (Rubeola, Red Measles)	From 7-18 days, usually 14 days.	Airborne by droplet spread or direct contact with nasal or throat secretions of an infected person.	Prodrome characterized by fever followed by reddened eyes, runny nose, and cough. Dusky-red blotchy rash appears on day 3 or 4 and lasts 4 to 7 days. Highly communicable from one day before the beginning of symptoms to 4 days after the appearance of the rash.	<p>CASE: Exclude from school until at least 4 days after appearance of the rash. Check immunization records of all students. Discuss with your local health department.</p> <p>CONTACTS: Exclude from school immediately on signs of prodrome.</p>
Meningitis, bacterial (H. influenzae**, meningococcal**, pneumococcal)	<p><b>H. influenzae:</b> From 2-4 days</p> <p><b>Meningococcal:</b> From 2-10 days, usually 3-4 days.</p> <p><b>Pneumococcal:</b> From 1-4 days</p>	By direct contact or droplet spread of nasopharyngeal secretions of an infected person.	Sudden onset of fever, headache, nausea, stiff neck and photophobia. Rash may occur in cases of meningococcal disease.	<p>CASE: Exclude from school during acute illness. Non-communicable after 24-48 hours of appropriate drug therapy.</p> <p>CONTACTS: School exclusion not indicated. Discuss with your local health department to determine if close contacts need prophylactic treatment for H. influenzae and meningococcal forms.</p>
Mumps**	From 14-25 days, usually 16-18 days.	By droplet spread or by direct contact with the saliva of an infected person.	Fever with swelling and tenderness of one or both parotid glands located below and in front of the ears. Unrecognized mild cases without swelling may occur. Communicable from 7 days before swelling until 9 days after.	<p>CASE: Exclude from school for 9 days after the onset of parotid gland swelling.</p> <p>CONTACTS: School exclusion not indicated.</p>

Disease	Incubation Period*	Transmission	Common Symptoms	Recommendations
Pediculosis (Head Lice)	Under optimum conditions, eggs hatch in 7-10 days and reach maturity 1-3 weeks later.	By direct contact with an infested person or their personal belongings such as combs, brushes, and hats.	Severe itching and scratching, often with secondary infection. Eggs of head lice (nits) attach to hairs as small, round, gray lumps.	CASE: Exclude from school until treated. CONTACTS: Direct inspection of head. School exclusion not indicated in absence of infestation.
Pertussis**	From 6-20 days, usually 9-10 days.	By direct contact with respiratory secretions of an infected person by the airborne route.	The initial stage begins with upper respiratory symptoms and increasingly irritating cough. The paroxysmal stage usually follows within 1 to 2 weeks, and lasts 1 to 2 months. Paroxysmal stage is characterized by repeated episodes of violent cough broken by a high-pitched inspiratory whoop and vomiting. Older children may not have whoop. Convalescence may require many weeks.	CASE: Exclude from school until a physician advises return (usually 5 days after initiation of appropriate antibiotic therapy). Discuss with your local health department. CONTACTS: Exclude on first indication of symptoms.
Ringworm of the Body (Tinea Corporis)	From 4 to 10 days.	By direct or indirect contact with lesions of an infected person or contaminated environmental surfaces.	Circular well-demarcated lesion that can involve face, trunk, or limbs. Itching is common.	CASE: Exclusion from school not indicated as long as lesions are covered or child is receiving treatment. During treatment, exclude from gymnasiums and swimming pools. CONTACTS: School exclusion not indicated.
Rubella** (German Measles)	From 14 to 21 days, usually 14 to 17 days.	By direct contact or droplet spread of nasopharyngeal secretions of an infected person.	Mild symptoms; slight fever, rash of variable character lasting about 3 days; enlarged head and neck lymph glands common. Joint pain may occur, especially in older children and adults. Communicable for 7 days before onset of rash and at least 7 days thereafter.	CASE: Exclude from school for 7 days after onset of rash. Avoid exposure to women in early pregnancy. Check immunization records of all students. Discuss with your local health department. CONTACTS: Those who are pregnant and not immunized should be urged to seek medical advice.
Scabies	From 2 to 6 weeks.	By direct skin-to-skin contact.	Begins as itchy raised areas around finger webs, wrists, elbows, armpits, belt-line, and/or genitalia. Extensive scratching often results in secondary infection.	CASE: Exclude from school until 24 hours of antibiotic treatment has been completed. CONTACTS: Direct inspection of body. School exclusion not indicated in absence of infestation.



Disease	Incubation Period*	Transmission	Common Symptoms	Recommendations
Streptococcal Diseases (Including Impetigo, Scarlet Fever, and "Strep" throat)	Variable, often 1-3 days, may be longer.	By direct contact with infected persons and carriers or by contact with their respiratory droplets.	<p>Impetigo: Multiple skin lesions usually of exposed area (e.g., elbows, legs, and knees), but may involve any area. Lesions vary in size and shape, and begin as blisters, which rapidly mature into brown crusts on a reddened base. Healing from center outward produces circular areas, which may resemble ringworm.</p> <p>Scarlet Fever: Fever, sore throat, exudative tonsillitis or pharyngitis. Sandpaper-like rash appears most often on neck, chest, and skin folds of arms, elbows, groin, and inner aspect of thighs.</p> <p>"Strep" throat: Sudden onset of fever, sore throat, exudative tonsillitis or pharyngitis, and enlarged lymph nodes. Symptoms may be absent in some cases.</p>	<p>CASE: Exclude from school until lesions are healed or until 24 hours of antibiotic treatment has been completed.</p> <p>CONTACTS: Exclusion from school not indicated. Observe carefully for symptoms.</p> <hr/> <p>CASE: Exclude from school during acute illness. Non-communicable after 24 hours of appropriate drug therapy.</p> <p>CONTACTS: Exclude on first indication of symptoms. Culturing of school contacts and treatment of carriers not usually indicated.</p> <hr/> <p>CASE: Exclude from school until 24 hours of antibiotic treatment has been completed.</p> <p>CONTACTS: Exclusion from school not indicated. Observe carefully for symptoms.</p>
<p><b>NOTE: THESE RECOMMENDATIONS APPLY ONLY TO SCHOOL-AGED CHILDREN</b>—A more complete discussion of these conditions and other communicable diseases may be found in Control of Communicable Diseases Manual (2004) published by the American Public Health Association and the Red Book 2003 Report of the Committee on Infectious Diseases published by the American Academy of Pediatrics. Additional information and consultation are also available through your local health department.</p> <p>* Based on the Control of Communicable Diseases Manual, 18th Edition (2004)</p> <p>** Officially reportable in Virginia to the local health department. All outbreaks and unusual occurrences of disease are also reportable.</p> <p>Virginia Department of Health, Office of Epidemiology, P.O. Box 2448, Richmond, Virginia 23218. Please visit our web site at <a href="http://www.vdh.virginia.gov">www.vdh.virginia.gov</a>.</p> <p>Revised March 2006</p>				

## How to Notify Parents of Illness and Disease

Family child care providers should immediately notify a parent when a child has been exposed to a communicable disease. A sample *Exposure Letter for Parents* is provided at the end of this chapter. This letter helps detail what the child has been exposed to; what the incubation period is; what the common symptoms are; exclusion recommendations; and an explanation on what the program and the parent can do to help prevent further spread of the disease or illness. *The Communicable Disease Reference Chart for School Personnel* and *Common Childhood Illness Chart* included earlier in this chapter can be used to complete this letter.

This letter was adapted from a Sample Letter to Families about Exposure to Communicable Disease, Model Child Care Health Policies, Pennsylvania Chapter, American Academy of Pediatrics, 2002.

## Medication

Each family child care provider should determine whether he/she will administer medication to children in care. Licensed providers who administer any prescription or over-the-counter medication other than topical skin gel, cream, or ointment are required to complete a Medication Administration Training. The Medication Administration Training (MAT) for Child Day Programs teaches best practice

and covers the administration of all medications, both prescription and nonprescription. To find a MAT approved trainer visit, [www.medhomeplus.org/MAT/index.php/findMATTrainer](http://www.medhomeplus.org/MAT/index.php/findMATTrainer) or to find a MAT class, access the TIPS (Training Information for Provider Success) calendar at, [www.dss.virginia.gov/family/cc\\_providertrain/tips.cgi](http://www.dss.virginia.gov/family/cc_providertrain/tips.cgi) for a class near you.

## Protecting Children in Your Family Child Care Program

Family child care providers can protect the children in their care by being knowledgeable about Licensing or other regulations and by receiving appropriate training.

Family child care providers are often more likely than center staff to form close relationships with parents or they may even be related to the children in their care. They also may reside in the same community or neighborhood as the children and their families. Because of this close contact, providers may know more about a family's situation than a center's providers would. These personal relationships may help family child care providers offer parents needed preventive or early intervention supports. While personal relationships can help providers detect possible abuse or neglect, they also can make it more difficult to report.<sup>14</sup>

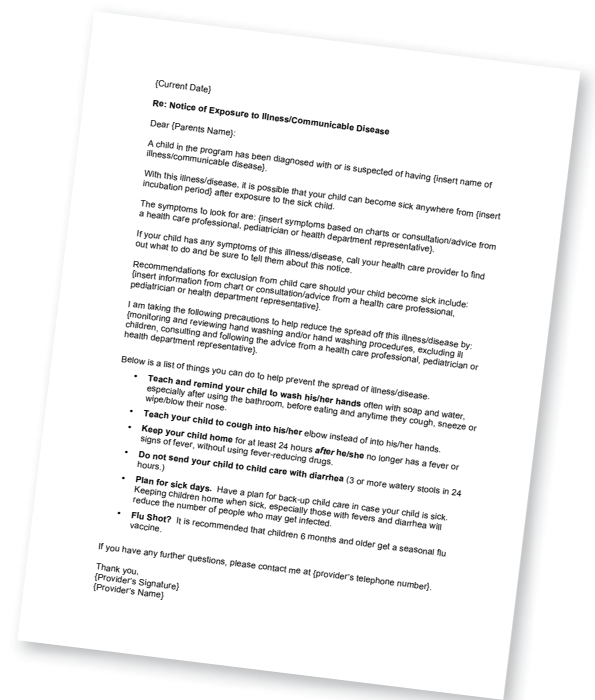
## Child Abuse and Neglect in Virginia

Each year in Virginia, over 45,000 children are reported to local social services departments for suspected child abuse or neglect. Abuse and neglect of children occurs within families and in other settings where children are provided care or services. These settings include schools, residential facilities, day care centers/homes, and recreational or sporting programs. Recognizing and reporting suspected child abuse and neglect are first steps toward ensuring the safety and wellbeing of children.

## What is Child Abuse and Neglect?

Section 63.2-100 of the Code of Virginia defines an abused or neglected child as any child under 18 years of age whose parent, guardian, or other person responsible for the child's care:

1. Causes or threatens to cause a non-accidental physical or mental injury.
2. Manufactures or sells certain drugs.
3. Neglects or refuses to provide adequate food, clothing, shelter, emotional nurturing, or health care.



4. Abandons the child.
5. Fails to provide adequate supervision in relation to the child's age and level of development.
6. Commits or allows to be committed any illegal sexual act upon a child including incest, rape, fondling, indecent exposure, prostitution, or allows a child to be used in any sexually explicit visual material.

7. Knowingly leaves a child alone in the same dwelling with a person who is not related to the child by blood or marriage and who is required to register as a violent sexual offender.

In addition, the law requires physicians to report to Child Protective Services (CPS) any newborn infant who tests positive for drugs.

A combination or pattern of indicators should alert you to the possibility of maltreatment. Indicators should be considered together with the explanation provided, the child's developmental and physical capabilities, and behavior changes.

Recognizing Child Abuse and Neglect		
	Physical Indicators	Behavioral Indicators
<b>Physical Abuse</b>	<ul style="list-style-type: none"> <li>• Unexplained bruises or burns on face, torso, back, buttocks, thighs</li> <li>• Multiple injuries in various stages of healing</li> <li>• Bruises/welts resembling instrument used e.g belt, cord</li> <li>• Human bite marks</li> <li>• Injuries regularly appearing after absence, weekend, etc.</li> <li>• Unexplained fractures, lacerations, abrasions</li> </ul>	<ul style="list-style-type: none"> <li>• Reports injury by caretaker</li> <li>• Uncomfortable with physical contact</li> <li>• Complains of soreness or move uncomfortably</li> <li>• Wears clothing inappropriate to weather (to cover body)</li> <li>• Afraid to go home</li> <li>• May be a chronic runaway (adolescents)</li> <li>• Behavior extremes (withdrawn, aggressive)</li> <li>• Apprehensive when other children cry</li> </ul>
<b>Physical Neglect</b>	<ul style="list-style-type: none"> <li>• Consistent hunger, poor hygiene</li> <li>• Unattended physical problems or medical needs</li> <li>• Consistent lack of supervision</li> <li>• Abandonment</li> </ul>	<ul style="list-style-type: none"> <li>• Reports no caretaker at home</li> <li>• Begs, steals food</li> <li>• Frequently absent or tardy</li> <li>• Constant fatigue, listlessness, or falling asleep in class</li> <li>• Extended stays at school (early arrival and late departure)</li> <li>• Shunned by peers</li> </ul>
<b>Sexual Abuse</b>	<ul style="list-style-type: none"> <li>• Sexually transmitted disease (pre-teens)</li> <li>• Pregnancy</li> <li>• Difficulty walking or sitting</li> <li>• Pain or itching in genital area</li> <li>• Torn, stained, or bloody underclothing</li> <li>• Bruises/bleeding in external genitalia</li> </ul>	<ul style="list-style-type: none"> <li>• Reports sexual abuse</li> <li>• Highly sexualized play</li> <li>• Detailed, age inappropriate understanding of sexual behavior</li> <li>• Role reversal, overly concerned for siblings</li> <li>• Exhibits delinquent behavior</li> <li>• May attempt suicide or other self-injury behavior</li> <li>• May have eating disorders</li> <li>• Deterioration in academic performance</li> </ul>
<b>Emotional Maltreatment</b>	<ul style="list-style-type: none"> <li>• May have frequent stomach aches, headaches or unexplained weight fluctuations</li> <li>• May have speech disorders</li> <li>• May lag in physical development</li> <li>• May have a non-organic, failure-to-thrive medical diagnosis</li> <li>• May have learning problems</li> </ul>	<ul style="list-style-type: none"> <li>• Exhibits age inappropriate behaviors such as thumb sucking, biting, head banging or rocking</li> <li>• Exhibits extreme behaviors such as over compliance, passivity, aggression, or withdrawal</li> <li>• Exhibits emotional or intellectual developmental delays</li> <li>• Exhibits cruel behavior or may seem to get pleasure from hurting others and/or animals</li> <li>• May abuse alcohol or drugs</li> <li>• May have eating disorders</li> </ul>

## Reporting

Anyone may report suspected abuse or neglect; however Section 63.2-1509 of the Code of Virginia requires that designated professionals who have contact with children immediately report their suspicions. It is not necessary to prove that abuse or neglect has occurred.

Reports can be made anonymously. If you choose to provide your name, it will not be released to the family who was reported, except by Court order. Persons reporting in good faith are immune from civil and criminal liability pursuant to Section 63.2-1512 of the Code.

## Local Department of Social Services Response

After a report is made, a child protective services (CPS) social worker will interview the child and siblings, the parents or caretakers, and the alleged abuser. The CPS social worker may also contact other persons having information about suspected abuse or neglect of the child(ren). The CPS social worker will conduct a child safety assessment; determine if child abuse or neglect occurred or if there is risk or harm; and develop a safety and services plan with the family when indicated. The primary goal of child protective services is to strengthen and support families in preventing the (re)occurrence of child maltreatment through community-based services.

Licensed Family Day Home regulation 22 VAC 40-111-200.B.7 states that – providers shall orient the substitute provider and assistant by the end of their first week of assuming job responsibilities and this orientation must include the requirement for reporting suspected child abuse and neglect.



## Additional Information

For information on child abuse and neglect, including prevention materials, and/or in-service training, contact your local social services department or the **Virginia Department of Social Services** at [www.dss.virginia.gov](http://www.dss.virginia.gov).

- Educators can complete an online course called **Child Abuse and Neglect: Recognizing, Reporting and Responding** found at [www.vcu.edu/vissta/training/va\\_teachers](http://www.vcu.edu/vissta/training/va_teachers). Learn how to recognize the warning signs of child abuse and neglect including recognizing when parents are under chronic stress and children are exhibiting negative/anxious behaviors or signs of physical abuse. You will also learn how to encourage families under stress to seek support services. Two hours of training credit is awarded for completing this class.
- **1-800-CHILDREN** is a toll free, statewide help line that is available Monday through Saturday from 8 am till 9 pm. Experienced professionals with advanced degrees offer a listening ear and can answer questions about a child's development and behavior, parenting and other topics. 1-800-CHILDREN has over 200 easy-to-read Parenting Tips from which to choose, and staff will assemble individualized packets based on the caller's interests.
- **Prevent Child Abuse Virginia** is a private, nonprofit organization that strives through advocacy, education, direct services and partnerships to eliminate child abuse and neglect in the Commonwealth. Learn more at [www.preventchildabuseva.org](http://www.preventchildabuseva.org).
- **Fairfax County** provides resources on Parenting and Supervision online, including information and strategies to help parents keep kids safe. There are brochures and handouts in multiple languages. All can be downloaded for free at: [www.fairfaxcounty.gov/dfs/childreneyouth/parenting-childsupervision-resources.htm](http://www.fairfaxcounty.gov/dfs/childreneyouth/parenting-childsupervision-resources.htm).

# Emergency Planning

Licensed providers are required to have an emergency preparedness and response plan as part of licensing requirements, but everyone who cares for children should have one. Regardless of where you are located, you face some risk of disasters. Knowing what events are most likely to happen near your home will help you be better prepared for a disaster. Planning will help decrease stress levels during a disaster and planning ahead helps to keep everyone in your care safe.

Most child care providers are prepared for natural disasters such as fire, tornado, and hurricanes; however, there are many other types of disasters a child care provider should think of when writing an emergency preparedness plan.

- home invasion/intruder
- vehicle accident
- power outages
- hazardous material spills
- gas outages or gas leaks
- tropical storms and high wind storms
- snow and ice storms

It is also important to develop a plan for closing in the case of an emergency. You may need to close due to severe weather that occurs either before or after children have arrived. Having an emergency closing plan in place is important to reduce confusion with assistants, substitutes, and families.

## Reducing the Risks

There are a few things you can do that will help you reduce your risk:

- Review and update your emergency preparedness plan yearly.
- Train assistants, substitutes, and household members on the plan.
- Have at least two unobstructed escape routes.
- Install smoke detectors in every room in your home (except kitchens and bathrooms) and in the hallways of your home.
- Install carbon monoxide detectors on all levels of your home.
- Regularly clean and check heating, cooling, gas and electrical systems and verify that they are in good working order.
- Inspect the outside of your home for potential hazards.

## Sample Emergency Closing Plan

### Closing Plan in Case of Emergency *Prior* to Children's Arrival

How I will make the decision to close:

\_\_\_\_\_

I will make the decision to close by \_\_\_\_\_ o'clock

How I will let assistants and substitutes know:

\_\_\_\_\_

How I will let families know:

\_\_\_\_\_

How I will make the decision when to re-open:

\_\_\_\_\_

### Closing Plan in Case of Emergency *After* Children's Arrival

How I will make the decision to close:

\_\_\_\_\_

I will make the decision to close by \_\_\_\_\_ o'clock

How I will let assistants and substitutes know:

\_\_\_\_\_

How I will let families know:

\_\_\_\_\_

How I will make the decision when to re-open:

\_\_\_\_\_





# Accidents and Injuries

Most injuries are preventable if steps are taken to ensure your home, the areas indoors and outdoors where the children play, is safe. By writing down and following regular routines and following a health and safety checklist, family child care providers can cut down on the number of accidents and injuries that occur. In addition to the blank forms provided at the end of this chapter, you will also find a completed Sample Daily Routine to help you as you develop your own routine.

## First Aid and CPR

Providers, substitute providers and assistants that are left alone with the children, should have current certificates in first aid and in cardiopulmonary resuscitation and rescue breathing appropriate for the ages of children in care. In addition to training, all caregivers need to have access to a first aid kit that allows them to tend to a child's injury. All caregivers should know the location of the kit before they begin working with the children.

First aid kits should be located in a place that is not accessible to the children but where it can be quickly retrieved when needed, e.g. in the home, accessible to outdoor play areas, in the vehicle during transportation, on field trips, or whenever children are in care.

## Parent Notification for Accidents and Injuries

There are times when all the necessary precautions are taken and a child is still injured. Anytime a child is injured and requires first aid, a provider should complete a written report for the parent. The written report should include details of how the injury happened, the actions taken (including details of first aid), any future actions that will be taken to prevent the injury from happening again, and a place for the provider's and parent's signatures. Parents/guardians should be notified of the injury the same day the incident occurs. Any injury reports should be placed in the children's records the same day they are completed.

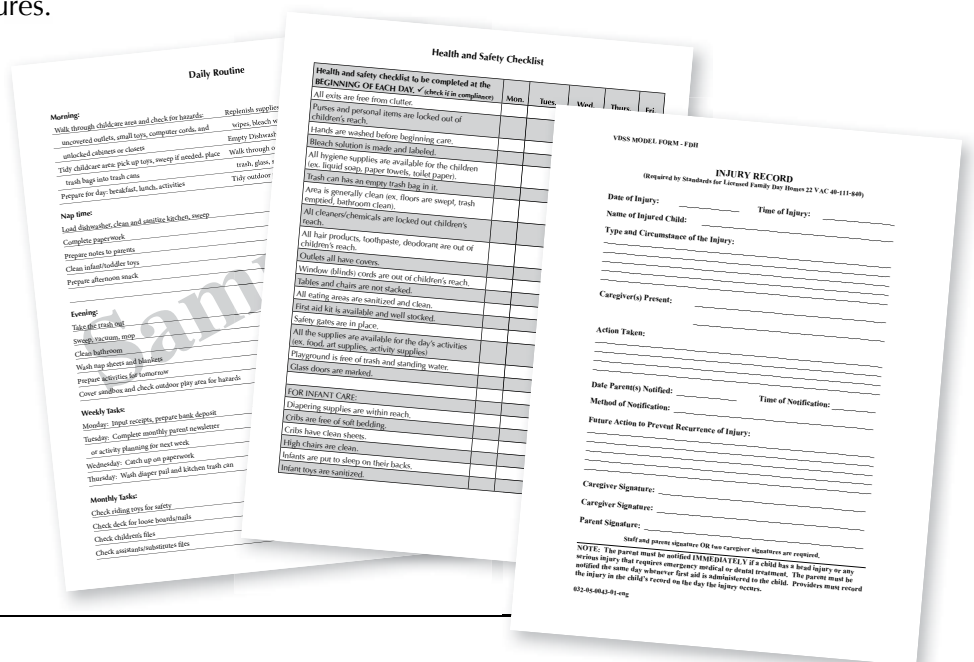
Serious injuries, such as a head injury, require immediate attention and notification of parents. Some parents may also appreciate a phone call if their child is injured; it benefits both you and the parents to find out their preference before an injury happens.

## First Aid Kit Supplies

- scissors
- tweezers
- assorted gauze pads
- adhesive tape
- adhesive bandages – band-aids of assorted sizes
- digital thermometer – batteries checked often
- antiseptic cleansing solution
- two (2) or more triangular bandages
- single use gloves such as surgical or examination gloves
- activated charcoal preparation – monitor the expiration date and replace as needed
- first aid instruction manual
- ice pack or cooling agent

## Additional Emergency Supplies:

- Working battery-operated flashlights with extra batteries
- A working portable battery-operated weather band radio with extra batteries





## Poison Control Information

Call **1-800-222-1222** for emergency treatment advice, questions about medications, and information about poisons. This number works in a way similar to dialing 9-1-1: no matter where you are located, by calling 1-800-222-1222 your call will be automatically routed to the closest regional poison center. Contacting a poison center is fast and easy wherever you are in the United States.

There are three poison control centers in Virginia:

### **Blue Ridge Poison Center**

University of Virginia Health Systems  
Box 800774  
Charlottesville, VA 22908  
Phone: (800) 222-1222  
[www.healthsystem.virginia.edu/brpc](http://www.healthsystem.virginia.edu/brpc)  
Serves: Virginia Beach, Central and Western Virginia

### **Virginia Poison Center**

Virginia Commonwealth University  
Box 980522  
Richmond, VA 23298-0522  
Phone: (800) 222-1222  
[www.poison.vcu.edu](http://www.poison.vcu.edu)  
Serves: East, Central and Peninsula

### **National Capital Poison Center**

George Washington University  
3201 New Mexico Ave., N.W., Suite 310  
Washington, DC 20016  
Phone: (800)222-1222  
[www.poison.org](http://www.poison.org)  
Serves Northern Virginia

Providers can request free poison safety brochures and magnets to give to families at [www.aapcc.org/dnn/PoisoningPrevention/Order-PoisonPreventionMaterials.aspx](http://www.aapcc.org/dnn/PoisoningPrevention/Order-PoisonPreventionMaterials.aspx). Sharing information with parents and teaching children poison safety can help save lives. Quill's Up! – Stay Away is a poison prevention program designed for preschool children. The program includes a video and activities as well as educational materials for parents and caregivers. Visit [www.poison.org/prevent/preschool.asp](http://www.poison.org/prevent/preschool.asp) to learn more about this free education program.

## Playground Safety

Outdoor play environments offer experiences that will enhance children's physical, emotional, social and intellectual development. Playgrounds deserve special attention to ensure that the area is safe for children as they explore and play. Below is a checklist that can help you review your playground for safety.<sup>15</sup>

- Climbing portions of slide and climbing equipment over 18 inches high indoor and outdoor, have shock-absorbing surface that helps reduce the risk of life-threatening injuries if a child falls, e.g. rubber tiles or mats.
- The highest climbing rung or platform on outdoor climbing equipment or top of a slide is not more than 6 feet high for school-age children and 4 feet high for preschool children.
- Equipment with platforms and ramps over 30 inches high have guardrails or barriers to prevent falls.
- All openings in guardrails and between ladder rungs are less than 3.5 inches apart or more than 9 inches to prevent entrapment areas.



- Areas surrounding playground equipment have at least 12 inches of loose fill, such as wood chips, mulch, sand, or pea gravel, to help protect children from the impact of a fall.
- There is at least a 6-foot use zone in all directions around all stationary pieces of equipment. Swings and slides have a larger use zone based on numerous factors (e.g., height of equipment).
- The play area is free of hazards including exposed concrete footings under equipment and exposed/raised tree roots or rocks that could cause a child to trip.
- Equipment is free of sharp edges, loose bolts or dangerous hardware like open “S” hooks or protruding bolts.
- Children play only on equipment designed for their age group. Equipment is clearly marked with the appropriate age group.

- Trampolines are not used.
- The playground is inspected each morning before the children play to ensure that equipment is good repair and that fences and gates are closed and secure.
- Adults report any problems to the appropriate person immediately.
- Children are not permitted to wear clothes/jackets with drawstrings or long straps, flip-flops, open-toed sandals or clogs to help prevent strangulation, slips and falls.
- Adults supervise children on the playground at all times. Adults position themselves to see the entire playground and near larger pieces of equipment to provide assistance when children need help.

For more information on playground safety visit the CPSC website: [www.cpsc.gov/CPSCPUB/PUBS/playpubs.html](http://www.cpsc.gov/CPSCPUB/PUBS/playpubs.html).

## Air Quality Index

Air Quality Index (AQI) is a measurement of air quality that is calculated from ozone and fine particle pollution measurements over the past few hours. A higher AQI indicates a higher level of air pollution, and consequently, a greater potential for health problems.

The Virginia Department of Environmental Quality (DEQ) monitors levels of ozone and particle pollution from stations around the state. Both of these are pollutants that, at high levels, may raise health concerns in some people including sensitive groups like young children. For young children, children with asthma and people with various health concerns, breathing sometimes can be more difficult in the summer because the air is filled with pollutants and particles. Providers can use the air quality information and forecast to evaluate the length of time that the children should play outdoors or when planning outdoor field trips.

The chart to the right helps explain which groups might be affected by the air quality. To monitor air quality visit: [www.deq.virginia.gov/airquality/](http://www.deq.virginia.gov/airquality/). Use the forecast provided on that website to plan your activities during the summer months.

Level	Color	Description
**	White	Air quality information is unavailable.
0-50	Green	Good air quality. Little or no health risk.
51-100	Yellow	Moderate air quality. People who are unusually sensitive to air pollution may be mildly affected.
101-150	Orange	Unhealthy for sensitive groups. These groups may experience health problems due to air pollution.
151-200	Red	Unhealthy. The general public may experience mild health effects. Sensitive groups may have more serious health problems.
201-300	Purple	Very unhealthy. Everyone is susceptible to more serious health problems.

## Field Trips and Transporting Children

Field trips expand children's learning through hands-on experience with the rich resources of the local community. Field trips increase children's knowledge and understanding and add realism to the topics they are learning. Good planning is a must for field trips.

Field trips do not have to be far from your home. The local library or a nature walk in your neighborhood are great field trips and create a change of scenery for the children. Field trips that require transporting children require more planning and more notice to parents, but all field trips require some planning. A provider should obtain permission slips from parents for any type of field trip.

Providers should have a basic plan for all field trips that addresses destination, parent permission, transportation, and safety.



### Field Trip Plan

1. Notify the destination of your plans to visit, how many children will be visiting and their ages.
2. Send home permission slips letting parents know when, where, and if there are any costs involved.
3. Request parent volunteers as needed.
4. Review parking arrangements, fees, location, and starting and ending times.
5. Prepare the children the day before the trip. Discuss the safety rules and what to expect.
6. Ensure all children have safety seats for the trip. All children under the age of 8 must be in a safety seat.
7. Decide how lunch will be handled during the field trip.
8. On the day of the field trip make sure all children and chaperones have name tags with child care name, address, and phone number. *(Do not write child's name or information on the name tag)*
9. Take first aid kit along on the field trip.
10. Ensure any volunteer drivers have directions to the field trip destination with a list of children they will be driving.
11. Bring emergency authorizations and contact information.
12. Check and double check the field trip checklist to be sure you have everything you need!

### Field Trip Checklist

- ✓ First aid kit
- ✓ Emergency releases for children
- ✓ Permission slips for children
- ✓ Money for fieldtrip
- ✓ Directions for chaperones
- ✓ Snack
- ✓ Lunch *(if needed)*
- ✓ Water and cups
- ✓ Phone number of destination
- ✓ Name tags with child care name on them for children and chaperones *(never put the child's name on the name tag)*
- ✓ Emergency phone numbers (i.e. 911 and poison control)
- ✓ Cell phone
- ✓ All children's necessities *(diapers, wipes, etc.)*

During transportation family child care home providers should follow Virginia's Child Restraint Device Law and other safety precautions including the Child Passenger Safety Tips included at the end of this chapter. Also included are sample field trip permission forms.

There are assistance programs for low-income Virginia residents who cannot afford a safety seat.

Contact the Virginia Department of Health, Division of Injury and Violence Prevention at 1-800-732-8333 for more information.

### Additional safety precautions for transportation and field trips to consider:

- The provider or caregiver driving is licensed and insured.
- An adult caregiver with First Aid and CPR certification is present during transportation and field trips.
- The vehicle being used for transportation meets safety standards set by the Virginia Department of Motor Vehicles, e.g., current state inspection and in good repair.
- The children are always transported in a safety seat or restraint based on Virginia Law.
- The children are never left unattended in a vehicle for any length of time, even a minute.
- Each child boards and leaves the vehicle from the curb side of the street.
- Providers/caregivers take a copy of the emergency contact information for all children that are being transported.
- A complete first aid kit is available during transportation and on field trips.
- All caregivers have access to a means of communication in case of an emergency, e.g. cellular phone, money for a pay phone, calling card.





## Sample Forms and Materials for Chapter 3

Infant Handwashing  
Wash Your Hands (English and Spanish)  
Gloving (English and Spanish)  
Diapering Procedures (English and Spanish)  
Safe Sleep Policy  
A Child Care Providers' Guide to Safe Sleep  
A Parent's Guide to Safe Sleep  
Weekly Menu  
Food Allergy Action Plan (English and Spanish)  
Family Checklist for Nutrition in Early Care and Education  
Family Checklist for Physical Activity in Early Care and Education  
Guidelines for the Use of Sanitizers and Disinfectants in Child Care Facilities  
Disinfecting Solution (English and Spanish)  
Cover Your Cough (English and Spanish)  
Keep Me Home If ... (English and Spanish)  
Notice of Exposure to Illness/Communicable Disease  
Shaken Baby Syndrome (English and Spanish)  
Emergency Preparedness and Response  
Emergency Preparedness and Response – Completed Sample  
Provisions of the Emergency Preparedness and Response Plan  
Record of Emergency Drills  
Daily Routine  
Daily Routine – Completed Sample  
Health and Safety Checklist  
Injury Record  
Injury Record – Completed Sample  
Field Trip Permission  
General Permission for Regularly Scheduled Trips  
Transportation Information for Parents  
Child Passenger Safety Fact Sheet  
Emergency Information and Transportation Checklist  
Permission to Participate in Swimming and Wading Activities

The most recent versions of the Virginia Department of Social Services Model Forms for Family Day Homes (VDSS Model Form – FDH) are available online, visit: [www.dss.virginia.gov/facility/child\\_care/licensed/fdh/](http://www.dss.virginia.gov/facility/child_care/licensed/fdh/)  
Before using one of these forms, check the website to be sure it is the most recent version.

The entire toolkit, including all sample forms and materials, is available online and can be printed as needed, visit: [www.smartbeginnings.org/Home/StarQualityInitiative/ForEarlyChildhoodProfessionals.aspx](http://www.smartbeginnings.org/Home/StarQualityInitiative/ForEarlyChildhoodProfessionals.aspx)



# Infant Handwashing

## When to Wash Infant's Hands

- Upon arrival
- Before and after infant receives bottle or food
- After diapering
- After contact with body fluids
- After outside play
- Before and after water play
- After handling pets
- Whenever hands are visibly dirty
- Before going home

## Handwashing Steps

- Turn on warm water (90-110°F in NC).
- Wet hands with water.
- Apply liquid soap.
- Wash hands for 10-15 seconds. Rub top and inside of hands, under nails and between fingers.
- Rinse hands with water.
- Dry hands with disposable paper towel.
- Turn off the water using paper towel.
- Throw paper towel into a lined trash container.



Very Young Infants

### Very Young Infants unable to support their heads

The infant is unable to hold head up or stand at sink, or the infant is too heavy for you to hold at sink.

Wash the infants hands with:

- disposable wipes
- or
- the three towel method (prepared ahead):
    1. dampened and soapy for washing infant's hands
    2. dampened with water for rinsing infant's hands
    3. dry for drying infant's hands



Young Infants

### Young Infants who can support their heads but not stand at the sink

You are able to hold the infant, but the infant cannot stand at the sink.

- Carry infant to sink.
  - Hold infant at the sink and wash infant's hands.
- Caution!** Do not push the infant's tummy into the sink.
- Back Aid** Place your foot on a 12" stool to lift your leg. Rest the infant on your knee at the sink.



Older Infants

### Older Infants who can stand at the sink

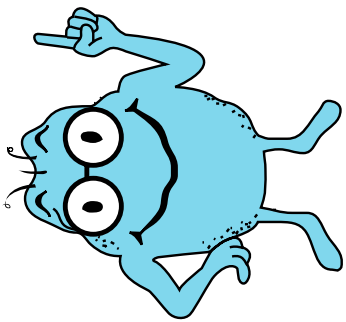
Infant can stand at a toddler height sink or on a stool at a sink.

- First wash your hands.
- Then assist the infant with hand washing.

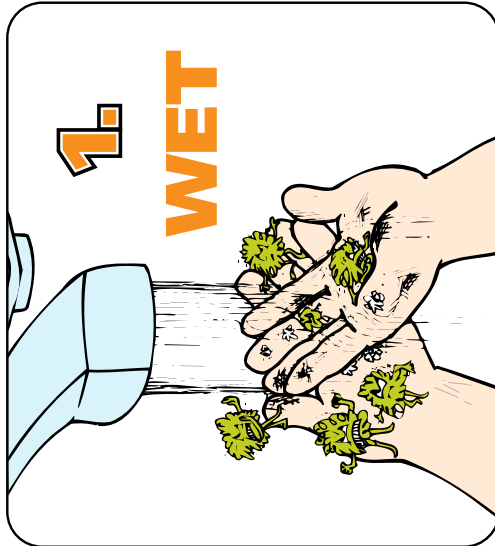
North Carolina Child Care Health & Safety Resource Center  
• 1.800.367.2229 • [www.healthychildcarenc.org](http://www.healthychildcarenc.org)

The development, translation, and mailing of the Infant Handwashing Poster are supported by funding from the Child Care and Development Fund Block Grant of the Child Care Bureau, Administration on Children and Families, USDHHS, through a contract between the NC Division of Child Development, NCDHHS, and the Department of Maternal and Child Health, School of Public Health, The University of North Carolina at Chapel Hill.



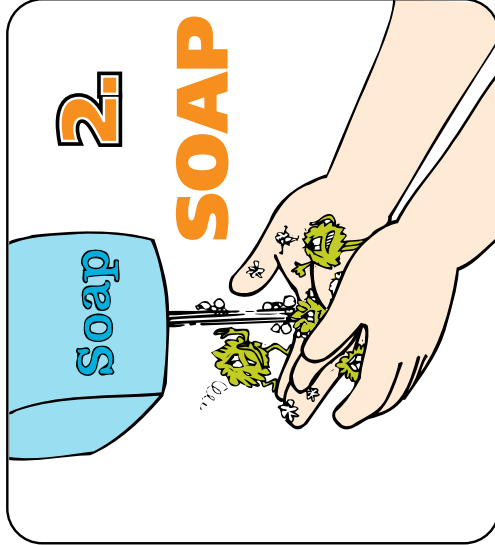


# Be a germ-buster . . . WASH YOUR HANDS



1.

WET



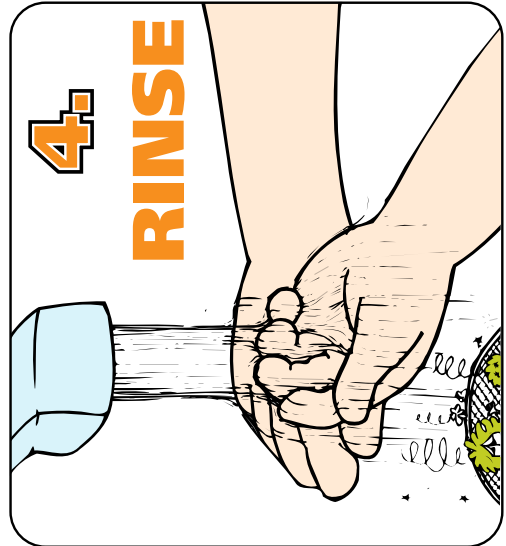
2.

SOAP



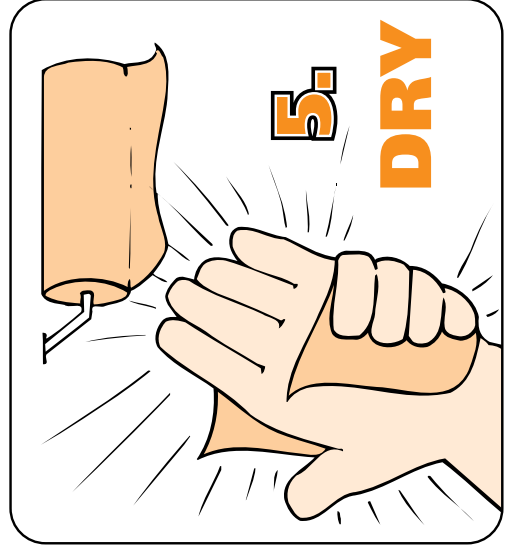
3.

WASH FOR  
20 SECONDS



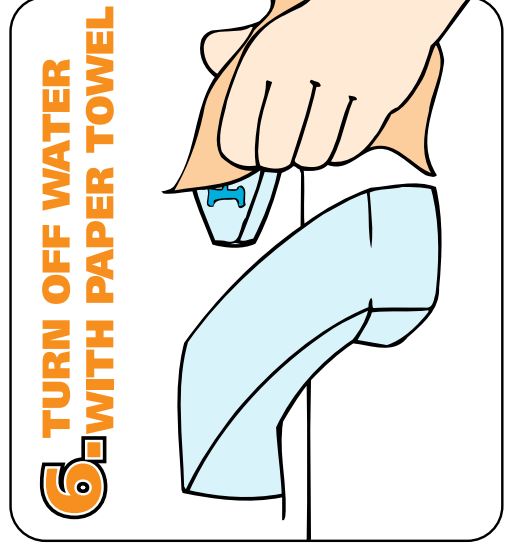
4.

RINSE



5.

DRY



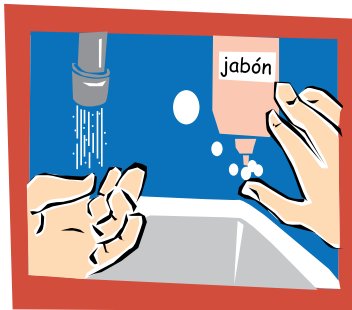
6. TURN OFF WATER  
WITH PAPER TOWEL

Poster courtesy of the Washington DOH

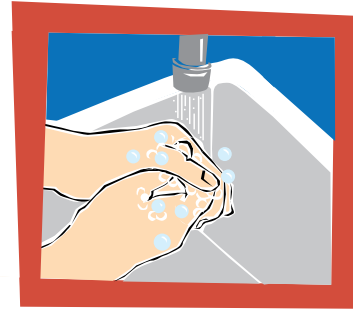




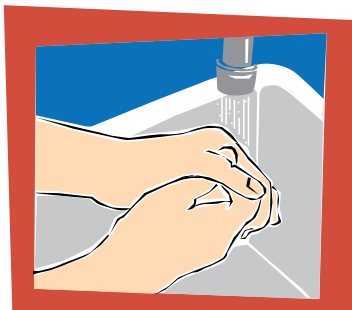
## Lávese las Manos Debidamente



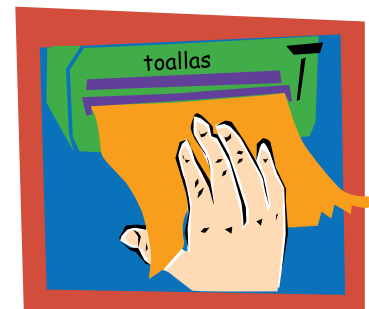
1. Mójese las manos y aplique jabón. Use agua corriente tibia que desagüe. Jabón líquido es lo mejor.



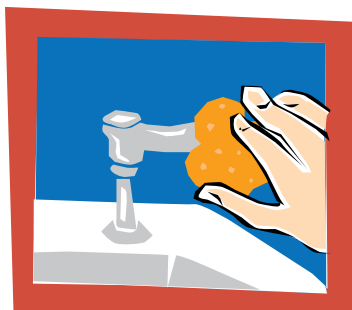
2. Frótese las manos vigorosamente por lo menos 10 segundos. Frote todas las superficies incluyendo el dorso de las manos, las muñecas, entre y bajo las uñas.



3. Enjuáguese bien las manos bajo el agua del grifo hasta que desaparezca toda la suciedad y el jabón.



4. Séquese las manos con una toalla de papel limpia.



5. Cierre el grifo con una toalla de papel. Debe cerrar la llave con una toalla de papel - no con sus manos limpias.



6. Deseche las toallas de papel usadas en un basurero de pedal, tapado, forrado con una bolsa plástica.

**STOP  
DISEASE**

## GLOVING



1. Put on a clean pair of gloves.



2. Provide appropriate care.



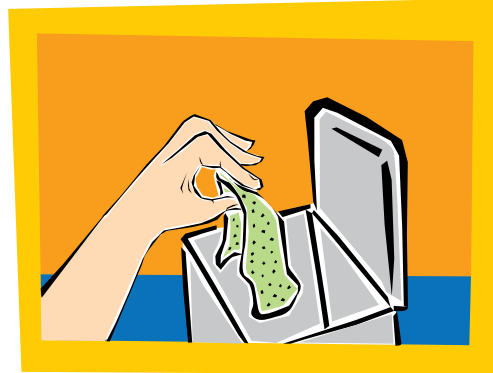
3. Remove each glove carefully. Grab the first glove at the palm and strip the glove off. Touch dirty surfaces only to dirty surfaces.



4. Ball up the dirty glove in the palm of the other gloved hand.



5. With the clean hand, strip the glove off from underneath at the wrist, turning the glove inside out. Touch clean surfaces only to clean surfaces.



6. Discard the dirty gloves immediately in a step can. Wash your hands.

**California Childcare Health Program**  
[www.ucsfchildcarehealth.org](http://www.ucsfchildcarehealth.org)

Rev. 01/03



# Usando Guantes



1. Póngase un par de guantes limpios.



2. Cure debidamente el lugar lastimado.



3. Quítese cuidadosamente cada guante. Agarre el primer guante por la palma y sáquese el guante. Toque superficies sucias solamente con superficies sucias.



4. Enrolle el guante sucio en la palma de la otra mano enguantada.



5. Meta la mano limpia debajo de la manga del guante por la muñeca, volteando el guante al revés. Toque superficies limpias solamente con superficies limpias.



6. Deseche los guantes sucios en un recipiente de pedal. Lávese las manos.



## DIAPERING PROCEDURES



### 1. Organize needed supplies within reach.

- Wash your hands and gather what you need.
- Place a disposable cover on the diapering surface.



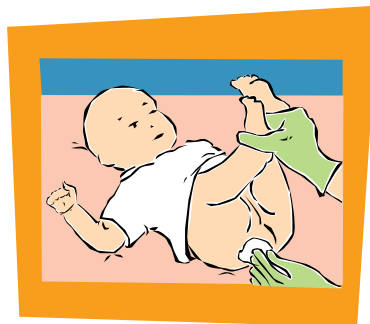
### 2. Avoid contact with soiled items.

- If using gloves, put them on now.
- Using only your hands, pick up the child.
- Provide steps for older children.
- Lay the child on the paper towel.
- Never leave the child unattended.



### 3. Remove the soiled diaper.

- Remove soiled diaper and soiled clothes.
- Fold the soiled surface inward.
- Put disposable diapers in a covered, plastic-lined trash can.
- Put soiled, reusable diaper and/or soiled clothes without rinsing in a plastic bag for parents.



### 4. Clean the child's diaper area.

- Use disposable wipes to clean and dry the child's bottom.
- If the child needs a more thorough washing, use soap, running water, and paper towels.
- Remove the disposable covering from beneath the child and discard it into a covered plastic-lined trash can.
- If you are wearing gloves, remove and dispose of them now into a covered, plastic-lined trash can.

California Childcare Health Program  
[www.ucsfchildcarehealth.org](http://www.ucsfchildcarehealth.org)

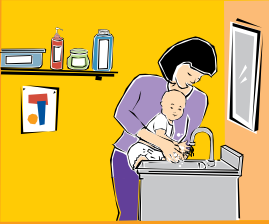
**STOP  
DISEASE**

## DIAPERING PROCEDURES

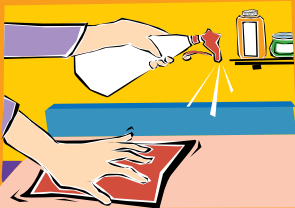


### 5. Put on a clean diaper and dress the child.

- Use a facial or toilet tissue to apply any necessary creams or ointments.
- Note and plan to report any skin problems such as redness.
- Slide a fresh diaper under the child, then adjust and fasten it. If pins are used, place your hand between the child and the diaper when inserting the pin.



### 6. Wash the child's hands and return the child to a supervised area.



### 7. Clean and sanitize the diaper changing surface.

- Clean and disinfect the diapering area, all equipment or supplies that were touched, and soiled crib or cot, if needed.



### 8. Wash your own hands thoroughly.

California Childcare Health Program  
[www.ucsfchildcarehealth.org](http://www.ucsfchildcarehealth.org)





## Procedimientos para Cambiar Pañales



### 1. Organice los objetos necesarios a su alcance.

- Lávese las manos y reúna lo que va a necesitar.
- Coloque un cubierta desechable sobre la superficie.



### 2. Evite el contacto con los objetos sucios.

- Si usa guantes, póngaselos ahora.
- Usando solamente sus manos, recoja al niño.
- Provea escaleras para los niños más grandes.
- Acueste al niño sobre la cubierta desechable.
- Nunca deje al niño desatendido.



### 3. Quite el pañal sucio.

- Quite el pañal y la ropa sucia.
- Doble la parte sucia hacia dentro.
- Ponga los pañales desechables en un basurero tapado forrado con una bolsa plástica.
- Ponga los pañales de tela y/o la ropa sucia en una bolsa plástica para dársela a los padres.



### 4. Limpie el lugar donde cambió el pañal.

- Use toallitas desechables para limpiar y secar al niño.
- Si el niño necesita una limpieza más a fondo, use jabón, agua corriente, y toallas de papel.
- Quite la cubierta desechable de debajo del niño y deséchela en un basurero tapado forrado con plástico.
- Si se puso guantes, quíteselos y deséchelos en un basurero tapado forrado con plástico.

California Childcare Health Program  
[www.ucsfchildcarehealth.org](http://www.ucsfchildcarehealth.org)



## Procedimientos para Cambiar Pañales



### 5. Póngale al niño un pañal limpio y vístalo.

- Use un pañuelo desechable o papel higiénico para aplicarle las cremas y ungüentos necesarios.
- Tome nota y haga planes para reportar cualquier problema de la piel como enrojecimiento.
- Ponga un pañal limpio debajo del niño, ajústelo y sujételo. Si usa alfileres, ponga su mano entre el niño y el pañal mientras coloca el alfiler.

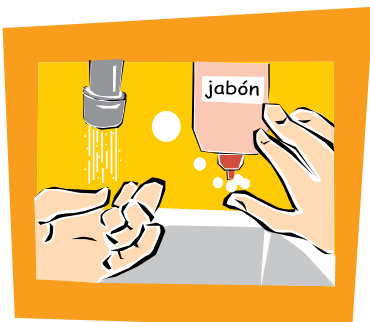


### 6. Lave las manos del niño y llévelo a un lugar supervisado.



### 7. Limpie y desinfecte la superficie donde cambió el pañal.

- Limpie y desinfecte la superficie donde cambió el pañal, todo equipo y objetos que tocó y, si es necesario, la cuna o la cama si se ensució.



### 8. Lávese bien las manos.

## Safe Sleep Policy

This Safe Sleep policy will be reviewed annually with all families enrolled in \_\_\_\_\_ (Name of Program) to familiarize them with the program's sleep policies for infants and to provide them with the current recommendations.

Safe sleep and napping practices reduce the risk of Sudden Infant Death Syndrome (SIDS) and the spread of contagious diseases. SIDS is the unexpected death of a seemingly healthy infant under one year of age for whom no cause of death can be determined. It is the leading cause of death in children from one to twelve months of age. The chance of SIDS occurring is highest when an infant first starts child care.

In order to maintain safe sleep practices, these policies and procedures will be followed:

- Healthy infants will always be put to sleep on their backs.
- Research shows that putting an infant to sleep on his back does not cause him to choke or aspirate.
- If a parent/guardian requests that their child be put to sleep in a position other than on their back, the parent must provide a Physician's Signed Note that explains how the infant should be put to sleep and the medical reason for this position. This note will be kept in the child's medical file and all staff will be notified of the infant's prescribed sleep position.
- Infants will be placed to sleep on a firm mattress that fits tightly in a crib that meets Consumer Product Safety Commission safety standards. The sheet will fit the mattress snugly.
- No toys, stuffed animals, pillows, crib bumpers, positioning devices (unless ordered by a health care provider) or extra bedding will be in the crib.
- Overheating is one of the risk factors for SIDS; to avoid overheating:
  - The room will be kept at a temperature that is comfortable for a lightly clothed adult.
  - Avoid excessive blankets and bedding.
  - Do not overdress infants when they sleep.
- The infant's head will remain uncovered when she sleeps.
- When an infant is able to roll from back to side or stomach, the infant will be placed to sleep on his back.
- Sleeping infants will be visually checked every 10 minutes. This is especially important during the first weeks an infant is in child care.
- Infants will not share cribs.
- Infants will never be put to sleep on a couch, chair, cushion, or an adult bed, even a twin bed.
- The child care program is a smoke-free environment. Infants exposed to smoke have an increased risk of SIDS.
- Awake infants will have supervised "Tummy Time" to allow for the development of strong back and neck muscles and prevent the development of flat areas on the head.
- The time infants spend in a car seat, swing or bouncy chair will be limited as this can delay motor development and may also cause the infant to develop a flat area on the back of her head.

*Adapted from the UCSF California Childcare Health Program.*



# A CHILD CARE PROVIDER'S GUIDE TO SAFE SLEEP

Helping you to reduce the risk of SIDS

## DID YOU KNOW?

- About one in five sudden infant syndrome (SIDS) deaths occur while an infant is being cared for by someone other than a parent. Many of these deaths occur when infants who are used to sleeping on their backs at home are then placed to sleep on their tummies by another caregiver. We call this “unaccustomed tummy sleeping.”
- Unaccustomed tummy sleeping increases the risk of SIDS. Babies who are used to sleeping on their backs and placed to sleep on their tummies are 18 times more likely to die from SIDS.

## WHO IS AT RISK FOR SIDS?

- SIDS is the leading cause of death for infants between 1 month and 12 months of age.
- SIDS is most common among infants that are 2-4 months old. However, babies can die of SIDS until they are 1 year old.

Because we don't know what causes SIDS, safe sleep practices should be used to reduce the risk of SIDS in every infant under the age of 1 year.

## KNOW THE TRUTH... SIDS IS NOT CAUSED BY:

- Immunizations
- Vomiting or choking

## WHAT CAN CHILD CARE PROVIDERS DO?

Follow these guidelines to help protect the infants in your care:

## CREATE A SAFE SLEEP POLICY

Create and use a written safe sleep policy—Reducing the Risk of Sudden Infant Death Syndrome, Applicable Standards from Caring for Our Children National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs outlines safe sleep policy guidelines. Visit <http://nrc.uchsc.edu/SPINOFF/SIDS/SIDS.htm> to download a free copy.

## A SAFE SLEEP POLICY SHOULD INCLUDE THE FOLLOWING:

- Healthy babies should always sleep on their backs. Because babies sleeping on their sides are more likely to accidentally roll onto their stomach, the side position is not as safe as the back and is not recommended.
- Require a physician's note for non-back sleepers that explains why the baby should not use a back-sleeping position, how the child should be placed to sleep, and a time frame that the instructions are to be followed.

- Use safety-approved cribs and firm mattresses (cradles and bassinets may be used, but choose those that are JPMA (Juvenile Products Manufacturers Association) certified for safety).

- Keep cribs free of toys, stuffed animals, and extra bedding.

- If a blanket is used, place the child's feet to the foot of the crib and tuck in a light blanket along the sides and foot of the mattress. The blanket should not come up higher than the infant's chest. Sleep clothing, such as sleepers, sleep sacks, and wearable blankets, are good alternatives to blankets.

- Sleep only 1 baby per crib.

- Keep the room at a temperature that is comfortable for a lightly clothed adult.

- Do not use wedges or infant positioners, since there's no evidence that they reduce the risk of SIDS.

- Never allow smoking in a room where babies sleep, as exposure to smoke is linked to an increased risk of SIDS.

- Have supervised “tummy time” for babies who are awake. This will help babies strengthen their muscles and develop normally.

- Teach all staff, substitutes, and volunteers about safe sleep policies and practices and be sure to review these practices often.

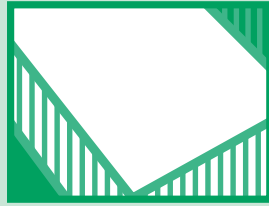
When a new baby is coming into the program, be sure to talk to the parents about your safe sleep policy and how their baby sleeps. If the baby sleeps in a way other than on her back, the child's parents or guardians need a note from the child's physician that explains how she should sleep, the medical reason for this position and a time frame for this position. This note should be kept on file and all staff, including substitutes and volunteers, should be informed of this special situation. It is also a good idea to put a sign on the baby's crib.

**If you are not sure of how to create a safe sleep policy, work with a child care health consultant to create a policy that fits your child care center or home.**

Supported in part by Grant No. U46 MC 04436 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.



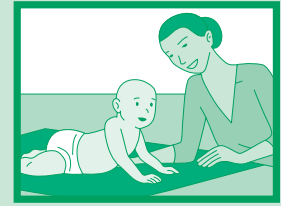
Face up to wake up – healthy babies sleep safest on their backs.



Do not place pillows, quilts, pillow-like toys, or anything in the crib.



If a light blanket is needed, tuck all sides along bottom half of crib, below baby's arms.



Supervised tummy time during play is important to baby's healthy development.

## SAFE SLEEP PRACTICES

- Practice SIDS reduction in your program by using the *Caring for Our Children* standards.
- Always place babies to sleep on their backs during naps and at nighttime.
- Don't cover the heads of babies with a blanket or overbundle them in clothing and blankets.
- Avoid letting the baby get too hot. The infant could be too hot if you notice sweating, damp hair, flushed cheeks, heat rash, and/or rapid breathing. Dress the baby lightly for sleep. Set the room temperature in a range that is comfortable for a lightly clothed adult.
- Talk with families about the importance of sleep positioning, and encourage them to follow these guidelines at home.

## SAFE SLEEP ENVIRONMENT

- Place babies to sleep only in a safety-approved crib with a firm mattress and a well-fitting sheet. Don't place babies to sleep on chairs, sofas, waterbeds, or cushions. Adult beds are NOT safe places for babies to sleep.
- Toys and other soft bedding, including fluffy blankets, comforters, pillows, stuffed animals, and wedges should not be placed in the crib with the baby. These items can impair the infant's ability to breathe if they cover his face.
- The crib should be placed in an area that is always smoke-free.

## OTHER RECOMENDATIONS

- Support parents who want to breastfeed or feed their children breast milk.
- Talk with a child care health consultant about health and safety in child care.
- Have a plan to respond if there is an infant medical emergency.
- Be aware of bereavement/grief resources.

## AM I A CHILD CARE PROVIDER?

Some child care providers are professionals with college degrees and years of experience, but other kinds of child care providers could be grandparents, babysitters, family friends, or anyone who cares for a baby. These guidelines apply to any kind of child care provider. If you ever care for a child who is less than 12 months of age, you should be aware of and follow these safe sleep practices.

If you have questions about safe sleep practices please contact Healthy Child Care America at the American Academy of Pediatrics at [childcare@aap.org](mailto:childcare@aap.org) or 888/227-5409. Remember, if you have a question about the health and safety of an infant in your care, ask the baby's parents if you can talk to the baby's doctor.

## RESOURCES:

American Academy of Pediatrics  
<http://www.aappolicy.org>  
*The Changing Concept of Sudden Infant Death Syndrome: Diagnostic Coding Shifts, Controversies Regarding the Sleeping Environment, and New Variables to Consider in Reducing Risk*  
<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;116/5/1245.pdf>

Healthy Child Care America  
<http://www.healthychildcare.org>

*Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care*, Second Edition. Visit the National Resource Center for Health and Safety in Child Care and Early Education Web site at <http://nrc.uchsc.edu/> to download a free copy. Hard copies are available from the American Academy of Pediatrics Bookstore at <http://www.aap.org>.

Healthy Kids, Healthy Care  
<http://www.healthykids.us>

National Institute for Child and Human Development Back to Sleep Campaign  
 Order free educational materials from the Back to Sleep Campaign at <http://www.nichd.nih.gov/sids/sids.cfm>

First Candle/SIDS Alliance  
<http://www.firstcandle.org>

Association of SIDS and Infant Mortality Programs  
<http://www.asip1.org/>

CJ Foundation for SIDS  
<http://www.cjsids.com/>

National SIDS and Infant Death Resource Center  
<http://www.sidscenter.org/>

The Juvenile Products Manufacturers Association  
<http://www.jpma.org/>

American Academy  
 of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Revised 2008

# A PARENTS' GUIDE TO SAFE SLEEP

Helping you to reduce the risk of SIDS

## DID YOU KNOW?

- About one in five sudden infant death syndrome (SIDS) deaths occur while an infant is in the care of someone other than a parent. Many of these deaths occur when babies who are used to sleeping on their backs at home are then placed to sleep on their tummies by another caregiver. We call this “unaccustomed tummy sleeping.”
- Unaccustomed tummy sleeping increases the risk of SIDS. Babies who are used to sleeping on their backs and are placed to sleep on their tummies are 18 times more likely to die from SIDS.

**You can reduce your baby's risk of dying of SIDS by talking to those who care for your baby, including child care providers, babysitters, family, and friends, about placing your baby to sleep on his back at night and during naps.**

## WHO IS AT RISK FOR SIDS?:

- SIDS is the leading cause of death for infants between 1 month and 12 months of age.
- SIDS is most common among infants that are 2-4 months old. However, babies can die of SIDS until they are 1 year old.

## WHAT CAN I DO BEFORE MY BABY IS BORN TO REDUCE THE RISK OF SIDS?

Take care of yourself during pregnancy and after the birth of your baby. During pregnancy, before you even give birth, you can reduce the risk of your baby dying from SIDS! **Don't smoke or expose yourself to others' smoke while you are pregnant and after the baby is born.** Be sure to visit a physician for regular prenatal checkups to reduce your risk of having a low birth weight or premature baby. Breastfeed your baby, if possible, at least through the first year of life.

## KNOW THE TRUTH... SIDS IS NOT CAUSED BY:

- Immunizations
- Vomiting or choking

## WHAT CAN I DO TO HELP SPREAD THE WORD ABOUT BACK TO SLEEP?

- Be aware of safe sleep practices and how they can be made a part of our everyday lives.
- When shopping in stores with crib displays that show heavy quilts, pillows, and stuffed animals, talk to the manager about safe sleep, and ask them not to display cribs in this way.
- Monitor the media. When you see an ad or a picture in the paper that shows a baby sleeping on her tummy, write a letter to the editor.
- If you know teenagers who take care of babies, talk with them. They may need help with following the proper safe sleep practices.
- Set a good example – realize that you may not have slept on your back as a baby, but we now know that this is the safest way for babies to sleep. When placing babies to sleep, be sure to always place them on their backs.

## IT IS EASY AND FREE TO MAKE SAFE SLEEP PRACTICES A PART OF YOUR DAILY LIFE.

This way, you will know that you are doing all that you can to keep your baby healthy and safe. Do your best to follow the guidelines above.

## WHERE IS THE SAFEST PLACE FOR MY BABY TO SLEEP?

The safest place for your baby to sleep is in the room where you sleep. Place the baby's crib or bassinet near your bed (within an arm's reach). This makes it easier to breastfeed and to bond with your baby.

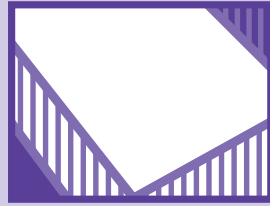
The crib or bassinet should be free from toys, soft bedding, blankets, and pillows. (See picture on next page.)

Supported in part by Grant No. U46 MC 04436 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.





Face up to wake up – healthy babies sleep safest on their backs.



Do not place pillows, quilts, toys, or anything in the crib.



If a light blanket is needed, tuck all sides along bottom half of crib, below baby's arms.



Supervised tummy time during play is important to baby's healthy development.

## HOW CAN I REDUCE MY BABY'S RISK?

Follow these guidelines to help you reduce your baby's risk of dying from SIDS.

### SAFE SLEEP PRACTICES

- Always place babies to sleep on their backs during naps and at nighttime. Because babies sleeping on their sides are more likely to accidentally roll onto their stomach, the side position is not as safe as the back and is not recommended.
- Don't cover the heads of babies with a blanket or overbundle them in clothing and blankets.
- Avoid letting the baby get too hot. The baby could be too hot if you notice sweating, damp hair, flushed cheeks, heat rash, and rapid breathing. Dress the baby lightly for sleep. Set the room temperature in a range that is comfortable for a lightly clothed adult.

### SAFE SLEEP ENVIRONMENT

- Place your baby in a safety-approved crib with a firm mattress and a well-fitting sheet (cradles and bassinets may be used, but choose those that are JPMA (Juvenile Products Manufacturers Association) certified for safety).
- Place the crib in an area that is always smoke free.
- Don't place babies to sleep on adult beds, chairs, sofas, waterbeds, or cushions.
- Toys and other soft bedding, including fluffy blankets, comforters, pillows, stuffed animals, and wedges should not be placed in the crib with the baby. These items can impair the infant's ability to breathe if they cover his face.
- Breastfeed your baby. Experts recommend that mothers feed their children human milk at least through the first year of life.

## TALK ABOUT SAFE SLEEP PRACTICES WITH EVERYONE WHO CARES FOR YOUR BABY!

When looking for someone to take care of your baby, including a child care provider, a family member, or a friend, make sure that you talk with this person about safe sleep practices. Bring this fact sheet along to help, if needed. If a caregiver does not know the best safe sleep practices, respectfully try to teach the caregiver what you have learned about safe sleep practices and the importance of following these rules when caring for infants. Before leaving your baby with anyone, be sure that person agrees that the safe sleep practices explained in this brochure will be followed all of the time.

## IS IT EVER SAFE TO HAVE BABIES ON THEIR TUMMIES?

Yes! You should talk to your child care provider about making tummy time a part of your baby's daily activities. Your baby needs plenty of tummy time while supervised and awake to help build strong neck and shoulder muscles. Remember to also make sure that your baby is having tummy time at home with you.

## TUMMY TO PLAY AND BACK TO SLEEP

- Place babies to sleep on their backs to reduce the risk of SIDS. Side sleeping is not as safe as back sleeping and is not advised. Babies sleep comfortably on their backs, and no special equipment or extra money is needed.
- "Tummy time" is playtime when infants are awake and placed on their tummies while someone is watching them. Have tummy time to allow babies to develop normally.

If you have questions about safe sleep practices please contact Healthy Child Care America at the American Academy of Pediatrics at [childcare@aap.org](mailto:childcare@aap.org) or 888/227-5409. Remember, if you have a question about the health and safety of your child, talk to your baby's doctor.

## RESOURCES:

American Academy of Pediatrics  
<http://www.aappolicy.org>  
*The Changing Concept of Sudden Infant Death Syndrome: Diagnostic Coding Shifts, Controversies Regarding the Sleeping Environment, and New Variables to Consider in Reducing Risk*  
<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;116/5/1245.pdf>

Healthy Child Care America  
<http://www.healthychildcare.org>

National Resource Center for Health and Safety in Child Care and Early Education  
<http://nrc.uchsc.edu>

Healthy Kids, Healthy Care: A Parent Friendly Tool on Health and Safety Issues in Child Care  
<http://www.healthykids.us>

National Institute for Child and Human Development Back to Sleep Campaign  
Order free educational materials from the Back to Sleep Campaign at  
<http://www.nichd.nih.gov/sids/sids.cfm>

First Candle/SIDS Alliance  
<http://www.firstcandle.org>

Association of SIDS and Infant Mortality Programs  
<http://www.asip1.org>

CJ Foundation for SIDS  
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National SIDS and Infant Death Resource Center  
<http://www.sidscenter.org/>

The Juvenile Products Manufacturers Association  
<http://www.jpma.org/>

American Academy  
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Revised 2008

Menu for Week of:	Day 1:	Day 2:	Day 3:	Day 4:	Day 5:
<p><b>BREAKFAST</b></p> <p><b>Meal Pattern</b></p> <ul style="list-style-type: none"> <li>▶ Juice or Fruit or Vegetable</li> <li>▶ Grains/Breads</li> <li>▶ Milk</li> </ul>	<p>Milk</p>	<p>Milk</p>	<p>Milk</p>	<p>Milk</p>	<p>Milk</p>
<p><b>AM SNACK</b></p> <p><b>Meal Pattern</b></p> <p>Select <b>two (2)</b> of the following:</p> <ul style="list-style-type: none"> <li>▶ Meat or Meat Alternate</li> <li>▶ Vegetable or Fruit or Juice</li> <li>▶ Grains/Breads</li> <li>▶ Milk</li> </ul>					
<p><b>LUNCH or SUPPER</b></p> <p><b>Meal Pattern</b></p> <ul style="list-style-type: none"> <li>▶ Meat or Meat Alternate</li> <li>▶ Vegetable/Fruit (2 servings of vegetable or fruit or both)</li> <li>▶ Grains/Breads</li> <li>▶ Milk</li> </ul>	<p>Milk</p>	<p>Milk</p>	<p>Milk</p>	<p>Milk</p>	<p>Milk</p>
<p><b>PM SNACK</b></p> <p><b>Meal Pattern</b></p> <p>Select <b>two (2)</b> of the following:</p> <ul style="list-style-type: none"> <li>▶ Meat or Meat Alternate</li> <li>▶ Vegetable or Fruit or Juice</li> <li>▶ Grains/Breads</li> <li>▶ Milk</li> </ul>					

\*Serving whole milk to children under two years of age is recommended.  
 \*\*Water is recommended as an additional beverage with snacks; however water is not part of the meal requirement.

Food Component	1 & 2 Years	3-5 Years	6-12 Years
<b>BREAKFAST</b>			
Milk, fluid	1/2 Cup	3/4 Cup	1 Cup
Fruit or Vegetable	1/4 Cup	1/2 Cup	1/2 Cup
Bread/Bread Alternate *	1/2 Slice	1/2 Slice	1 Slice
<b>LUNCH or SUPPER</b>			
Milk, fluid:	1/2 Cup	3/4 Cup	1 Cup
Meat or Meat Alternate:	1 Ounce	1 1/2 Ounces	2 Ounces
Cheese	1 Ounce	1 1/2 Ounces	2 Ounces
Yogurt, plain or flavored, Unsweetened or Sweetened	1/2 Cup	3/4 Cup	1 Cup
Egg	1/2 Egg	3/4 Egg	1 Egg
Cooked Dry Beans/Peas	1/4 Cup	3/8 Cup	1/2 Cup
Cottage cheese	1/4 Cup	3/8 Cup	1/2 Cup
Peanut Butter or other nut or seed butters	2 Tbsp.	3 Tbsp.	4 Tbsp.
Nuts and/or Seeds**	1/4 Cup	1/2 Cup	3/4 Cup
<b>Vegetable/Fruit:</b> Serve 2 or more separate and identifiable fruit/vegetables dishes	1/4 Cup Total	1/2 Cup Total	3/4 Cup Total
<b>Bread/Bread Alternate:*</b>	1/2 Slice	1/2 Slice	1 Slice

**SNACK – Select 2 of 4 Components**

Milk, fluid:	1/2 Cup	3/4 Cup	1 Cup
100% Juice, Fruit or Vegetable:	1/2 Cup	1/2 Cup	3/4 Cup
Meat / Meat Alternate:**	1/2 Ounce	1/2 Ounce	1 Ounce
Bread / bread Alternate:*	1/2 Slice	1/2 Slice	1 Slice

\*An acceptable serving of a bread alternate (cornbread, biscuits, muffins, etc.) is made of whole grain or enriched meal or flour, or a serving of whole-grain or enriched cereal, or cooked enriched or whole grain pasta product.

\*\*Not more than 1 ounce of nuts and/or seeds may be used in any meal and may not contribute more than 50% of the total requirement of meat / meat alternate.

Bread Equivalents: These foods may be mixed / matched to obtain the required bread equivalents	
Breads	1 Slice
Grains	1/2 Cup
Pasta	1/2 Cup
Cereal – DRY	1/3 Cup
Cereal – HOT	1/4 Cup

Meat Equivalents: These foods may be mixed / matched to obtain the required meat equivalents	
Meat	1 Ounce
Eggs	1/2 Egg
Peanut Butter	2 Tbsp.
Beans	1/4 Cup
Yogurt	1/2 Cup

# Food Allergy Action Plan

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  Yes (higher risk for a severe reaction)  No

Place  
Student's  
Picture  
Here

Extremely reactive to the following foods: \_\_\_\_\_

## THEREFORE:

- If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
- If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

### Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough

HEART: Pale, blue, faint, weak pulse, dizzy, confused

THROAT: Tight, hoarse, trouble breathing/swallowing

MOUTH: Obstructive swelling (tongue and/or lips)

SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)

GUT: Vomiting, crampy pain



### 1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications: \*
  - Antihistamine
  - Inhaler (bronchodilator) if asthma

\*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

### MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth

SKIN: A few hives around mouth/face, mild itch

GUT: Mild nausea/discomfort



### 1. GIVE ANTIHISTAMINE

2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

## Medications/Doses

Epinephrine (brand and dose): \_\_\_\_\_

Antihistamine (brand and dose): \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if asthmatic): \_\_\_\_\_

## Monitoring

**Stay with student; alert healthcare professionals and parent.** Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician/Healthcare Provider Signature \_\_\_\_\_

Date \_\_\_\_\_

TURN FORM OVER

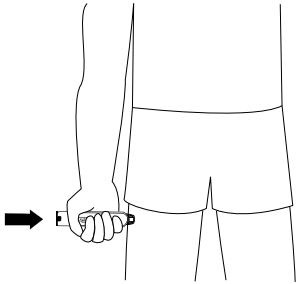
Form provided courtesy of FAAN ([www.foodallergy.org](http://www.foodallergy.org)) 7/2010

**EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions**

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds



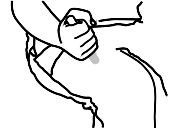
DEY™ and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

**Twinject® 0.3 mg and Twinject® 0.15 mg Directions**



Remove caps labeled “1” and “2.”

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.



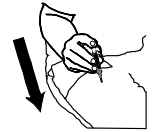
**SECOND DOSE ADMINISTRATION:**  
If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.



Slide yellow collar off plunger.

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



**Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions**



Remove **GREY** caps labeled “1” and “2.”



Place **RED** rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

**Contacts**

Call 911 (Rescue squad: ( ) - ) Doctor: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_

**Other Emergency Contacts**

Name/Relationship: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_

Name/Relationship: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_

Form provided courtesy of FAAN ([www.foodallergy.org](http://www.foodallergy.org)) 7/2010

# Plan de Emergencia Contra Alérgenos Alimenticios

Nombre del estudiante: \_\_\_\_\_

Fecha de nacimiento: \_\_\_\_\_ Profesor: \_\_\_\_\_

ALERGIA: \_\_\_\_\_

Asmático Sí\*  No  \*Alto riesgo de sufrir una reacción alérgica grave

Coloque la  
foto del  
niño aquí.

## ◆ PASO 1: TRATAMIENTO ◆

### Síntomas:

### Administre el medicamento indicado\*\*:

\*\* (Sera determinado por el medico que autorice el tratamiento)

Si ha ingerido un alérgeno alimenticio pero *no aparecen síntomas*:

Boca Picazón e inflamación en los labios, la lengua, o boca

Piel Ronchas, erupción de la piel con picazón y/o hinchazón en la cara o extremidades

Intestino Náusea, retortijón abdominal, vómitos y/o diarrea

Garganta† Picazón y/o sensación de tirantez en la garganta, ronquera y tos seca recurrente

Pulmón† Falta de respiración, tos repetitiva y/o respiración sibilante

Corazón† Pulso filiforme, desmayo, palidez, baja presión, piel azulada

Otro† \_\_\_\_\_

Epinefrina  Antihistamínico

Epinefrina  Antihistamínico

Epinefrina  Antihistamínico

Epinefrina  Antihistamínico

Epinefrina  Antihistamínico

Epinefrina  Antihistamínico

Epinefrina  Antihistamínico

Epinefrina  Antihistamínico

Epinefrina  Antihistamínico

Si la reacción avanza (afectando a varias de las áreas arriba mencionadas), administre:

La gravedad de los síntomas puede cambiar rápidamente. †Estos síntomas pueden progresar y poner en peligro su vida.

### DOSIS

**Epinefrina:** inyecte el EpiPen®, EpiPen® Jr., Twinject® 0.3 mg, o Twinject® 0.15 mg por vía intramuscular (indique uno). (Si desea consultar las instrucciones completas, lea al dorso)

**Antihistamínico:** administre \_\_\_\_\_  
medicamento/dosis/vía de administración

**Otro:** administre \_\_\_\_\_  
medicamento/dosis/vía de administración

**AVISO IMPORTANTE:** En caso anafilaxia, usted no puede confiar en el uso de inhaladores y/o antihistaminas como reemplazos de la epinefrina.

## ◆ PASO 2: LLAMADAS DE EMERGENCIA ◆

1. Llame al 911 o al servicio público de ambulancias (Rescue Squad). Indique que la reacción alérgica ha sido tratada pero que puede ser necesaria una dosis adicional de epinefrina.

2. Dr. \_\_\_\_\_ al \_\_\_\_\_

3. Contactos de emergencia:

Nombre/Parentesco familiar	Teléfono(s)	
a. _____	1.) _____	2.) _____
b. _____	1.) _____	2.) _____



NO VACILE EN SUMINISTRAR EL MEDICAMENTO O EN LLAMAR A UNA AMBULANCIA AUN CUANDO NO PUEDE LOCALIZAR A LOS PADRES O AL DOCTOR

Firma del padre o la madre / guardián \_\_\_\_\_

Fecha \_\_\_\_\_

Firma del doctor \_\_\_\_\_  
(Necesaria)

Fecha \_\_\_\_\_

### MIEMBROS DEL PERSONAL CAPACITADOS

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

- Sala \_\_\_\_\_  
Sala \_\_\_\_\_  
Sala \_\_\_\_\_

#### Instrucciones Para el Uso del Autoinyector EpiPen® and EpiPen® Jr.

- Hale la tapa de seguridad gris.



- Coloque la punta negra sobre la parte exterior de su muslo (siempre inyecte sobre el muslo).



- Presione fuerte hacia adentro, en la parte exterior de su muslo, con un movimiento rápido hasta que funcione el mecanismo autoinyector del EpiPen®. Sostenga el inyector en su lugar sin moverlo y cuente hasta 10. Luego retire el inyector EpiPen® y masajee la zona inyectada por durante 10 segundos.

#### Twinject® 0.3 mg y Twinject® 0.15 mg Instrucciones:



- Quite la tapa identificada con el número 1 y después la tapa identificada con el número 2.
- Coloque la punta redonda sobre la superficie del muslo y presione firmemente hacia abajo hasta que la aguja penetre la piel. Mantenga esta posición por 10 segundos y luego retírela.



#### ADMINISTRACION DE LA SEGUNDA DOSIS:

Si los síntomas no mejoran después de 10 minutos, administre la segunda dosis:

- Desenrosque la punta redonda y hale la jeringa desde su recipiente, sosteniéndolo por la banda azul a nivel de la base de la aguja.
- Remueva la banda amarilla del émbolo.
- Inserte la aguja dentro del muslo a través de la piel, presionando el émbolo completamente hacia abajo y luego retírela.



Después de usar el inyector EpiPen® o el Twinject®, llame al servicio público de ambulancias (Rescue Squad). Lleve la unidad usada a la sala de emergencia. Usted deberá permanecer en observación durante por lo menos 4 horas en la sala de emergencia.

Para los niños que son alérgicos a varios alimentos, utilice un formulario para cada alimento.

\*\* Lista de verificación de medicamentos adaptada del formulario Authorization of Emergency Treatment (Autorización para tratamientos de emergencia) desarrollado por la Mount Sinai School of Medicine (Escuela de medicina de Mount Sinai). Uso autorizado.



Junio/2007

# Family Checklist for Nutrition in Early Care and Education

From *Preventing Obesity in Early Care and Education Programs*  
Selected Standards from *Caring for Our Children: National Health and Safety Performance Standards*

## Do you see the following practices carried out?



### Infant Feeding

- \_\_\_\_\_ Infants (babies less than 12 months of age) are fed only human milk or formula, never cow's milk.
- \_\_\_\_\_ Infants are fed when hungry and are allowed to stop a feeding, when they show signs of fullness.
- \_\_\_\_\_ Caregivers and teachers always hold infants for bottle-feeding of human milk or formula (the same formula that is used at home).
- \_\_\_\_\_ Mothers are encouraged to breastfeed on-site, if possible, and breastfeeding families are welcomed.
- \_\_\_\_\_ Infants are not fed solid foods in a bottle or infant feeder unless the feeding is written in the infant's care plan by the child's primary care provider.
- \_\_\_\_\_ Infants are offered solid food no sooner than four months of age, and preferably around six months of age, as agreed upon with their families.



### Specific Foods and Drinks

- \_\_\_\_\_ Children (youngsters over 12 months of age) are served 100% full strength fruit juice in small amounts, 4-6 ounces; none is given to infants.
- \_\_\_\_\_ Children are not served concentrated sweetened foods or drinks (e.g., candy, soft drinks, or fruit punch).
- \_\_\_\_\_ Menus provide age-appropriate whole grains, vegetables, fruits, chicken, fish, and beans, and avoid salty and fried foods as well as trans and saturated fats.
- \_\_\_\_\_ From the age of two, children are served skim or 1% pasteurized milk unless whole milk is written in the child's care plan by the child's primary care provider.
- \_\_\_\_\_ Clean and sanitary drinking water is readily available throughout the day and children are encouraged to drink it.



### Nutrition Plans and Policies

- \_\_\_\_\_ Written menus and food guidelines are in place for the nutritional requirements of the children.
- \_\_\_\_\_ Children are served age-appropriate portions that meet national requirements\* for children in early care and education. \*Child and Adult Care Food Program, US Department of Agriculture
- \_\_\_\_\_ Toddlers and older infants are encouraged to feed themselves. Caregivers sit with them and supervise their use of child-sized cups, spoons, forks, and fingers.



### Behavior and Socialization

- \_\_\_\_\_ Mealtime is relaxed and enjoyable – a time when adults and children talk together and share conversation and learning opportunities with each other.
- \_\_\_\_\_ Older children are involved in serving food as well as setting and cleaning tables.
- \_\_\_\_\_ Children are not forced or bribed to eat (food is not used as a reward or a punishment) and eat only when seated.



## Teaching opportunities for children 2 and over

Caregivers and teachers promote good nutrition by regularly including nutrition topics in the curriculum such as:

- Eating healthy foods,
- What foods have vitamins and what they do for us,
- How and where fruits and vegetables grow, and
- What is a food pyramid?

Please see: <http://teamnutrition.usda.gov/Resources/TwoBiteClub.pdf>



## How families can help caregivers and teachers promote good nutrition:

- Don't put your baby to bed with a bottle, even just water. It is a hard habit to unlearn and makes it more difficult for a caregiver who isn't giving your child a bottle in the crib.
- Serve nutritious foods at home; you can set an example and build good habits by eating healthy foods.
- Encourage young children to try new foods by being eager to taste and making mealtime fun. Plan meals and snacks, grocery shop, and cook with older kids.
- Ask your child's primary care provider if s/he would be willing to speak at a family meeting about the importance of healthy eating.
- To celebrate your child's special occasions, check with your child's caregiver or teacher about what is appropriate and appreciated - fresh whole fruit? Or non-food items like books, CDs, or a washable birthday cape and crown?
- Consider a slow cooker as a gift for a caregiver or teacher; it can reduce kitchen time for caregivers and teachers.

## Additional Resources

Bright Futures in Practice: Nutrition

<http://www.brightfutures.org/nutrition/pdf/index.html>

Child and Adult Care Food Program (CACFP)

<http://www.fns.usda.gov/cnd/Care/default.htm>

Dietary Guidelines for Americans 2010

<http://www.health.gov/dietaryguidelines/dga2010/DietaryGuidelines2010.pdf>

Making Food Healthy and Safe for Children, 2nd Ed. (*note: this may take some time to load if you don't have broadband Internet service*)

[http://nti.unc.edu/course\\_files/curriculum/nutrition/making\\_food\\_healthy\\_and\\_safe.pdf](http://nti.unc.edu/course_files/curriculum/nutrition/making_food_healthy_and_safe.pdf)

American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education. 2010. Preventing Childhood Obesity in Early Care and Education: Selected Standards from Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd Edition.

[http://nrckids.org/CFOC3/PDFVersion/preventing\\_obesity.pdf](http://nrckids.org/CFOC3/PDFVersion/preventing_obesity.pdf)

## Additional Organizations

The Child Care Nutrition Resource System:

<http://www.nal.usda.gov/childcare/>

The Food and Nutrition Information Center

<http://www.nal.usda.gov/fnic/>

**Family Checklist for Nutrition in Early Care and Education** is based on *Preventing Childhood Obesity in Early Care and Education Programs - Selected Standards from "Caring for Our Children: National Health and Safety Performance Standards, 3<sup>rd</sup> Ed."* (Caring for Our Children, 3<sup>rd</sup> Ed. is to be published in 2011) American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education.

**Disclaimer:** This material is for reference purposes only and shall not be used as a substitute for medical/dental consultation, nor be used to authorize actions beyond a person's licensing, training, or ability

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# Family Checklist for Physical Activity in Early Care and Education

From *Preventing Obesity in Early Care and Education Programs*  
Selected Standards from *Caring for Our Children: National Health and Safety Performance Standards*

## Do you see the following practices carried out?



### Opportunities for Physical Activity

- \_\_\_\_\_ Infants have supervised tummy time daily. Tummy time begins as a three-five minute period and is gradually increased.
- \_\_\_\_\_ Infants have outdoor activity and/or carriage/stroller rides daily, weather permitting.
- \_\_\_\_\_ Caregivers and teachers schedule two or three active playtimes for children daily, indoors and/or outdoors weather permitting, during an 8-hour day.
- \_\_\_\_\_ Children are led in two or more active games and/or movement activities daily by a caregiver or teacher.
- \_\_\_\_\_ Children are given ample physical activity time each 8-hour day (toddlers, 60-90 minutes; preschoolers, 90 - 120 minutes).



### Encouragement of Physical Activity

- \_\_\_\_\_ Caregivers and teachers wear clothing and shoes that allow for easy movement.
- \_\_\_\_\_ Caregivers and teachers encourage families to dress children for active play.
- \_\_\_\_\_ Children are urged to run where space is ample and safe outdoors.
- \_\_\_\_\_ Caregivers and teachers include movement and physical action in children's indoor play and learning activities.
- \_\_\_\_\_ Caregivers and teachers take part in training to learn activities and games that promote children's physical activity.
- \_\_\_\_\_ Children are encouraged to drink clean and sanitary water throughout their activities.



### Limiting Screen (TV, DVD, Computer) Time

- \_\_\_\_\_ Children under two years of age don't watch TV, DVDs or use computers while at the child care program.
- \_\_\_\_\_ Children two years and older have no more than one-half hour total screen time (TV, DVD, computer) per week.
- \_\_\_\_\_ Children do not watch TV or DVDs during meals or snack-times.
- \_\_\_\_\_ Children's use of computers at early care and education is limited to periods of 15 minutes or less (except for school-age children for whom computer time may be extended for homework or school projects).



### Policies and Practices Promoting Physical Activity

- \_\_\_\_\_ There is a written plan in place for promoting children's physical activity.
- \_\_\_\_\_ Caregivers and teachers arrange the environment to encourage active and safe play for all children.



## Teaching opportunities for children 2 and over

Caregivers and teachers promote children's physical activity by regularly including age appropriate physical activity in the curriculum:  
Learning games, such as ball games, Duck-Duck Goose, Simon Says, Dancing, jumping, skipping to music,  
Acting, presenting skits with role playing (a bucking bronco!) and Tumbling!



## How families can help caregivers and teachers promote physical activity:

- Limit the time that children spend in front of the TV and at the computer and praise your child's caregiver and/or teacher for doing the same.
- Play outdoors with your child(ren) and build good habits by having fun together (making a snowman, raking leaves).
- Encourage young children to role-play by suggesting animals to imitate.
- Ask your child's primary care provider if s/he would be willing to speak at a family meeting at the early care and education program about the importance of physical activity.
- To help your child to be ready for active play, dress him or her in easy-moving, comfortable clothing. Check with your child to make sure his or her feet have room to play safely, too.

## Additional Resources

Bright Futures: <http://www.brightfutures.org/physicalactivity/pdf/index.html>

Little Voices for Healthy Choices: <http://ehsnrc.org/Activities/littlevoices.htm>

Healthy Children: Motor Activity and Self-Play:

<http://www.healthychildren.org/English/ages-stages/preschool/nutrition-fitness/pages/Motor-Activity-and-Self-Play.aspx>

American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education. 2010. *Preventing Childhood Obesity in Early Care and Education: Selected Standards from Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd Edition.* [http://nrckids.org/CFOC3/PDFVersion/preventing\\_obesity.pdf](http://nrckids.org/CFOC3/PDFVersion/preventing_obesity.pdf)

This Web site provides features and resources for early childhood, <http://www.aahperd.org/headstartbodystart/>

American Academy of Pediatrics' Web site dedicated to the prevention of childhood overweight and obesity. <http://www.aap.org/obesity/index.html>

I am moving, I am learning: <http://eclkc.ohs.acf.hhs.gov/hslc/ecdh/Health/Nutrition/Nutrition%20Program%20Staff/IMIL/lamMovingIam.html>

**Family Checklist for Physical Activity in Early Care and Education** is based on *Preventing Childhood Obesity in Early Care and Education Programs - Selected Standards from "Caring for Our Children: National Health and Safety Performance Standards, 3rd Ed."* (Caring for Our Children, 3rd Ed. is to be published in 2011) American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education.

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## **Guidelines for the Use of Sanitizers and Disinfectants in Child Care Facilities**

### **Selection**

The selection of cleaning and disinfection solutions should be based primarily on the safety and efficacy of the product and the surface to be cleaned and/or disinfected.

All disinfectants should be registered by the Environmental Protection Agency (EPA). Information on EPA-registered disinfectants can be found on their website at: <http://epa.gov/oppad001/chemregindex.htm>.

Although most EPA registered disinfectants are effective against most organisms commonly found in child care settings, certain organisms such as norovirus are more difficult to kill. In addition, special attention should be given to areas contaminated with blood and body fluid spills.

Sodium hypochlorite or chlorine bleach is an effective and safe alternative in disinfecting most surfaces in child care settings when diluted and applied appropriately. It is effective against norovirus and bloodborne pathogens.

A number of facilities are moving toward using “green” products. If using green products, these facilities must follow the same guidelines put forth by the EPA and be certain the products are EPA-registered.

### **Definitions**

**Cleaning-** Removing, usually by using a mild detergent and water visible dirt, soil and other debris.

**Sanitization-** Reducing the number of bacterial contaminants to safe levels. Most effective on hard surfaces and on items not contaminated with body fluids.

**Disinfecting-** The destruction of pathogenic and other microorganisms on surfaces.

### **Common Types of Disinfectants**

**Phenolics-**environmental disinfectants that are bactericidal, virucidal, fungicidal, and tuberculocidal. Commercial phenolics are not sporacidal. Some studies have shown that higher concentrations are needed to effectively kill some viruses seen in child care centers. They are typically used in hospitals to clean the environment and noncritical

*Updated February 1, 2011*





medical equipment. Some products can be irritating to the skin. All safety warnings should be carefully considered, especially when using on bassinets and cribs.

**Quaternary ammonia**-environmental disinfectants that are bactericidal, fungicidal, and virucidal (enveloped viruses). They are not tuberculocidal, sporocidal or effective against nonenveloped viruses (norovirus). They are typically used to clean floors, furniture, walls and equipment that touches intact skin (blood pressure cuffs).

**Chlorine (sodium hypochlorite)**-is a safe, inexpensive and effective broad spectrum disinfectant when diluted appropriately. Chlorine is considered bactericidal, virucidal, fungicidal, sporocidal and tuberculocidal depending on the concentration. Bleach can be used on a variety of surfaces. Specific precautions when using bleach are listed below.

### **Cleaning and Disinfecting Procedures**

All facilities should have a written procedure that includes the steps to take in cleaning and disinfecting environmental surfaces. The procedure should include any recommendations that should be considered when using specific products, e.g., proper dilutions, storage, safety measures.

Surfaces must be cleaned prior to applying any disinfectant. Specifically, surfaces must be washed then rinsed of soap and debris and then disinfected by submerging or soaking with the appropriate solution and allowed to air dry.

Soft furnishing and play equipment in Infant and Toddler settings should be equipped with removable covers that can be laundered. To clean or disinfect, wash soiled soft items/linens/soft toys in detergent and hot water at least 140-160° F and dry completely on highest heat dryer setting. Studies have shown that bleach adds an extra margin of safety and can be activated at water temperatures between 135°-145°F.

### **Disinfecting specific surfaces**

For any surfaces with visible debris, remove debris and clean with a mild detergent before applying the disinfectant.

**Blood or body fluid spills**- First absorb spill with absorbent chemical or material (paper towel) and place in appropriate disposal container. Clean area with detergent and rinse. Liberally apply disinfectant and air dry.

**Hard surfaces**-Remove debris, clean area with detergent and apply EPA-registered disinfectant.

*Updated February 1, 2011*

**Carpet/Upholstered Furniture-** Remove visible debris with absorbent material. Steam clean (heat activation) 158° F for 5 minutes or 212°F for 1 minute for complete activation.

**Linens/clothing/textiles-** Remove debris. Separate contaminated from uncontaminated clothing. Minimize movement of soiled linens and laundry. Ideally wash heavily contaminated items in detergent and hot water at least 140-160° F and dry completely on highest dryer setting. Studies have shown that bleach adds an extra margin of safety and can be activated at water temperatures between 135°-145°F.

**Corrodible surfaces (damaged by bleach)-** Select and EPA-registered disinfectant safe and effective in cleaning the surface.

### **Personal Protective Equipment**

Cleaning and disinfection procedures should always be performed wearing appropriate person protective equipment (PPE), e.g., gloves, gowns and face shields. Gloves should always be used when handling disinfectants and cleaning surfaces, additional PPE should be selected based on the likelihood of exposure to other parts of the body. If vigorous cleaning is anticipated, utility gloves should be provided. Hands should be thoroughly washed after removing gloves.

### **Chlorine Bleach considerations and recommendations**

Household bleach is an effective agent against most bacteria and viruses. It is important to follow recommended dilution guidelines for specific surfaces. Certain precautions should always be adhered to when using bleach, including:

- Dilute and perform disinfection procedures and in a well-ventilated area. Adverse effects of inappropriate mixtures of household cleaners usually are caused by prolonged exposure to an irritant gas in a poorly ventilated area
- Avoid combining bleach with acids (like vinegar) or ammonia (Windex). Potential irritants released from such mixtures are chlorine gas, chloramines and ammonia gas
- Wear appropriate personal protective equipment as chlorine bleach is corrosive and irritating to mucosal tissue, skin, eyes and upper and lower respiratory tract
- It is recommended using a “pump” or “pour” bottle instead of a spray bottle to avoid aerosolizing the bleach solution
- Prepare bleach solutions daily.
- Open bottles of chlorine bleach should be discarded after 30 days
- If a splash occurs to mucosal tissues, immediately flush with water

*Updated February 1, 2011*



A number of child care settings choose **not** to use a bleach based agent. If you are a facility that does **not** use a bleach based agent, be sure that it is an EPA-registered BACTERICIDAL agent, not a BACTERIAL STATIC agent. You will also need to be aware of what specific bacteria and viruses the agent kills. This will be listed on the bottle or package insert.

## Recommended bleach concentrations and mixing instructions

Application	<sup>1</sup> Bleach per Gallon of Water	Household Concentration	Dilution	Recommended Labeling
Dishes, eating utensils and mouthed toys (after detergent cleaned and rinsed) to be submerged in bleach solution for at least one minute	1 teaspoon	~50 ppm (parts per million)	1:1000	Sanitizer for eating utensils and mouthed toys – for submersion purposes
Tables, food prep areas, non-mouthed toys, cots	1 Tablespoon	<200 ppm	1:200	Sanitizer for food contact areas – spray until glistening and leave for 2 minutes prior to wiping dry
Diaper changing areas, toilets, surfaces contaminated with bodily secretions/excretions	¼ cup	~600 ppm	1:100	Disinfectant for diaper changing station, toileting areas
For areas saturated with blood or blood products (OSHA standard)	1 1/2 cup	~6000 ppm	1:10	This dilution should always be used for blood spills.

**Use only household chlorine bleach (6.00% sodium hypochlorite)**

*These recommendations include CDC guidelines for bleach dilutions using household bleach measurement terms and equivalent parts per million (ppm) that can be used to translate recommendations for use in the clinical setting. Premier's Safety Institute has expanded the information to include the use of chlorine bleach as a sanitizing agent in dietary settings consistent with EPA U.S. Gov't regulations (21CFR Part 178)*

*Updated February 1, 2011*



## References

Guideline for Disinfection and Sterilization in Healthcare Facilities, CDC, HICPAC, 2008. [http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection\\_Nov\\_2008.pdf](http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov_2008.pdf)

Guidelines for the Use of Sanitizers and Disinfectants in Child Care Facilities  
Colorado Department of Public Health and Environment,  
[http://www.cdphe.state.co.us/cp/Institutions/childcarecenters/CPDGuideline350\\_revE\\_Sanitizersdisinfectants.pdf](http://www.cdphe.state.co.us/cp/Institutions/childcarecenters/CPDGuideline350_revE_Sanitizersdisinfectants.pdf)

Guidelines for Environmental Infection Control in Healthcare Facilities. CDC, HICPAC, 2003.  
[http://www.cdc.gov/ncidod/dhqp/gl\\_environinfection.html](http://www.cdc.gov/ncidod/dhqp/gl_environinfection.html)

Guidelines for Environmental Cleaning and Disinfection of Norovirus, Michigan Department of Health, 2009, [http://www.michigan.gov/documents/Guidelines\\_for\\_Environmental\\_Cleaning\\_125846\\_7.pdf](http://www.michigan.gov/documents/Guidelines_for_Environmental_Cleaning_125846_7.pdf)

Premier Safety Share, Premier Safety Institute, November 24, 2008. [http://www.premierinc.com/quality-safety/tools-services/safety/pSS/Bulletin\\_CDCGuide-11202008.htm](http://www.premierinc.com/quality-safety/tools-services/safety/pSS/Bulletin_CDCGuide-11202008.htm)

*Updated February 1, 2011*

**STOP  
DISEASE**

## DISINFECTING SOLUTION

### Mixing a Disinfecting Solution

- Mix 1/4 cup bleach in 1 gallon of water OR mix 1 tablespoon bleach in 1 quart water.
- Place in labeled spray bottle out of reach of children in the bathroom, the diapering area, and the kitchen (include percentage of bleach on label).
- Wash surfaces first with soap or detergent and water.
- Spray on solution and allow to air dry.
- Make the solution fresh daily.

### Weaker Solution for toys, eating utensils, etc.

- 1 tablespoon bleach + 1 gallon of water.

### Ways to apply a bleach solution

- Use a spray bottle for diaper cleaning surfaces, toilets and potty chairs
- Use cloths rinsed in bleach solution for food preparation areas, or large toys, books and activity center
- Dip the object into a container filled with the bleach solution



California Childcare Health Program  
[www.ucsfchildcarehealth.org](http://www.ucsfchildcarehealth.org)

Rev. 01/03



## Solución Desinfectante

### Preparando una solución desinfectante

- Mezcle 1/4 de taza de blanqueador (cloro) en 1 galón de agua, o Mezcle 1 cucharada de blanqueador en un litro de agua.
- Viértala en un rociador rotulado, y guárdela en el baño, en el lugar donde cambia los pañales, y en la cocina, fuera del alcance de los niños (incluya en la etiqueta el porcentaje de blanqueador).
- Primero lave las superficies con jabón o detergente y agua.
- Rocíe la solución y oreé hasta que se seque.
- Prepare esta solución fresca diariamente.

### Una solución más leve para juguetes, utensilios de mesa, etc.

- 1 cucharada de blanqueador + 1 galón de agua

### Formas de aplicar la solución de cloro

- Utilice un rociador para las superficies donde cambia pañales, inodoros y bacinillas.
- Utilice paños impregnados con la solución de blanqueador para limpiar las superficies donde se preparan los alimentos, o para limpiar juguetes grandes, libros, y en el centro de actividades.
- Sumerja el objeto en un recipiente lleno de la solución de blanqueador.



California Childcare Health Program  
[www.ucsfchildcarehealth.org](http://www.ucsfchildcarehealth.org)



Stop the spread of germs that make you and others sick!

# Cover your Cough



Cover your mouth and nose with a tissue when you cough or sneeze

or  
cough or sneeze into your upper sleeve, not your hands.



Put your used tissue in the waste basket.



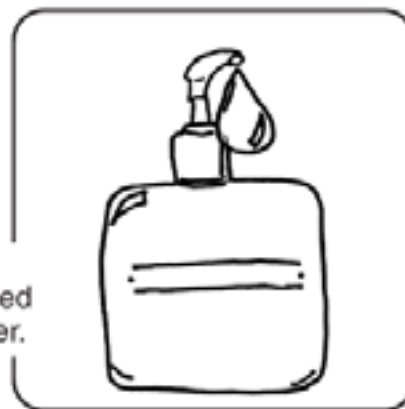
# Clean your Hands

after coughing or sneezing.

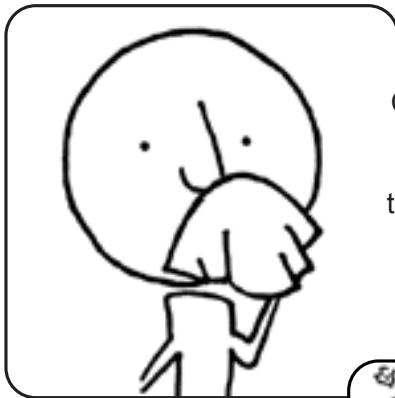


Wash hands with soap and warm water

or  
clean with alcohol-based hand cleaner.



# Cubra SU tos



Cubra su boca y nariz con un kleenex cuando tosa o estornude

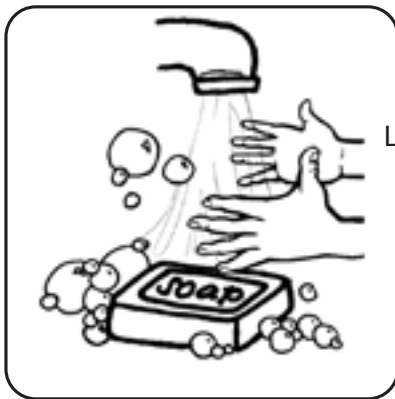
o tosa o estornude en la manga de su camisa, no en sus manos.



Deseche el kleenex sucio en un basurero.

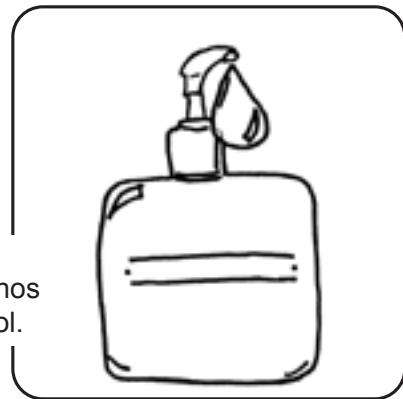


# Lávese las manos después de toser o estornudar.



Lávese con agua tibia y jabón

o límpiense con un limpiador de manos a base de alcohol.



Minnesota Department of Health  
625 N Robert Street, PO Box 64975  
St. Paul, MN 55164-0975  
651-201-6414 TDD/TTY 651-201-5797  
www.health.state.mn.us



Minnesota  
Antibiotic  
Resistance  
Collaborative



ASSOCIATION FOR PROFESSIONALS IN  
INFECTION CONTROL AND EPIDEMIOLOGY, INC.

Spanish  
IC#41-1428

# Keep Me Home If...

I'm vomiting



Two or more times in 24 hours.

I have a rash or head lice



Body rash, with a fever or itching, or head lice

I have diarrhea



3 or more watery stools in 24 hours.

I have an eye infection



Thick mucus or pus draining from the eye.

I have a sore throat



With fever or swollen glands.

I'm just not feeling very good



Unusually tired, pale, lack of appetite, confused or cranky.

I have a fever



AND sore throat or rash, vomiting, diarrhea, earache, or just not feeling good.



Seattle-King County Department of Public Health • California Childcare Health Program • Helpline 800-333-3212

# When Your Child is Sick:

1. Have plans for back up child care.
2. Tell your caregiver what is wrong with your child, even if your child stays home.



# Déjame en Casa si ...

Vomito		Dos o más veces en 24 horas.
Si tengo salpullido, o piojos de la cabeza		Salpullido por todo el cuerpo con fiebre o piojos de la cabeza.
Si tengo diarrea		3 or más excrementos bien aguados en 24 horas.
Si tengo una infección en el ojo		Moco espeso o pus que sale del ojo.
Si me duele la garganta		Con fiebre o glándulas hinchadas.
Si no me siento muy bien		Si estoy cansado(a), pálido(a), con poco apetito, confundido(a) y malhumorado(a) sintiéndose bien.
Si tengo fiebre		Y dolor de garganta o salpullido, diarrea, dolor de oído o no sintiéndose bien.



Seattle-King County Department of Public Health

California Childcare Health Program • Helpline 800-333-3212

**1. Tenga planes de cuidado para su niño(a).  
 Cuando su niño(a) está enfermo: 2. Avise a su proveedor(a) que la pasa a su niño(a),  
 aunque su niño(a) se quede en casa.**

{Current Date}

**Re: Notice of Exposure to Illness/Communicable Disease**

Dear {Parents Name}:

A child in the program has been diagnosed with or is suspected of having {insert name of illness/communicable disease}.

With this illness/disease, it is possible that your child can become sick anywhere from {insert incubation period} after exposure to the sick child.

The symptoms to look for are: {insert symptoms based on charts or consultation/advice from a health care professional, pediatrician or health department representative}.

If your child has any symptoms of this illness/disease, call your health care provider to find out what to do and be sure to tell them about this notice.

Recommendations for exclusion from child care should your child become sick include: {insert information from chart or consultation/advice from a health care professional, pediatrician or health department representative}.

I am taking the following precautions to help reduce the spread off this illness/disease by: {monitoring and reviewing hand washing and/or hand washing procedures, excluding ill children, consulting and following the advice from a health care professional, pediatrician or health department representative}.

Below is a list of things you can do to help prevent the spread of illness/disease.

- **Teach and remind your child to wash his/her hands** often with soap and water, especially after using the bathroom, before eating and anytime they cough, sneeze or wipe/blow their nose.
- **Teach your child to cough into his/her** elbow instead of into his/her hands.
- **Keep your child home** for at least 24 hours **after he/she** no longer has a fever or signs of fever, without using fever-reducing drugs.
- **Do not send your child to child care with diarrhea** (3 or more watery stools in 24 hours.)
- **Plan for sick days.** Have a plan for back-up child care in case your child is sick. Keeping children home when sick, especially those with fevers and diarrhea will reduce the number of people who may get infected.
- **Flu Shot?** It is recommended that children 6 months and older get a seasonal flu vaccine.

If you have any further questions, please contact me at {provider's telephone number}.

Thank you,  
{Provider's Signature}  
{Provider's Name}

# Shaken Baby Syndrome (SBS)

People who shake babies are almost always parents or caregivers, who act rashly out of stress, anger or frustration when the baby is crying uncontrollably.

Shaking a baby in a moment of frustration can cause serious harm or death. Common triggers for shaking a child include toilet training, perceived misbehavior and crying. Other triggering events include feeding problems and interrupting an activity the adult caregiver is trying to complete.

When an infant is shaken, the head jerks back and forth rapidly, causing the brain to slam repeatedly against the inside of the skull. The resulting damage can cause permanent disability or even death. Because babies have weak neck muscles

and heavy heads, even a few seconds of forceful shaking can cause serious damage. Impact to the head is believed to accompany most abusive head injuries. Abusive Head Trauma (AHT) describes abusive head injury caused by both shaking and blunt impact to the infant.

Jerking or violently shaking a baby causes more harm than dropping a baby head-first onto a hard surface from a height of several feet. The effect of the shaking can cause permanent brain damage, blindness or in up to 25% of cases, death.

Children of any age can die from being shaken. If you suspect the baby has been injured from being shaken, take the baby immediately to the doctor.

## Common Triggers Include:

- crying
- toilet training
- perceived misbehavior
- feeding problems
- interrupting an activity the adult caregiver is trying to complete.

**It is estimated that each year about 1,200 to 1,400 babies die or suffer injury from abusive head trauma.** Frustration and fatigue may make you feel like you're about to lose your cool. **Don't do it!**

## What Happens When a Baby Is Shaken?

Because of infants' weak neck muscles and large head-to-body ratio, violent or sustained shaking can lead to:

- Cessation of breathing and heartbeat
- Decreased level of consciousness and vomiting
- Partial or total blindness
- Learning and Physical disabilities
- Extreme irritability
- Seizures
- Limp arms and legs
- Hearing impairments
- Speech disabilities
- Cognitive disabilities
- Cerebral palsy
- Behavior disorders
- Death



## My Baby's Crying Plan

People I trust and can call for help,  
when my baby cries:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Doctor: \_\_\_\_\_

Phone: \_\_\_\_\_

**Remember: Don't leave your baby with a boyfriend/girlfriend if care-taking will be too much for them. Because you can care for your baby doesn't mean someone you're dating can do the same.**

## Additional Resources

**Prevent Child Abuse Virginia**  
1-800-CHILDREN

**Child Abuse & Neglect Hotline**  
1-800-552-7096

**Family Violence & Sexual Assault  
Hotline** 1-800-838-8238

**National Center on Shaken Baby  
Syndrome**  
[www.dontshake.org](http://www.dontshake.org)

## How To Soothe Your Baby — And You.

To soothe baby, *and you*, here are some things to try:

- Make sure your baby is not wet, hungry or running a fever.
- Lay your baby down in his crib and walk away to see if he will quiet down on his own.
- While sitting, hold your baby across your knees and pat her back gently.
- Take the baby for a walk in a stroller.
- A wind-up swing might work; monitor carefully to make sure the baby doesn't slump over.
- People — and toddlers — learn at different paces. When potty training, remember that your child really does want to please you.
- Give it a rest and step away. Make sure the baby is safe and step away for a few minutes. Chill out, breathe, call a friend.

**Remember: It's more important to stay calm than to stop the crying.**

# El Síndrome de Bebé Sacudido (SBS)

En casi todo caso, la frustración y el estrés de lidiar con el incesante llorar de un bebé es lo que precipita a los padres o proveedores de cuidados a sacudir a un niño.

Las sacudidas al bebé pueden resultar en graves daños, aun la muerte. La acción de sacudir al niño hace que la cabeza se jala a gran velocidad de acá para allá y el cerebro pegue repetidamente contra la parte interior del cráneo. Esto suele ocurrir debido a la disparidad de tamaño entre el adulto y el niño así como la fuerza del sacudimiento y el impacto. Los daños provocados pueden provocar invalidez permanente, y, peor aun, la muerte del bebé.

Los débiles músculos del cuello del niño combinado con su cabeza pesada hace que una sacudida violenta de aun unos pocos segundos resulte en graves daños a los bebés y niños pequeños. La mayoría de los casos de maltrato que resultan en heridas cerebrales son provocados por un golpe a la cabeza. El

Las frustraciones de ver a su bebé llorar, algún imaginado mal comportamiento del niño y la demora en adaptarse el niño a usar el baño son factores comunes que pudieran incitar el acto de sacudir violentamente al niño.

trauma cerebral provocado tanto por las sacudidas así como los golpes directos al niño se conoce como Traumatismo Craneal Abusivo (AHT).

Ningún padre se cree capaz de sacudir con fuerza a su niño, pero los estudios indican claramente que el llorar de los niños es lo que mas provoca a los proveedores de cuidados a sacudirlos violentamente e infligirles heridas.

¿Sabía usted que los jalones y sacudidas violentas de los bebés son más peligrosas que si dejara a su niño caer sobre una superficie duro de algunos metros de altura? Estas sacudidas fuertes pueden causar daño cerebral permanente, ceguera, y en un 25 por ciento de los casos, la muerte del niño.

Cualquier niño, sin importar su edad, puede morir de una sacudida violenta. Si sospecha que su bebé se ha lesionado por motivo de una sacudida, debe llevarlo al doctor inmediatamente.

**Se calcula que unos 1.200 a 1.400 bebés mueren o sufren heridas de traumático craneal abusiva.** La fatiga y las frustraciones de ser padre pudieran hacerle perder los estribos. Pero antes de perder la calma, deténgase por un momento.

**Una sacudida violenta y prolongada combinado con los débiles músculos del cuello el niño y el tamaño de su cabeza en comparación con su cuerpo, pueden resultar en:**

- Cortar la respiración y el latido del corazón
- Irritabilidad persistente
- Ataques
- Brazos y piernas sin fuerzas
- Niveles de conciencia reducidos y vómitos
- Retrasos de aprendizaje y discapacidades físicas.
- Ceguera parcial o completa
- Impedimentos auditivos
- Problemas del habla
- Inhabilidad cognitivo
- Parálisis cerebral
- Trastornos de comportamiento
- Muerte

## Lo que debo hacer cuando llora mi bebé.

Estas son las personas con quienes puedo contar en busca de ayuda cuando llora mi bebé.

Nombre: \_\_\_\_\_

Número Telefónico: \_\_\_\_\_

Nombre: \_\_\_\_\_

Número Telefónico: \_\_\_\_\_

Nombre: \_\_\_\_\_

Número Telefónico: \_\_\_\_\_

*Acuérdese: No deje su bebé a cuidar con su novio o novia si a este se le hace muy abrumador atenderlo. El mero hecho de que sea su novio o novia no hace que sean aptos de atender a su bebé tan bien como usted.*

## Recursos

**Prevención de Maltrato de Niños de Virginia**

1-800-CHILDREN

**Línea de Ayuda para Niños Maltratados y Descuidados**

1-800-552-7096

**Línea de Ayuda para la Violencia Doméstica y el Acoso Sexual**

1-800-838-8238

**Centro Nacional del Síndrome de Bebé Sacudido**

[www.dontshake.org](http://www.dontshake.org)

## Como tranquilizar a su bebé Y también a usted.

- Recueste su bebé en la cuna y distánciese un poco para ver si se tranquiliza el niño.
- Siéntese y recueste su bebé sobre sus rodillas dándole suaves palmaditas.
- Monte al bebé en su cochecito y váyanse a dar una caminata juntos.
- Si tiene un columpio de cuerdas coloca el bebé allí cerciorándose de que no se desplome el niño.
- Recuerde- No todos aprendemos al mismo paso y esto incluye nuestros pequeñuelos. El niño que no se adapta con prontitud a usar el baño no lo hace adrede para frustrarle a usted.
- Déle tiempo al tiempo. Retírese. Asegúrese que esté bien el niño y tómese usted unos minutos para reponerse. Respire profundo. Llame a un amigo.

*Acuérdese que es mejor mantenerse usted calmado que calmar a su bebé a todo costo.*

**EMERGENCY PREPAREDNESS AND RESPONSE PLAN**  
(Required by Standards for Licensed Family Day Homes 22 VAC 40-111-800, 810, & 820)

\_\_\_\_\_  
Name of Family Day Home

**A. Name, Address, and Telephone Number of Person to Provide Emergency Backup Care (must be 18 years of age and be able to arrive at the home within 10 minutes):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B. EVACUATION (Due to Fire or \_\_\_\_\_)**

**Primary Route to Exit the Home (try to avoid hazardous areas such as furnace room, wooden stairs, and take advantage of firewalls)**\_\_\_\_\_

\_\_\_\_\_

**Secondary Route to Exit the Home:**\_\_\_\_\_

\_\_\_\_\_

**Designated Safe Assembly Point Outside the Home:**\_\_\_\_\_

\_\_\_\_\_

**Method Used to Alert Provider of Emergency:**\_\_\_\_\_

\_\_\_\_\_

**Method to Alert Children, Caregivers, and Household Members of Emergency:**\_\_\_\_\_

\_\_\_\_\_

**Methods to Ensure Everyone is Evacuated (room searches, head counts):**\_\_\_\_\_

\_\_\_\_\_

**Methods to Alert Emergency Responders After Evacuation (who calls 911/how?)**\_\_\_\_\_

\_\_\_\_\_



**Methods to Alert Emergency Back-up Caregiver (how will her contact information be available at the assembly point?)** \_\_\_\_\_

\_\_\_\_\_

**Methods to Ensure Everyone Arrived Safely at Assembly Point:** \_\_\_\_\_

\_\_\_\_\_

**Methods to Ensure Children’s Safety and Supervision at Assembly Point: (who will supervise children while someone meets emergency responders; how will emergency supplies such as blankets, medications, water, telephones, protection from rain/snow be readied and how will these supplies be made available at the assembly point):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Methods to Ensure Children’s and Caregiver’s Emergency Contact Information is Available After Evacuation:** \_\_\_\_\_

\_\_\_\_\_

**Methods to Contact Parents After Evacuation:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Methods to Ensure Children are Released Only to Parent or Designated Person:** \_\_\_\_\_

\_\_\_\_\_



**C. SHELTER IN PLACE (Due to Tornado, Severe Storms, Loss of Utilities, or \_\_\_\_\_)**

**Designated Safe Location Within the Home:** \_\_\_\_\_

\_\_\_\_\_

**Primary Route to Safe Location** \_\_\_\_\_

\_\_\_\_\_

**Secondary Route to Safe Location:** \_\_\_\_\_

\_\_\_\_\_

**Method Used to Alert Provider of Emergency:** \_\_\_\_\_

\_\_\_\_\_

**Method to Alert Children, Caregivers, and Household Members of Emergency:** \_\_\_\_\_

\_\_\_\_\_

**Methods to Ensure Everyone is Moved to Safe Location (using daily attendance sheet, performing room searches and head counts, etc):** \_\_\_\_\_

\_\_\_\_\_

**Methods to Alert Emergency Responders After Arrival in Safe Location (who calls 911/how?)** \_\_\_\_\_

\_\_\_\_\_

**Methods to Ensure Everyone Arrived at Safe Location (using daily attendance sheet, performing room searches and head counts, etc):** \_\_\_\_\_

\_\_\_\_\_

**Methods to Ensure Children's Safety and Supervision at Safe Location: (who will supervise children while someone meets emergency responders; how will emergency supplies such as blankets, medications, water, food, toileting supplies, telephone be readied and how will these supplies be made available at the safe location):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





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**Methods to Ensure Children’s and Caregiver’s Emergency Contact Information is Available After Movement to Safe Location:** \_\_\_\_\_

---

**Methods to Contact Parents:** \_\_\_\_\_

---

**Methods to Ensure Children are Released Only to Parent or Designated Person:** \_\_\_\_\_

---

**D. RELOCATION (Due to flooding, loss of utilities, or \_\_\_\_\_)**

**Designated Relocation Site Away from the Area of the Home:** \_\_\_\_\_

---

**Method Used to Alert Provider of Emergency:** \_\_\_\_\_

---

**Method to Alert Children, Caregivers, and Household Members of Emergency:** \_\_\_\_\_

---

**Methods to Alert Emergency Back-up Caregiver (how/when will she be contacted)** \_\_\_\_\_

---

**Method to Alert Relocation Site:** \_\_\_\_\_

---



**Method to Transport Children and Caregivers to Relocation Site (prior arrangements made for emergency transportation resources, if necessary):** \_\_\_\_\_

\_\_\_\_\_

**Method to Alert Extra Transportation Providers:** \_\_\_\_\_

\_\_\_\_\_

**Methods to Ensure Everyone is Moved to Relocation Site (using daily attendance record, performing room searches and head counts):** \_\_\_\_\_

\_\_\_\_\_

**Primary Route to Relocation Site** \_\_\_\_\_

\_\_\_\_\_

**Secondary Route to Relocation Site:** \_\_\_\_\_

\_\_\_\_\_

**Methods to Ensure Everyone Arrived Safely at Relocation Site (using daily attendance record, head counts, name tags):** \_\_\_\_\_

\_\_\_\_\_

**Methods to Ensure Children's Safety and Supervision at Relocation Site: (who will supervise children; how will emergency supplies such as blankets, medications, water, food, telephones be readied and how will these supplies be made available at the relocation site):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Methods to Ensure Children’s and Caregiver’s Emergency Contact Information is Available After Relocation:** \_\_\_\_\_

\_\_\_\_\_

**Methods to Contact Parents After Relocation:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Methods to Ensure Children are Released Only to Parent or Designated Person:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ **Date Plan Prepared**

\_\_\_\_\_ **Provider’s Signature**

_____ <b>Date of Annual Plan Review</b>	
<b>Plan Updated</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, date assistant and substitute provider trained</b> _____
_____ <b>Provider’s Signature</b>	

_____ <b>Date of Annual Plan Review</b>	
<b>Plan Updated</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, date assistant and substitute provider trained</b> _____
_____ <b>Provider’s Signature</b>	

_____ <b>Date of Annual Plan Review</b>	
<b>Plan Updated</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, date assistant and substitute provider trained</b> _____
_____ <b>Provider’s Signature</b>	



**EMERGENCY PREPAREDNESS AND RESPONSE PLAN**  
(Required by Standards for Licensed Family Day Homes 22 VAC 40-111-800, 810, & 820)

Annie Beth Childs  
Name of Family Day Home

**A. Name, Address, and Telephone Number of Person to Provide Emergency Backup Care (must be 18 years of age and be able to arrive at the home within 10 minutes):**

Sue Apple  
123 Main St  
Main City, Virginia 12345  
(123) 456-7890

**B. EVACUATION (Due to Fire or other dangerous situation inside home )**

**Primary Route to Exit the Home (try to avoid hazardous areas such as furnace room, wooden stairs, and take advantage of firewalls)** Out sliding glass doors in art room.

**Secondary Route to Exit the Home:** Outside door from playroom to driveway.

**Designated Safe Assembly Point Outside the Home:** Large slide in backyard.

**Method Used to Alert Provider of Emergency:** \_\_\_\_\_

Smoke detector, or other indicators of fire, smoke or other danger in home.

**Method to Alert Children, Caregivers, and Household Members of Emergency:** \_\_\_\_\_

Same as above plus provider will tell everyone "Fire Drill."

**Methods to Ensure Everyone is Evacuated (room searches, head counts):** \_\_\_\_\_

Grab attendance form on way out, count heads, search rooms if needed.

**Methods to Alert Emergency Responders After Evacuation (who calls 911/how?)** \_\_\_\_\_

Provider will call 911 on home phone (cordless) or cell phone.



**Methods to Alert Emergency Back-up Caregiver (how will her contact information be available at the assembly point?)** Contact information will be in phones and in emergency bin (see below).

**Methods to Ensure Everyone Arrived Safely at Assembly Point:** \_\_\_\_\_

Head counts, take attendance, carry children who need help, guide other children.

**Methods to Ensure Children’s Safety and Supervision at Assembly Point: (who will supervise children while someone meets emergency responders; how will emergency supplies such as blankets, medications, water, telephones, protection from rain/snow be readied and how will these supplies be made available at the assembly point):** \_\_\_\_\_

Emergency bin with blankets, jackets, rain gear, phone numbers, water and other supplies will be kept in shed. Shoes and emergency medications will be stored near door to allow provider to grab them on way out of door. Provider and Emergency Backup Provider will supervise children.

**Methods to Ensure Children’s and Caregiver’s Emergency Contact Information is Available After Evacuation:** \_\_\_\_\_

Contact information will be in emergency bin (see above) and in cell phone.

**Methods to Contact Parents After Evacuation:** \_\_\_\_\_

Once children are settled and emergency responders are contacted, parents will be called.

**Methods to Ensure Children are Released Only to Parent or Designated Person:** \_\_\_\_\_

Provider will check child record forms (copy in emergency bin) to ensure only designated people pick child up.



**C. SHELTER IN PLACE (Due to Tornado, Severe Storms, Loss of Utilities, or other dangers \_\_\_\_\_) outside of home.**

**Designated Safe Location Within the Home:** The child care bathroom.

**Primary Route to Safe Location** Playroom to art room to hall bathroom.

**Secondary Route to Safe Location:** Out secondary door from playroom to hall to bathroom.

**Method Used to Alert Provider of Emergency:** \_\_\_\_\_

Weather radio, TV alerts, computer alert, or visually seeing a danger.

**Method to Alert Children, Caregivers, and Household Members of Emergency:** \_\_\_\_\_

Provider will announce "Tornado Drill."

**Methods to Ensure Everyone is Moved to Safe Location (using daily attendance sheet, performing room searches and head counts, etc):** \_\_\_\_\_

Carry younger children and infants, "herd" older children, count heads and compare to attendance.

**Methods to Alert Emergency Responders After Arrival in Safe Location (who calls 911/how?)** \_\_\_\_\_

Provider will call 911 on home phone or cell phone.

**Methods to Ensure Everyone Arrived at Safe Location (using daily attendance sheet, performing room searches and head counts, etc):** \_\_\_\_\_

Head counts and confirm with attendance.

**Methods to Ensure Children's Safety and Supervision at Safe Location: (who will supervise children while someone meets emergency responders; how will emergency supplies such as blankets, medications, water, food, toileting supplies, telephone be readied and how will these supplies be made available at the safe location):** \_\_\_\_\_

Emergency supplies and contact information will be kept in red bag in bathroom.





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**Methods to Ensure Children’s and Caregiver’s Emergency Contact Information is Available After Movement to Safe Location:** \_\_\_\_\_

Copies of Record forms will be kept in red bag and field trip backpack.

**Methods to Contact Parents:** \_\_\_\_\_

Provider will use home phone or cell phone to contact parents.

**Methods to Ensure Children are Released Only to Parent or Designated Person:** \_\_\_\_\_

Child record forms will be checked before releasing child.

**D. RELOCATION (Due to flooding, loss of utilities, or hazardous waste spill on interstate or other danger.)**

**Designated Relocation Site Away from the Area of the Home:** \_\_\_\_\_

Becky Plum, 456 Main St, Main City, Virginia 12345 (098) 765-4321

**Method Used to Alert Provider of Emergency:** \_\_\_\_\_

TV alerts, computer alerts, weather radio, or direct contact by emergency responders.

**Method to Alert Children, Caregivers, and Household Members of Emergency:** \_\_\_\_\_

Provider will explain situation to all.

**Methods to Alert Emergency Back-up Caregiver (how/when will she be contacted)** \_\_\_\_\_

Emergency Back-up will be phoned as soon as we know we have to evacuate.

**Method to Alert Relocation Site:** \_\_\_\_\_

Provider will call Relocation site to alert them.



**Method to Transport Children and Caregivers to Relocation Site (prior arrangements made for emergency transportation resources, if necessary):** \_\_\_\_\_

Provider will transport children in personal vehicle.

**Method to Alert Extra Transportation Providers:** N/A

**Methods to Ensure Everyone is Moved to Relocation Site (using daily attendance record, performing room searches and head counts):** \_\_\_\_\_

Attendance will be checked prior to leaving. Head counts will be done in car and at relocation site. Rooms will be searched before leaving.

**Primary Route to Relocation Site** (insert detailed directions)

**Secondary Route to Relocation Site:** (insert detailed directions)

**Methods to Ensure Everyone Arrived Safely at Relocation Site (using daily attendance record, head counts, name tags):** \_\_\_\_\_

Attendance will be checked before we get out of the car at the relocation site.

**Methods to Ensure Children’s Safety and Supervision at Relocation Site: (who will supervise children; how will emergency supplies such as blankets, medications, water, food, telephones be readied and how will these supplies be made available at the relocation site):** \_\_\_\_\_

Relocation site will have enough supplies at her home to accommodate us. Any medications needed will be brought with us. Emergency/field trip backpack will be brought with us.

**Methods to Ensure Children’s and Caregiver’s Emergency Contact Information is Available After Relocation:** \_\_\_\_\_

Emergency backpack will contain this information (child record form) and will be brought to relocation site.

**Methods to Contact Parents After Relocation:** \_\_\_\_\_

Provider will call each parent on her cell phone or with relocation site’s phone.

**Methods to Ensure Children are Released Only to Parent or Designated Person:** \_\_\_\_\_

Child record forms will be checked before releasing child.

\_\_\_\_\_  
**Date Plan Prepared**

\_\_\_\_\_  
**Provider’s Signature**

_____ <b>Date of Annual Plan Review</b>	
<b>Plan Updated</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, date assistant and substitute provider trained</b> _____
_____ <b>Provider’s Signature</b>	

_____ <b>Date of Annual Plan Review</b>	
<b>Plan Updated</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, date assistant and substitute provider trained</b> _____
_____ <b>Provider’s Signature</b>	

_____ <b>Date of Annual Plan Review</b>	
<b>Plan Updated</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, date assistant and substitute provider trained</b> _____
_____ <b>Provider’s Signature</b>	



## PROVISIONS OF THE EMERGENCY PREPAREDNESS AND RESPONSE PLAN

*Before the child's first day of attendance, parents must be informed of the provisions in the home's Emergency Preparedness and Response Plan (Standards for Licensed Family Day Home 22 VAC 40-111-70 A 16).*

To the Parent (s) of \_\_\_\_\_ (child's name):

This letter is to assure you of our concern for the safety and welfare of children attending  
\_\_\_\_\_ (insert name of family day home).

Our Emergency Plan provides for response to all types of emergencies. Depending on the circumstance of the emergency, we will use one of the following protective actions:

- *Immediate evacuation* Children are evacuated to a safe area near the home in the event of a fire, etc.
- *In-place sheltering* Sudden occurrences, weather or hazardous materials related, may dictate that taking cover inside the home is the best immediate response.
- *Relocation* Total evacuation of the home may become necessary if there is a danger in the area. In this case, children will be taken to a relocation site at \_\_\_\_\_

\_\_\_\_\_  
(insert name/physical address of relocation site)

We ask that you not call during the emergency. This will keep the main telephone line free to make emergency calls and relay information.

We will have your contact information with us and you will be contacted as soon as possible following any emergency action so that arrangements can be made for you and you child to be safely reunited.

In your child's record at this home are the names of persons you have authorized to pick up your child if you not able to do so. Please ensure that only those persons you have authorized attempt to pick up your child.

We specifically urge you **not** to attempt to make different arrangements during an emergency. This will only create additional confusion and divert staff from their assigned emergency duties.

In order to assure the safety of your children and our staff, we ask for your understanding and cooperation. Should you have additional questions regarding our emergency operating procedures, please let us know.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

032-05-0611-00-eng



# Daily Routine

**Morning:**

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**Mid-Day/Nap time:**

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**Evening:**

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**Weekly Tasks:**

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**Monthly Tasks:**

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## Daily Routine

### Morning:

Walk through childcare area and check for hazards: uncovered outlets, small toys, computer cords, and unlocked cabinets or closets	Replenish supplies in diapering area: diapers, bags, wipes, bleach water Empty Dishwasher
Tidy childcare area: pick up toys, sweep if needed, place trash bags into trash cans	Walk through outdoor play area and check for hazards: trash, glass, sticks, broken toys
Prepare for day: breakfast, lunch, activities	Tidy outdoor play area: sweep patio and sidewalk

### Nap time:

Load dishwasher, clean and sanitize kitchen, sweep

Complete paperwork

Prepare notes to parents

Clean infant/toddler toys

Prepare afternoon snack

### Evening:

Take the trash out

Sweep, vacuum, mop

Clean bathroom

Wash nap sheets and blankets

Prepare activities for tomorrow

Cover sandbox and check outdoor play area for hazards

### Weekly Tasks:

Monday: Input receipts, prepare bank deposit

Friday: Wash 'big kid' toys

Tuesday: Complete monthly parent newsletter

or activity planning for next week

Wednesday: Catch up on paperwork

Thursday: Wash diaper pail and kitchen trash can

### Monthly Tasks:

Check riding toys for safety

Check first aid kit

Check deck for loose boards/nails

Conduct fire drills and check smoke alarm batteries

Check children's files

Complete food program paperwork, parent newsletter,

Check assistants/substitutes files

tax paperwork, etc.

## Health and Safety Checklist

<b>Health and safety checklist to be completed at the BEGINNING OF EACH DAY. ✓ (check if in compliance)</b>	<b>Mon.</b>	<b>Tues.</b>	<b>Wed.</b>	<b>Thurs.</b>	<b>Fri.</b>
All exits are free from clutter.					
Purses and personal items are locked out of children's reach.					
Hands are washed before beginning care.					
Bleach solution is made and labeled.					
All hygiene supplies are available for the children (ex. liquid soap, paper towels, toilet paper).					
Trash can has an empty trash bag in it.					
Area is generally clean (ex. floors are swept, trash emptied, bathroom clean).					
All cleaners/chemicals are locked out children's reach.					
All hair products, toothpaste, deodorant are out of children's reach.					
Outlets all have covers.					
Window (blinds) cords are out of children's reach.					
Tables and chairs are not stacked.					
All eating areas are sanitized and clean.					
First aid kit is available and well stocked.					
Safety gates are in place.					
All the supplies are available for the day's activities (ex. food, art supplies, activity supplies)					
Playground is free of trash and standing water.					
Glass doors are marked.					
<b>FOR INFANT CARE:</b>					
Diapering supplies are within reach.					
Cribs are free of soft bedding.					
Cribs have clean sheets.					
High chairs are clean.					
Infants are put to sleep on their backs.					
Infant toys are sanitized.					

## INJURY RECORD

(Required by Standards for Licensed Family Day Homes 22 VAC 40-111-840)

**Date of Injury:** \_\_\_\_\_ **Time of Injury:** \_\_\_\_\_

**Name of Injured Child:** \_\_\_\_\_

**Type and Circumstance of the Injury:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Caregiver(s) Present:** \_\_\_\_\_  
\_\_\_\_\_

**Action Taken:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date Parent(s) Notified:** \_\_\_\_\_ **Time of Notification:** \_\_\_\_\_

**Method of Notification:** \_\_\_\_\_

**Future Action to Prevent Recurrence of Injury:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Caregiver Signature:** \_\_\_\_\_

**Caregiver Signature:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_

Staff and parent signature OR two caregiver signatures are required.

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**NOTE:** The parent must be notified IMMEDIATELY if a child has a head injury or any serious injury that requires emergency medical or dental treatment. The parent must be notified the same day whenever first aid is administered to the child. Providers must record the injury in the child's record on the day the injury occurs.

032-05-0043-01-eng



### INJURY RECORD

(Required by Standards for Licensed Family Day Homes 22 VAC 40-111-840)

**Date of Injury:** September 15, 2010      **Time of Injury:** 10:30 AM

**Name of Injured Child:** Stephen Jones

**Type and Circumstance of the Injury:**

Stephen was playing on the floor in the block area and pinched the pinky on his right hand while trying to shut the door on the toy dump truck.

**Caregiver(s) Present:** Ms. Michele and Ms. Cary

**Action Taken:**

After Ms. Michele comforted Stephen, she assessed the pinch on his finger. The finger was red but the skin was not broken so she applied a bag of ice on the finger for 10 minutes. Ms. Michele looked over the dump truck, a screw on the truck's door is loose and has been removed from the block area until repaired.

**Date Parent(s) Notified:** September 15, 2010      **Time of Notification:** 5:15 PM

**Method of Notification:** Ms. Cary reviewed this report today with Mrs. Jones when she picked Stephen up.

**Future Action to Prevent Recurrence of Injury:**

Tighten door on the dump truck and return truck to block area if it doesn't pose a hazard. Review toys and equipment weekly for good repair. Repair or discard broken toys or equipment as needed.

**Caregiver Signature:** Ms. Michele Jefferson

**Caregiver Signature:** Ms. Cary Shelton

**Parent Signature:** Mrs. Shelia Jones

Staff and parent signature OR two caregiver signatures are required.

**NOTE:** The parent must be notified IMMEDIATELY if a child has a head injury or any serious injury that requires emergency medical or dental treatment. The parent must be notified the same day whenever first aid is administered to the child. Providers must record the injury in the child's record on the day the injury occurs.



## Field Trip Permission

I give \_\_\_\_\_ permission to take my child, \_\_\_\_\_,  
(Name of provider) (Name)  
on a field trip to \_\_\_\_\_ on \_\_\_\_\_.  
(Name and location) (Date)

The fee for this field trip is \$\_\_\_\_\_.

Please sign and return your child's permission slip by \_\_\_\_\_ so your child may participate in this learning experience.

\_\_\_\_\_  
Parent's Signature Date

- I would like to be a chaperone and understand we will be leaving at \_\_\_\_\_ and need to arrive on time. The fee for chaperones is \$\_\_\_\_\_ per adult. (Time)
- No, I will not be able to chaperone. I understand that if I do not chaperone, my child will ride in another parent's car or the provider's car.

***Please remember to bring in your permission slips and the cost of the field trip, even if you plan to be a chaperone, by the deadline. By Virginia Standards I must still have this information ahead of time even if the parent is going on the field trip. One permission slip needs to be filled out for each of your children.***

**GENERAL PERMISSION FOR REGULARLY SCHEDULED TRIPS**

(Required by Standards for Licensed Family Day Homes 22 VAC 40-111-980 A)

Child's Name	
Routine Trip Destination(s)	
Mode of Transportation:  <input type="checkbox"/> Walking  <input type="checkbox"/> School bus  <input type="checkbox"/> Public transportation  <input type="checkbox"/> Provider vehicle _____ Name of Driver  <input type="checkbox"/> Other vehicle _____ Name of Driver	
<b>I grant permission for my child to participate in the regularly scheduled trips described above.</b>	
_____	_____
<b>Parent's Signature</b>	<b>Date</b>



## Transportation Information for Parents

Volunteers must have valid driver's license, insurance and working seat belts.

At present any child 8 years of age and under must use a car seat.

All children must be in safety seats that are in compliance with federal motor vehicle safety standards.

Please remember when volunteering for a field trip you will be transporting someone else's child in your car. Please take the extra precautions, as you would want with your own child.

You will be given directions to our destination along with emergency information on the children in your vehicle.

**NO CHILD IS ALLOWED IN THE FRONT SEAT OF THE VEHICLE AT ANYTIME.**

**NEVER LEAVE A CHILD OF ANY AGE UNATTENDED IN YOUR VEHICLE!**

### **RECOMMENDED SAFETY EQUIPMENT:**

If you don't keep a fully stocked first aid kit in your car, bring your home's first aid kit when you transport children. For your peace of mind and the safety of the children, you might want to consider also stocking your vehicle with the following items:

- A fire extinguisher
- Emergency flags or warning triangles
- A warm blanket
- A working flashlight
- Chains
- A tool kit
- A gallon jug of water mixed with antifreeze
- An extra quart of oil. Do not carry gasoline in your vehicle.

Travel by motor vehicles has become an essential part of our daily lives, especially if you have children. However, it's easy to forget how dangerous motor vehicles can be. Because vehicles are designed to protect adults, children are especially susceptible to injury and death if involved in a car crash. You can significantly reduce the likelihood of your children being injured in a crash by properly securing them in child safety seats that are appropriate for their age and size.

## Childhood Motor Vehicle Injuries in Virginia, 2009

- In 2009, there were 19 motor vehicle traffic (MVT) deaths among children 14 and under.
- There were a total of 156 MVT injury hospitalizations among children 14 and under in 2009.
- The median charge per episode of care was \$23,285, and the average length of stay was 5 days.
- Over 6 million dollars were billed due to childhood MVT hospitalizations.
- One-half of MVT-related hospitalizations involved a traumatic brain injury.

### PREVENTION TIPS:

- **Step 1 - Infant-** Infants should ride in a rear-facing safety seat until at least 1 year old AND at least 20 pounds. The American Academy of Pediatrics recommends using the rear-facing child safety seat longer if the seat has higher weight and height limits specified by the manufacturer, which can be as high as 40-45 pounds for newer seats. Virginia law prohibits placing an infant in the front seat of a vehicle with an active passenger airbag.
- **Step 2-Toddler-** When children outgrow their rear-facing safety seats they should ride in forward-facing child safety seats, in the back seat, until they reach the upper weight or height limit of that particular safety seat. It is best to use a 5 point harness as long as the safety seat will allow before graduating to a belt positioning booster.
- **Step 3 - Booster Seat-** Once children outgrow their forward-facing seats, they should ride in booster seats, in the back seat, until the vehicle seat belts fit properly. Seat belts fit properly when the lap belt lays across the upper thighs and the shoulder belt fits across the chest (usually when they are 4'9" tall).
- **Step 4 - Seat Belt-** When children outgrow their booster seats they can use the vehicle seat belts in the back seat, if they fit properly. A proper fit includes the following:
  - The child is tall enough to sit against the vehicle's seat back with her knees bent comfortable over the edge of the seat.
  - The shoulder belt lies across the child's chest, not at the neck or face.
  - The lap belt is low and snug across the thighs, not across the belly.
  - The child can ride in this position for the duration of the car ride.

**Virginia law requires all children age 7 years and younger to be properly secured in a child safety seat or booster seat regardless of the child's weight or height.**

If you are unable to afford a safety seat or need help installing one, go to [www.preventinjuriesva.com](http://www.preventinjuriesva.com) or call 1-800-732-8333.

Division of Injury and Violence Prevention  
**Virginia Department of Health**  
1-800-732-8333  
[www.vahealth.org/injury](http://www.vahealth.org/injury)

Revised 11/10

## Emergency Information and Transportation Checklist

*\*I am a family child care provider/caregiver.*

Name of Provider: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Call the following numbers in case of an emergency: \_\_\_\_\_

\_\_\_\_\_

Police, Fire and Rescue — 911    Poison Control — 1-800-222-1222

### First aid kit contents for transportation and field trips.

- Scissors
- Tweezers
- Digital thermometer
- Assorted gauze pads
- Triangular bandages (2)
- Adhesive tape
- Single use gloves
- Adhesive Band-aids, assorted sizes
- First aid instruction manual
- Activated charcoal preparation (to be used only on the advice of physician or Poison control)
- An ice pack or cooling agent

**Caregiver - remember if you are the only person transporting children - YOU are required to have current First Aid AND CPR training.**

**If this is a field trip - at least one adult on the field trip needs to have current First Aid AND CPR training.**

### Additional information:

- Is the vehicle in good repair? Is the registration and inspection current?
- Are the required safety restraints present and are they being used correctly?
- Do you have a list of the children that are being transported?
- Have you prepared a document outlining the routes frequently driven by caregivers for program business (such as field trips, pickup/drop off of children to or from schools, etc.)?
- Is this document kept in vehicle (notebook or folder) that is used to transport children to and from the family child care home?
- Do you have an emergency preparedness document with local emergency contact information, potential shelters, hospitals and evacuation routes?

*Resource: Adapted from the Transportation Checklist and Emergency Information, The Director's Toolbox, Division of Child Care and Development, Virginia Department of Social Services, 2007.*

**PERMISSION TO PARTICIPATE IN SWIMMING AND WADING ACTIVITIES**

Licensing standards at 22 VAC 40-111-660 require:

- A parent’s written permission before a child participates in swimming or wading activities;
- A parent’s written statement advising of the child’s swimming skills before the child is allowed in water above the child’s shoulder height; and
- When one or more children are in water more than 2 feet deep -
  - At least 2 caregivers to be present and able to supervise the children; and
  - An individual (may be one of the caregivers) currently certified trained in basic water rescue, lifeguarding, or water safety.

<b>My child is a:</b> <input type="checkbox"/> Swimmer <input type="checkbox"/> Non-swimmer	
<b>Other Information on Child's Swimming Skills (if applicable):</b>  	
<b>I give permission for my child to participate in swimming/wading activities:</b>  <hr/>	<b>Date of Permission (valid for one year)</b>  
<b>Parent’s Signature</b>	



Chapter 4

# Child Development



# Chapter 4: Child Development

The first three years of life is a period of incredible growth in all areas of a child's development. A newborn's brain is about 25% of its approximate adult weight. But by age 3, it has grown dramatically, to about 80% of its approximate adult weight.<sup>16</sup> The more stimulating a child's environment, the more a child develops and learns.

The period of early childhood provides children the foundation for overall academic and life success; therefore, it is important that child care providers have an environment that is engaging and that is designed to meet the needs of the children. After all, the children in our care today will be tomorrow's presidents, CEOs, nurses, doctors, and parents.

Child development refers to changes in children's skill development. This process involves learning and mastering skills like sitting, walking, talking, skipping, and tying shoes. Children learn these skills, called developmental milestones, during predictable time periods.

- Children develop at different times and no two children will be the same.
- Children develop physically, mentally, and socially.
- Children need to have support to develop.
- Children's behavior is a direct result of how they feel.

Children learn through observation and experience:

- Children are always watching. Those around them should be setting a good example.
- Observing helps children to understand the world around them.
- Children learn self help skills by doing for themselves. It takes them time to learn these skills, so patience is important.
- Providers should offer children many opportunities and plenty of time to practice new skills. Providers should offer children many opportunities to observe and interact with others.

As more research becomes available on brain development, child care providers continue to make adjustments to how they interact with children and the approaches they take in helping children learn new skills.

## Virginia's Milestones of Child Development

The *Milestones of Child Development*, developed by the Alignment Project Team and published by the Virginia Department of Social Services in 2008, illustrates milestones in development for young children from birth to kindergarten entry. Parents, early childhood educators, and any adult in a child's life can refer to the *Milestones of Child Development* to see children holistically and to gain a greater understanding of expectations for young children from birth to kindergarten.



Children learn and develop by experiencing the world around them. A child's development in one area often influences and/or depends upon the development in other areas; no single area is more important than another. The *Milestones of Child Development* covers six content areas (developmental domains) and each of these developmental domains has columns (strands) of developmental indicators. There are indicators of what children are learning, examples of what adults may observe children doing, and strategies to help adults support children's development.





## Mixed Age Groups

Most family child care providers work with mixed age groups where the children have a wide variety of abilities and interests. Caring for a mixed age group presents a unique set of challenges and benefits for a family child care provider. Providers may need to:

- increase flexibility in daily routines such as nap or meal times to accommodate different aged children,
- provide a wide range of choices in activity to accommodate various ability levels and interest,
- select toys and materials that can be used in many different ways, and
- consider ages of children when setting up the child care space to ensure safety of younger children while still having materials accessible to the older children.

Familiarizing yourself with Virginia's *Milestones of Child Development* is helpful when planning activities for a mixed age group. In October 2009 the Florida Family Child Care Home Association developed the following list of benefits<sup>17</sup> of having a mixed age group:

- 1. Developmentally Appropriate** The mixed-age group environment is a very normal and natural setting. The real world is full of people of all ages, just as in the child's family, neighborhood, and community. Although schools and many child care centers choose to segregate children by ages, this does not reflect real life.
- 2. Provider Continuity** Children are not moved to a new classroom and new teacher when they have a birthday or master a certain skill. It is difficult for families and children to frequently have to transfer feelings of trust, comfort and affection to another teacher.
- 3. Individual Attention** Family child care providers are more accepting of uneven development. They are able to focus on each child as an individual rather than on just one child in a group of children. Teachers of same-age groups may be more tempted to expect children to learn at the same pace.
- 4. Family/Sibling-Like Relationships** These relationships can be fostered, and are sources of trust, affection, comfort, and closeness. Research has shown that age is not an important factor for friendship choices.
- 5. Experience Different Roles** Each child has the opportunity to play various roles such as the youngest, middle, or oldest of the group, and therefore have exposure to different learning experiences.
- 6. Social Development Enhanced** Each child has the opportunity to interact with a variety of behavior and continuously practice cooperative work and play skills (sharing, taking turns, expressing feelings, being helpful to others, etc.).
- 7. Builds Leadership Skills and Self-Esteem** The older children have the opportunity to lead, instruct, assume responsibility, and nurture others. They also strengthen their own skills and knowledge already acquired through the process of tutoring others.
- 8. Learning from Other Children** The younger children are exposed to more complex play, advanced language, and educational activities by observing and imitating the older children. They often learn better from other children than from adults.
- 9. Therapeutic for "At Risk" Children** Children with difficulty following rules are encouraged to remind the younger ones of the rules and therefore often learn to obey and control their own behavior. Children with low self-esteem have the opportunity to refine their social skills and interact in a non-competitive way around the younger children.
- 10. Minimizes Competitive Pressures** Many children are at various learning levels and will have age-specific needs at different times. In mixed-age groups, they are not usually compared to their same-age peers and therefore will not usually feel the need to compete.
- 11. "Waiting Time" is Minimized** Many activities are open-ended or coordinated for all ages – with all children involved. The older children are usually able to be helpful and assist with holding the door open, hand washing, putting up toys, setting the table, etc.

## Stages of Play

Children learn about themselves and the world through play. As caregivers and educators, we know the importance of providing many play opportunities for children. It is also important to remember that each child plays differently. According to the categories of play developed by M.B. Parten in the 1930's, children go through distinct stages of play as they grow and develop. At each stage, how a child interacts with toys and other children directly corresponds to his developmental skills and needs. When planning experiences and activities for children, consider how their development affects the way they play. While all children develop at their own pace, most will progress through the following four stages of play.

**Solitary Play** occurs when a child is around other children but is playing alone and not paying attention to others. At this stage, infants and young toddlers learn about the world around them through their senses and explore toys, objects and people by looking, touching, grasping and tasting. They discover relationships between their bodies and the environment ("I can make this rattle move!") and begin to learn about cause and effect ("Look what happens when I drop the rattle!"). They also begin to participate in and control interactions with caregivers, and enjoy games such as peek-a-boo.

As young children become more aware of others in their world, they begin to engage in **Parallel Play**. Toddlers explore their environment with newly discovered physical skills and enjoy playing independently with toys. They begin to see themselves as part of a social group, but are still egocentric, or self-centered in their thinking. At this stage children play next to each other with the same game or activity, but do not necessarily interact or play together. For example, you may see two young children playing with blocks, but you will notice that they are not building together or talking to each other about what they are doing.

As children develop more interest in their peers and more skills to interact with others, they enter the **Associative Play** stage. At this stage, children may play the same game with one another, but are not necessarily working together. They enjoy watching their peers and imitating others, but have limited interaction while playing together. For example, two children playing dress up may each be using the same materials and talking to each other about what they are doing, but they are not playing together to create one game or narrative. You may hear each child talking about what he is doing ("I have the blue one"; "I am wearing the big hat"), but the words tend to be monologue in nature, rather than conversational.

As children develop more advanced social skills and begin to learn to navigate friendships, they enter the stage of **Cooperative Play**. At this stage, two or more children talk to each other and work together to play a game. For example, you may see older preschool age children working together to build a large block tower or acting out a dramatic play story. Children



at this stage are learning how to compromise, seek adult help in resolving conflicts, practice alternatives to aggression, and better manage their emotions. These newly developed social and emotional skills enable and encourage children to play in groups for longer periods of time. As children enter the school age years, they are able to play more elaborate games with formal rules, such as sports and board games.<sup>18</sup> The following sites have more information about the stages of child development and ways to support play:

[www.pbs.org/wholechild/providers](http://www.pbs.org/wholechild/providers)  
[www.talaris.org](http://www.talaris.org)  
[www.nccic.org](http://www.nccic.org)  
[www.zerotothree.org](http://www.zerotothree.org)



## Outdoor Play

Outdoor play is important to a child's development for many reasons. Children develop many skills while playing outdoors such as, exploring, fine motor, gross motor, social skills and risk taking skills. Take the indoors out. Reading books outdoors under a shady tree brings new life to an old story. Lying under a tree drawing a picture of what is seen opens a child's creativity. Singing and dancing in the rain brings a smile to anyone's face, and having a picnic lunch with all your friends sparks wonderful conversations. Childhood obesity has been linked to the lack of time spent outdoors by children. Help children in your care live healthy productive lives and avoid the risks of obesity and other serious illnesses by taking them outdoors daily.

It is part of a child care provider's job to watch the weather and know what the day has in store for the children in care. Children should be allowed to go outside if it is at least 20 degrees and no more than 90 degrees. The key to playing outdoors with children is to make sure they are dressed appropriately for the weather.

Children love to play in the rain and snow and should be allowed to have these experiences. There may be times when a provider needs to limit the

amount of time outdoors in extreme weather. There is no research to support the common myth that children catch cold from playing outside in cold weather, rain, or snow; however, research does support the importance of children playing outdoors for at least one hour per day.



## Interest Areas

Interest areas, also known as learning centers, are areas in the childcare environment designed for children to learn through play. Children benefit from having clearly defined, well-equipped interest areas that are arranged to promote independence, foster decision making, and encourage involvement. Below is information on many different types of interest areas, which may be placed both indoors and outdoors at the family child care home.

### *Literacy, library, reading, or book area:*

A literacy area should be designed so it is relaxing and cozy for the children. This area should be placed in an area that is not too noisy and is protected from active play. This area is ideally a carpeted area where the children are able to reach all the materials by themselves. This area may be your circle-time or group time space. Children learn vocabulary, pre-reading skills, and a love of books through the literacy area.

### *Dramatic play area:*

The dramatic play area is frequently one of the busiest interest areas; therefore, placement of this area should accommodate the increased amount of activity that will be expected to occur. This



area is frequently set up to look like a home, which allows children to re-create the social roles they see in their everyday life. Design of this area depends on the amount of space available. Placing this area next to the block area allows the two areas to share materials. Children learn problem solving, negotiating, communication, and cooperation skills through activities in the dramatic play area.

### *Block area:*

The block area is designed for imaginative and constructive play. The materials provided for the children will set the stage for learning. The block area should be out of the way of traffic and near other noisy learning centers. This area will need plenty of space for the children to build. The ideal flooring for this interest area is smooth, flat, and carpeted. If possible include shelving in this area so children can see the materials available to them. Children learn about cause and effect, size, shape, distance, and collaboration through play in the block area.

### Art area:

The art area will inspire the children's creativity and self expression. This area can be used for group activities and also as a free-choice area allowing children to explore the art materials on their own. When choosing a space for an art area attempt to place it near a water source and in a place that is easily cleaned. Some providers hang dry erase boards on the walls, or use glass doors as easels or a surface to paint on. In addition to developing hand-eye coordination and fine motor control in the art area, children also develop language.

### Science area:

The science area is stocked with interesting materials that invite children to explore and investigate. When possible, place this area near natural lighting. Having the science area near the kitchen may be helpful since cooking involves science. It may be convenient to combine this area with the math area. Pets can be an excellent source for learning more about science. Providers may also encourage the children to collect items from nature to place in the science area. While playing in the science area, children learn observation, classifying, and logic.

### Math area:

To interest young children, introduce math activities that refer to their everyday lives. Math activities may include counting the number of children present or counting how many plates are needed for lunch time. The math area may be combined with other areas or math materials may be placed throughout all of the interest areas. Children learn one to one correspondence, counting, sorting, and classifying through the math area.

### Music and movement area:

The music and movement area is another area where children often show creativity and self expression.

The best place for this interest area is an open area with storage. A basket or bin containing the music and movement materials works well.

Children work their large muscles, develop language, and develop self expression through experience with music and movement materials.

### Sensory area:

Sensory play includes sand and water play, and experiences with other materials that engage children's senses. It's most convenient to place this interest center in an area that is easily cleaned and near water. Children learn cause and effect, hand-eye coordination, fractions, and measurements in the sensory area.



## Family Child Care Environment Rating Scale Revised Edition (FCCERS-R)

Aspects of the environment assessed by this tool include:

- Space and Furnishing
- Personal Care Routines
- Listening and Talking
- Activities
- Interaction
- Program Structure
- Parents and Provider

The majority of a child's day in care is spent learning through play. The Family Child Care Environment Rating Scale – Revised Edition (FCCERS-R), by Thelma Harms, Debby Cryer and Richard M. Clifford – is a tool used by early childhood experts and providers to assess the quality of care of the family child care program for infants through school-age children. This resource is used throughout the

world to help providers improve the environment and practices in their program. This resource is also one of the assessment measures used in the Virginia Star Quality Initiative. The FCCERS-R identifies materials that enable children of all ages to explore and gain new skills through hands-on-learning. Below is a list of materials suggested for inclusion in a family child care home based on the FCCERS-R tool. Numbers of materials and categories were drawn largely from the “Good” level of quality as defined by the FCCERS-R tool. Many of these materials can be homemade to reduce expenses.

### **Recommended Materials**

#### **Books**

Books can be gathered together in baskets or accessible shelves in multiple locations in the children’s play area. Books should be in good repair and age appropriate. It is recommended that there are at least 12 books available for each age group in the care of the provider; but no less than 2 books for each child in the group. Consider including books depicting the following categories:

- People of different races, ages, genders and cultures
- Animals; farm, pets, ocean, birds, reptiles
- Familiar Objects; balls, cars, people, pets
- Familiar Routines; going to the grocery store, morning routines
- People with different abilities; wearing glasses, using a walker, cane or wheelchair
- Nature/Science; plants, seasons, recycling, weather
- Different Languages; English, Spanish, Chinese, etc.

#### **Fine Motor**

It is recommended that there be at least 10 appropriate fine motor toys available for infants/toddlers in the family child care home.



#### **Appropriate materials for infants:**

- Rattles to shake and grasp (of different textures, colors, shapes, with varying noises)
- Safe hanging things to bat at or to grasp
- Small soft grasping toys, such as animals, rings, or dolls
- Simple stacking rings
- Clean teething toys
- Large pop beads
- Cause-and-effect toys, which respond with sounds or other responses when buttons are pushed

#### **Appropriate materials for toddlers:**

- Containers to drop objects into
- Bead mazes
- Sets of manipulatives with larger than preschool-sized pieces, such as links, interlocking stars, or medium-sized interlocking blocks
- Simple lacing toys
- Finger paints
- Large watercolor markers
- Puzzles with knobs and large pieces
- Crayons
- Glue sticks

It is recommended that preschoolers have access to at least 3 items from 4 different categories (small building materials, art materials, manipulatives and puzzles):

#### **1. Small Building Materials**

- Interlocking Blocks
- Lincoln logs
- Small blocks, inch cubes
- Bristle Blocks
- Tinker Toys
- Magnetic Blocks

#### **2. Art Materials**

- Crayons, watercolor markers
- Colored pencils
- Paints (tempera, watercolors, finger paints)
- Paper
- Tools (hole punch, scissors, stencils)
- Play dough, clay



### 3. Manipulatives

- Lacing cards w/strings
- Pegs with peg boards
- Snaps
- Links
- Nuts and bolts
- Gears
- Beads and strings in various sizes, colors, shapes
- Parquet shapes or other shapes used to make designs
- Other toys with pieces to link or fit together, such as pop beads, snap cubes, magnetic blocks, Mr. Potato Head, toy train tracks
- Zip, snap, and button toys, such as dolls with clothes to fasten or dressing frames

### 4. Puzzles

- Puzzles
- Picture puzzles in frames with differing numbers of pieces
- Puzzles with knobs
- Puzzles without frames, such as floor puzzles, jigsaw puzzles

### Art

It is recommended that toddlers use art materials at least 3 times a week.

#### Young toddler (12-23 months):

- Large, non-toxic crayons
- Large paper taped to a surface
- Non-toxic finger paint
- Large, non-toxic chalk

#### Older toddler (24-30 months):

- Watercolor markers
- Tempera paints
- Paper of different sizes and colors
- Easy-to-use scissors
- Unbreakable chalk board with chalk and erasers
- Play dough to manipulate with fingers and with simple tools (rollers, plastic or wooden utensils that are safe and free of sharp or pointed ends, but not cookie cutters)
- Large self-stick stamps, stickers, and tape
- Scrap paper and cut-out pictures for collage with glue sticks

It is recommended that preschoolers are offered art daily, and have 2 choices of materials from the 4 categories (drawing materials, paints, collage materials, tools).

### Drawing Materials

- Paper
- Nontoxic markers
- Crayons

### Paints

- Finger paint
- Water-color paints
- Tempera paints
- Appropriate brushes

### Collage materials

- felt
- magazine pictures
- yarn
- cotton balls
- pom-poms
- sequins
- feathers
- natural objects
- cardboard tubes

### Tools

- safe scissors
- stencils
- staplers
- brushes
- tape dispensers with tape
- hole punches
- sponges
- rollers
- tools to use with play dough

### Music and Movement

It is recommended that there are at least 10 musical toys available to children, with at least 3 for each age group.

#### Adult-initiated activities:

- Recording a child or a group singing and playing it back for them to listen to
- Singing to a child during hand washing
- Playing recorded music for children
- Humming and rocking a baby to sleep
- Chanting and doing finger plays
- Singing softly to children before or after nap time
- Singing a “clean up” song during transitions
- Encouraging children to clap to music
- Singing while using puppets with a small group of children
- Singing and playing records or CDs of different tempo
- Singing in different pitches
- Playing a simple musical toy for a child
- Playing a musical instrument alongside children playing the same instrument

### **Child-initiated activities:**

- Pulling or pushing toys that make musical sounds when rolled
- Playing with noise-making rattles
- Shaking wrist bells
- Banging cymbals or clackers
- Pressing keys or buttons on musical toys
- Grasping and shaking soft objects with bells inside
- Using beaters on drums, xylophones, or bells

### **Movement experiences:**

- Dancing while holding a non-mobile infants, so he can feel the movements w/music
- Holding hands with one or two children and swaying to music
- Gently bouncing a child on lap to rhythms or a song
- Encouraging older infants and toddlers to move to recorded music as a free choice activity
- Encouraging 2-year-olds to dance or move to the tempo of music
- Encouraging children to clap to different rhythms
- Encouraging a small group to move and dance with musical instruments or scarves

### **Consider using various types of music with the children on a regular basis:**

- |                                |                       |
|--------------------------------|-----------------------|
| • Vocal and instrumental music | • Rock                |
| • Children's song              | • Reggae              |
| • Opera                        | • Rhythm and blues    |
| • Classical                    | • Lullabies           |
| • Jazz                         | • Rap                 |
| • Lively or quiet              | • Folk songs          |
|                                | • Country and western |

*A list of well known rhymes and songs is included at the end of this chapter.*



### **Blocks**

It is recommended that there be enough blocks and space for building to accommodate the number and ages of children in care. Consider having two sets for each age group in the family child care home:

#### **Toddlers:**

- |  |   |
|--|---|
| • Lightweight, hollow brick blocks made of cardboard | • Geometric-shaped blocks used with shape sorters |
| • Fabric covered blocks                              | • Blocks with bells inside                        |
| • ABC wooden blocks larger than 2"                   | • Homemade blocks                                 |
| • Hard and soft plastic blocks of different sizes    | • Wooden or hard foam unit blocks                 |

#### **Preschool/Kindergarten:**

- |  |   |
|--|---|
| • Unit blocks  | • Sets of people, such as families of different races and ages or community helpers |
| • Large hollow blocks  |   |
| • Homemade blocks  |   |
| • Accessories  |   |
| • Animals of various types, including farm animals, zoo animals, pet animals, or dinosaurs | • Small vehicles, such as cars, trucks, or airplanes                                |

### **Dramatic Play**

#### **Infants (3-5 examples of materials is recommended):**

- |                |                  |
|----------------|------------------|
| • Dolls        | • Pots and Pans  |
| • Soft animals | • Toy telephones |

#### **Toddlers (2 or more of each is recommended):**

- |                            |                                   |
|----------------------------|-----------------------------------|
| • Dress-up clothes         | • Doll furnishings                |
| • Child sized furniture    | • Play buildings with accessories |
| • Cooking/eating equipment | • Toy telephones                  |
| • Play foods               | • Soft animals                    |
| • Dolls                    |                                   |

#### **In addition to the above materials, preschoolers will enjoy:**

- |                                    |   |
|------------------------------------|---|
| • Dress-up clothes                 | • Uniforms of various work roles                                  |
| • Shirts/blouses for men and women | • Hats of many types  |
| • Dresses, skirts, pants, jackets  | • Accessories, jewelry, hair clips, purses, tote bags, briefcases |
| • Footwear                         | • Office play   |
| • Ties                             | • Restaurants   |
| • Aprons for cooking               |   |

- Construction workers
- Medical
- Farmer or gardener
- Fantasy
- Leisure

*It is recommended that there be sufficient materials for preschoolers to carry out complex play with 2 different themes*

### **Math/Number**

Consider providing 5 different math learning materials appropriate for each age group.

#### **Infants and Toddlers:**

- Nested cups
- Shape sorters
- Rattles of various shapes
- Cradle gyms with hanging shapes
- Stacking rings
- Numbers and shape board books
- Simple shape puzzles
- Toy telephones
- Cash registers w/ numbers

#### **Preschoolers:**

- Small objects used in counting activities
- Balance scales
- Rulers
- Number puzzles
- Magnetic numbers
- Geometric shapes
- Attribute blocks
- Books on counting and shapes
- Number games
- Dominoes, number lotto

#### **School-agers:**

- Rulers
- Tape measures
- Number lines
- Unit rods and cubes
- Geo boards
- Math card and board games
- Calculators
- Parquetry blocks

### **Nature and Science**

It is recommended that children have daily experiences with living plants or animals indoors. Preschoolers will benefit from at least 9 different examples of nature related materials in the family child care home from 3 of the 4 categories (collections of natural objects; living things; nature/science books, pictures, games or toys and; nature and science tools).

#### **Collections of Natural Objects**

- Leaves
- Seashells
- Rocks
- Pinecones
- Birds' nest
- Different types of wood

### **Living Things**

- House plants
- Garden
- Pet
- Window bird feeder
- Ant farm
- Worm farm
- Butterfly hatching kit
- Eggs that hatch
- Aquarium with fish, snails or other animals

### **Books and Pictures:**

- Animals, space, weather, rocks
- Posters
- Photographs
- Drawings

### **Toys:**

- Realistic zoo & farm animals, insects
- Puzzles w/ realistic nature or science content
- Scent boxes
- Realistic plastic vegetables and fruits
- An infant mat with realistic nature or science pictures displayed
- Realistic animal-shaped rattles
- Large magnets with which toddlers can experiment
- Magnifying glasses for older toddlers

### **Tools**

- Magnets
- Magnifying glasses
- Sink and float
- Shaking cans filled with differing substances
- Smelling cans
- Plastic translucent color paddles
- Rain gauge
- Cooking scale
- Watering can



## Toilet Training

Toilet training is an important developmental milestone that many parents look to their family child care provider for assistance. It is important for parents and providers to understand that a child's readiness to begin toilet training should be based on their developmental level and not their age. A child may be ready to begin toilet training anywhere from 18 months to 42 months of age.

There are many decisions to be made when it comes to toilet training, and providers and parents should agree, use the same approach, and work together when making these decisions. A child may have set backs or a difficult time after a change

such as; moving, divorce, birth of a new sibling, or even an upcoming vacation. It is best for the child if they have a regular routine once training begins. Toilet training is a joint effort between parents and providers when children are in child care.

## Children's Behavior

There are many influences on a child's behavior right from birth: biology, culture, and environment are the biggest influences on a child's behavior. When most people hear the word "behavior" they think of negative behaviors even though positive behaviors exist.

Children inherit physical features from their parents as well as behavior traits (biological influence). A child's personality, likes and dislikes, how she reacts to a situation, and if a child is social or shy are all features they inherit from their parents.

Social/emotional development influences children's behavior. Children often behave differently when they are with other children. There is a natural desire to be accepted by peers. When children are exposed to other children on a daily basis their behavior can be influenced by the social interactions they experience every day. The relationships a child develops in a safe and supportive environment influences their ability to express their own feelings.

Culture is made up of behaviors, ideas, attitudes, values, and traditions that are shared by a large group of people. There are many different beliefs

from many different cultures and being culturally aware can help a provider understand not only a child's behavior but their parents' behavior as well. Different cultures have different views on child rearing.



Environmental influences come from a child's home life as well as from the community he/she lives in. The family child care home where a child is enrolled is part of her daily community. The child's daily environment can have a positive or a negative influence on a child's behavior. Children are positive by nature, but an environment that is restrictive, negative, and sad can change that positivity very quickly. An environment that is nurturing, safe, positive, and understanding will promote positive behaviors in children.



## Behavior Management

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It is important that child care providers give children clear expectations for behavior and use effective strategies that guide children's behavior in a positive way. Behavior expectations are most often met when they are clearly stated, enforced in a consistent and predictable manner, and understood by children and parents. Family child care providers may want to engage parents and children in establishing rules for behavior. There may be rules established about safety, hurting feelings, and respecting others.

Being proactive is an important part of behavior management and involves anticipating problem behavior before it happens. Children will test the limits and some will do it repeatedly. There may be opportunities to use challenging behavior to teach problem-solving skills. A family child care provider can manage behavior proactively by being aware of all children even when working with an individual child or a small group, by stating behavioral expectations before beginning an activity, and by commenting on children's positive behaviors when they occur.

Another behavior management technique is redirection. Effective redirection means that the problem or disruptive behavior ends and does not escalate. Effective redirection can be a brief reminder, a gentle touch, or an eye gaze from the provider to the child.<sup>19</sup>

Helping children develop positive behaviors is one way that providers prepare children for success in school and in life. Providers who provide children with consistent, predictable rules and expectations help promote children's regulation of their own behavior. When providers monitor behavior carefully and promote positive peer interaction by demonstrating kindness, warmth, and understanding, they are building social skills for the children in their care. Helping children stay busily engaged with activities throughout the day is an effective method to promote positive behavior and increase learning in the family child care home.

Every child is different, so offering children alternative activities that address their individual needs may increase positive behaviors. Many behavior concerns can be reduced by following these behavior management techniques and providing a well designed environment where children are consistently involved in activities.

### *Challenges from Your Own Children*

Many family child care providers join the profession of caring for other's children in order to influence their own children and spend time with them. This places a provider in a unique position. It can be very stressful for the provider and the children in care when the child presenting challenges lives in the home.

Children may find it difficult to share under normal circumstances, but when the decision is made to open a family child care home your child is asked to share her family, her home, and her toys with other children on a daily basis. Your own children may test the limits and may behave as though the rules do not apply to them. Below are possible solutions to help your own children accept sharing their home and their parent with other children:

- Make sure your child has their own space, an "off limits" to child care space.
- Spend one-on-one time with your child daily.
- Stick to the rules, especially when your child challenges them.
- Understand sharing does not come naturally and allow your child to have some toys/items they do not have to share.
- Do not feel guilty when your child misbehaves in front of parents. Just because you work with children, does not mean your children will be perfectly behaved.
- Listen to your child; allow them to express their feelings and concerns about the other children.

## Early Intervention

### Here are a few common definitions you should know.

**Early Childhood Intervention** is a collection of services provided by public and private agencies and designed by law to support eligible children and families in enhancing a child's potential for growth and development from birth through age three.

**Evaluation** is a procedure used by qualified professionals to determine a child's initial and continuing eligibility which focuses on determining the status of the infant or toddler in all of the developmental areas: cognitive, social/emotional, physical (including vision and hearing), communication, and adaptive.

**Individualized Education Program (IEP)** describes the educational program that has been designed to meet that child's unique needs. Each child who receives special education and related services must have an IEP. Each IEP must be designed for one child and must be a truly individualized document. The IEP creates an opportunity for teachers, parents, school administrators, related services personnel, and children (when age appropriate) to work together to improve educational results for children with disabilities. The IEP is the cornerstone of a quality education for each child with a disability.

**Individualized Family Service Plan (IFSP)** is the written plan for providing early intervention and other services to eligible children and families that:

- 1) is developed jointly by the family and appropriate professionals,
- 2) is based on a multidisciplinary evaluation and assessment of the child and family,
- 3) has a family directed statement of resources, priorities and concerns if the family wishes, and
- 4) includes services necessary to enhance the development of the child and the capacity of the family to meet the child's developmental needs.

Providers and other caregivers who work with children in the program should request and help support the goals and objectives of the services being provided for the child and family.

The birth of a baby is an exciting time for families, a cause for celebration, and a time for wondering what the possibilities will be for that child's future. What happens when the child has special needs or develops special needs? Providers can assist families and offer support by giving them information about the systems and resources in their community that help children with special needs, especially when families concerns about their child become a reality.

Parents of children with special needs, e.g., developmental delays or special health care needs often choose family child care providers for the smaller environment and a lower provider-child ratio. Providers should be familiar with terms used to describe special needs and with community resources that support all families.

### **Infant & Toddler Connection – Supporting Children with Developmental Delays**

The Infant Toddler Connection can assist parents and caregivers when there might be a concern that a child might have a developmental delay and/or a disability. The Infant and Toddler Connection assists families of children birth through three in helping their child learn and develop through everyday activities and routines so they can participate fully in family and community activities.<sup>20</sup>

### **Who is eligible for the Infant & Toddler Connection of Virginia?**

- Infants and toddlers with 25% or greater delay in one or more developmental area(s): cognitive, adaptive, receptive or expressive language, social/emotional, fine motor, gross motor, vision, hearing development
- Infants and toddlers with atypical development – as demonstrated by atypical/questionable sensory-motor responses, social-emotional development, or behaviors, or an impairment in social interaction and communication skills along with restricted and repetitive behaviors
- Infants and toddlers with a diagnosed physical or mental condition that has a high probability of resulting in developmental delay – e.g., cerebral palsy, hearing or vision impairment, Down syndrome or other chromosomal abnormalities, central nervous system disorders, effects of toxic exposure, failure to thrive, etc.



### **What prompts a referral?**

- You or the parent of an infant or toddler has concerns or suspicions about the child's development. Screening using a standardized developmental screening test (as recommended by the American Academy of Pediatrics) will help identify children who may be in need of early intervention services. A diagnosed physical or mental condition is not required.

### **How are referrals made?**

- Contact the Infant & Toddler Connection "central point of entry" for the city or county in which the family resides or call the state toll free number: 1-800-234-1448, or click on "Central Directory" at [www.infantva.org](http://www.infantva.org). You may make the referral for the family, or provide contact information to the family. Referrals should be made as soon as the concern is identified.

### **What information should be provided to the early intervention system when referring a child?**

- Child's name, gender, and date of birth
- Name, address, and telephone number of the parent or legal guardian
- Reason for referral (child has suspected or confirmed developmental delay or disability)
- Health and physical information, including vision and hearing, results of any neurological or developmental evaluations and any other information pertinent to the child's physical and developmental status and needs
- Your name and telephone number

### **What should I discuss with the family?**

- All children referred receive an eligibility determination, with parent consent. Eligibility determination plus any needed developmental screenings and assessments are provided at no cost to the family.
- The family is not obligated to accept services
- If the child is found eligible for participation in the system, the family will guide the development of an Individualized Family Service Plan (IFSP) that identifies the services and supports needed to promote the child's development and support the family in the daily activities and routines with their child

- No child or family is denied services and supports identified on the IFSP because of their inability to pay

### **Care Connection for Children – Supporting Children with Special Health Care Needs**

Care Connection for Children is a statewide network of centers of excellence for children with special health care needs (CSHCN) that provide leadership in the enhancement of specialty medical services; care coordination; medical insurance benefits evaluation and coordination; management of the CSHCN Pool of Funds; information and referral to CSHCN resources; family-to-family support; and training and consultation with community providers on CSHCN issues.

For more information on the eligibility criteria, services and contacts for Care Connection of Children visit, [www.vahealth.org/specialchildren/cccpprogram.asp](http://www.vahealth.org/specialchildren/cccpprogram.asp).

Parents and caregivers are often the first to notice when a child is not learning or growing at the same rate as other children. Included at the end of this chapter is a Child Development checklist that outlines what to expect from children during the ages from birth to three years. Using this checklist can help identify children that may need supports and services to reach his or her fullest potential.

### **Inclusion**

Inclusion means ALL children learning together in settings that address the needs and interests of each child (including those with disabilities). Inclusive child care provides and includes experiences that are appropriate for children with and without disabilities – playing and learning together with typical daily experiences and routines.

- All children learn skills and make developmental gains at expected rates in inclusive settings
- Children usually do not imitate behaviors that are inconsistent with their own developmental levels
- All children have strengths they can share with others
- Rejection of young children with disabilities by other children is rare
- Successful inclusion depends heavily on the attitude of the caregivers

## Components of Early Literacy

Children prepare to read long before they enter school. Early literacy is everything children know about reading and writing before they can actually read and write. This is sometimes referred to as “pre-reading and pre-writing skills”.<sup>21</sup>

**1** **Print Motivation** is getting a child interested and excited about books and reading. From birth children should have positive connections with books, especially when stories are read aloud to them. A child with good print motivation enjoys being read to, looks at the illustrations in books independently, and likes trips to the library. Research shows that children who have three books read aloud to them each week do better in school than children who do not have positive experiences with sharing books.



### What can you do?

- Make sharing books a time to be close to children. Allow them to sit in your lap and have your undivided attention.
- Encourage children to select the book to be read and turn the pages.
- Use a puppet or stuffed animal to help tell the story.
- Read aloud using fun voices and noises and using loud and soft sounds.
- Let the children see that you enjoy reading.

**2** **Print Awareness** is noticing print, not only in books but words in their environment. Print is everywhere and children need to learn that it has meaning and purpose. Knowing how to handle a book and how to follow words on a page (from top to bottom, left to right) are also important components of this skill.

### What can you do?

- When sharing books, follow the words you are reading with your finger.
- Point out signs everywhere you go; at the grocery store, while you are driving, on labels, and on menus.
- Help children recognize their own names.
- Label items in your home (couch, table, chair, etc).

**3** **Phonological Awareness** is when children connect the sounds of words through rhymes, stories, songs and play. It is also being able to hear and manipulate the smaller sounds in words. Understanding that words are made up of smaller sounds is key to successfully learning how to read.

### What can you do?

- Help children think of words that start with the same sound as their names.
- Clap the syllables of a word, like two claps for “kitchen.”
- Make up silly words by changing the first sound in a word.
- Recite and repeat favorite nursery rhymes. Knowing words is directly related to learning how to read.

**4** **Vocabulary** skills help young children learn how to name things and communicate with others. The more words they are exposed to, the more words they will know. Most children enter school knowing between 3,000 and 5,000 words.

### What can you do?

- Talk to the children about everything you are doing during the day and why. For example, when in the kitchen cooking explain how you follow the recipe, cut up vegetables, or why you keep food in the refrigerator.
- Use magnetic letters to form words.
- Use a variety of descriptive words in your own vocabulary. For example, “The apple is red, crunchy, and sweet.”
- When driving around town, talk about where you are going, why you are going there, and the places that you pass along the way.

**5** **Narrative Skills** help children describe things or events and instill a deeper understanding of how stories work. This includes telling and retelling stories, describing ideas, and putting events in chronological order.

**What can you do?**

- Make stories interactive by asking, “What do you think is going to happen first... next... last?”
- Ask children to tell you about something that happened during the day.
- Encourage children to use puppets, stuffed animals, or other toys to make up their own story.
- Inspire imaginative and dramatic play by providing your child with a dress-up box.
- Encourage children to tell you about things that have a regular sequence to them; for example how a seed becomes a flower or how to get ready for bed.
- When children tell you a story, write it down in their words.

**6** **Letter Knowledge** is discovering that letters in the alphabet are different from each other, that there are capital and lower case letters that each letter has a different sound, and that letters are everywhere. The more experiences young children have with looking at, talking about, and drawing letters, the better prepared they will be to learn to read.

**What can you do?**

- Share a variety of alphabet books.
- Teach children the letters in their name.
- Draw letters in the dirt or sand, with sidewalk chalk, or in the snow.
- Point out familiar letters in signs and labels.
- Sing the alphabet song.



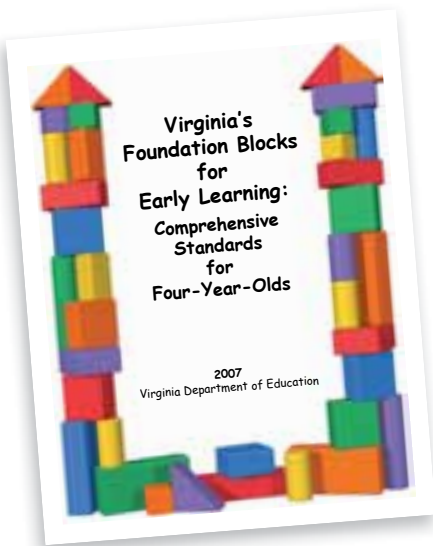
## Foundation Blocks for Early Learning Programs: *Comprehensive Standards for Four-Year-Olds*

Virginia's *Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds* was developed by the Virginia Department of Education, revised in 2007. This document establishes a measurable range of skills and knowledge essential for four-year-olds to be successful in kindergarten.

The purpose of this document is to provide early childhood educators a set of minimum standards in literacy, mathematics, science, history and social science, physical and motor skill development, and personal and social development with indicators of success for entering kindergarten that are derived from scientifically-based research. The standards reflect a consensus of children's conceptual learning, acquisition of basic knowledge, and participation in meaningful and relevant learning experiences.

The material is organized for use as a tool for early childhood educators in developing curriculum and meaningful classroom activities. Each Foundation Block is in box format, and is organized to build towards the Virginia Kindergarten Standards of Learning. Following the boxes are expectation indicators for the Foundation Blocks. Sample teaching activities are included to assist teachers in the planning of meaningful classroom activities.

Providers can access the full Foundation Blocks document online at [www.doe.virginia.gov/instruction/early\\_childhood/preschool\\_initiative/foundationblocks.pdf](http://www.doe.virginia.gov/instruction/early_childhood/preschool_initiative/foundationblocks.pdf).



## School Readiness

The first five years of life are critical to a child’s lifelong development. Young children’s earliest experiences and environments set the stage for future development and success in school and life. Early experiences actually influence brain development, establishing the neural connections that provide the foundation for language, reasoning, problem solving, social skills, behavior and emotional health.

Families and communities play critical roles in helping children get ready for school. Children from families that are economically secure and have healthy relationships are more likely to succeed in school. Infants and young children thrive when parents and families are able to surround them with love and support and opportunities to learn and explore their world. Communities are vibrant when they provide social support for parents, learning opportunities for children, and services for families in need.

Schools can improve the readiness of young children by making connections with local child care providers and preschools and by creating policies that ensure smooth transitions to kindergarten. Children entering kindergarten vary in their early experiences, skills, knowledge, language, culture and family background. Schools must be ready to address the diverse needs of the children and families in their community and be committed to the success of every child.<sup>22</sup>

Over the past few years, Virginia has worked to bring a state and community focus to the importance of early childhood. This section provides an explanation of Virginia’s Plan for Smart Beginnings, the Virginia Star Quality Initiative and Virginia’s Definition of School Readiness. This chapter also includes information and resources for providers to implement a kindergarten transition plan.

### Virginia’s Plan for Smart Beginnings

Virginia’s Plan for Smart Beginnings is a comprehensive effort to strengthen the birth-to-five continuum to ensure that children enter kindergarten ready for school and ready for life. In partnership with the Virginia Department of Social Services Office of Early Childhood Development (VDSS/OECD), the Virginia Early Childhood Foundation works to spearhead efforts relating to Virginia’s Plan for Smart Beginnings, a strategic plan to improve, integrate, and evaluate all early childhood services, infrastructure, and public engagement efforts in the Commonwealth.

Smart Beginnings coalitions throughout the state are led by local stakeholders representing all sectors

of a community including business, education, social services, health care, mental health, faith, non-profits, government and parents. These coalitions work locally to support the goals, objectives and

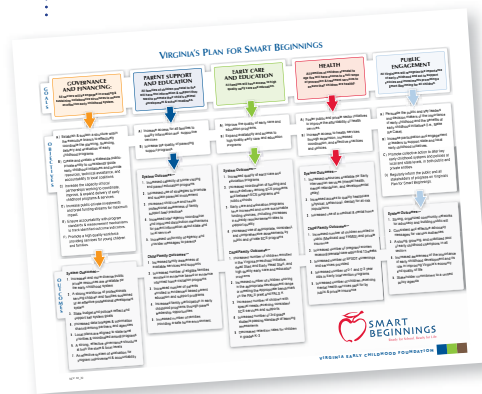
strategies of Virginia’s Plan for Smart Beginnings. To achieve the plan’s goal to ensure that every child is ready for success in school and in life, Virginia’s plan consists of five umbrella goals concerning the following areas:

- Governance and Financing
- Parent Support and Education
- Early Care and Education
- Health
- Public Engagement

A copy of Virginia’s Plan for Smart Beginnings can be found at [www.smartbeginnings.org](http://www.smartbeginnings.org).

### Virginia Star Quality Initiative

Virginia Star Quality Initiative (VSQI), a quality, rating and improvement system was developed to assess, improve, and communicate the level of quality in early care and education settings for families to reference when selecting care for their children. VSQI is a voluntary program for classroom-based programs and family child care homes. This initiative is jointly implemented by the VDSS/OECD and the Virginia Early Childhood Foundation; and supports Virginia’s Plan for Smart Beginnings – under Goal Three – to increase the quality of early care and education programs.





Providers that volunteer to participate in VSQI, will have visits from experts, be paired with mentors and will receive feedback on possible improvements to their child-care businesses, as well as support to make improvements. To learn more about VSQI visit [www.smartbeginnings.org](http://www.smartbeginnings.org).

### *Virginia's Definition of School Readiness*

“School readiness” describes the capabilities of children, their families, schools, and communities that will best promote student success in kindergarten and beyond. Each component — children, families, schools and communities — plays an essential role in the development of school readiness. No one component can stand on its own.

- **Ready Children.** A ready child is prepared socially, personally, physically, and intellectually within the developmental domains addressed in Virginia’s Foundation Blocks for Early Learning: literacy, mathematics, science, history and social science, physical and motor development, and personal and social development. Children develop holistically; growth and development in one area depends upon development in other areas.
- **Ready Families.** A ready family has adults who understand they are the most important people in the child’s life and take responsibility for the child’s school readiness through direct, frequent, and positive involvement and interest in the child. Adults recognize their role as the child’s first and most important teacher, providing steady and supportive relationships, ensuring safe and consistent environments, promoting good health, and fostering curiosity, excitement about learning, determination, and self-control.
- **Ready Schools.** A ready school accepts all children and provides a seamless transition to a high-quality learning environment by engaging the whole community. A ready school welcomes all children with opportunities to enhance and build confidence in their skills, knowledge, and abilities. Children in ready schools are led by skilled teachers, who recognize, reinforce, and extend children’s strengths and who are sensitive to cultural values and individual differences.

- **Ready Communities.** A ready community plays a crucial part in supporting families in their role as primary stewards of children’s readiness. Ready communities, including businesses, faith based organizations, early childhood service providers, community groups and local governments, work together to support children’s school and long term success by providing families affordable access to information, services, high quality child care, and early learning opportunities.

To learn more about School Readiness in Virginia, including Indicators of School Readiness, visit [www.earlychildhood.virginia.gov/school\\_readiness.shtml](http://www.earlychildhood.virginia.gov/school_readiness.shtml).

### *Kindergarten Transitions*

Children and their families experience a variety of changes as they move from an early childhood program to kindergarten, including increased academic demands; a more complex social environment; less time with teachers due to larger class sizes; more transitions during the school day; and decreased opportunities for direct family support and connections.<sup>23</sup>

The collaboration and partnership between family child care providers and schools can be a vital connection that directly benefits children and families. To build this partnership you can:

- work to develop relationships with school personnel, e.g., principals and kindergarten teachers;
- become knowledgeable of important dates & processes for school registration;
- visit a kindergarten classroom to learn routines and expectations for rising kindergartners;
- provide an environment that supports learning objectives, e.g. *Virginia’s Milestones of Child Development* and *Virginia’s Foundation Blocks for Early Learning Programs: Comprehensive Standard for Four-Year-Olds*; and
- develop a variety of approaches to communicate important information to families.

The transition process is not defined as a single event but a collection of practices and activities that is implemented over time.<sup>24</sup>

Resources to implement this plan are included at the end of this chapter, and consist of:

- A Planning Guide for Kindergarten Transitions
- Kindergarten Readiness Skills Checklist
- Parent Letter # 1 *Sample Letter*
- Parent Letter # 2 *Sample Letter*

## Interactions

Another important aspect of preparing children for success in school and in life is helping children to develop character traits, curiosity, and relationship skills that they will need when they arrive at kindergarten. In order for children to gain some of these important skills, the interactions they have with caregivers are crucial. In the early years of a child's life, all learning takes place through social interaction.<sup>25</sup> Many young children spend a significant amount of time in child care, so the interactions and relationships they have with the provider are extremely important. In fact these relationships will be the most significant non-parental relationships they have in their early years.<sup>26</sup> Young children look to their caregivers as a source of emotional support, and research suggests that high quality child-teacher relationships may even serve as a protective factor for children experiencing certain risk factors.<sup>27</sup>

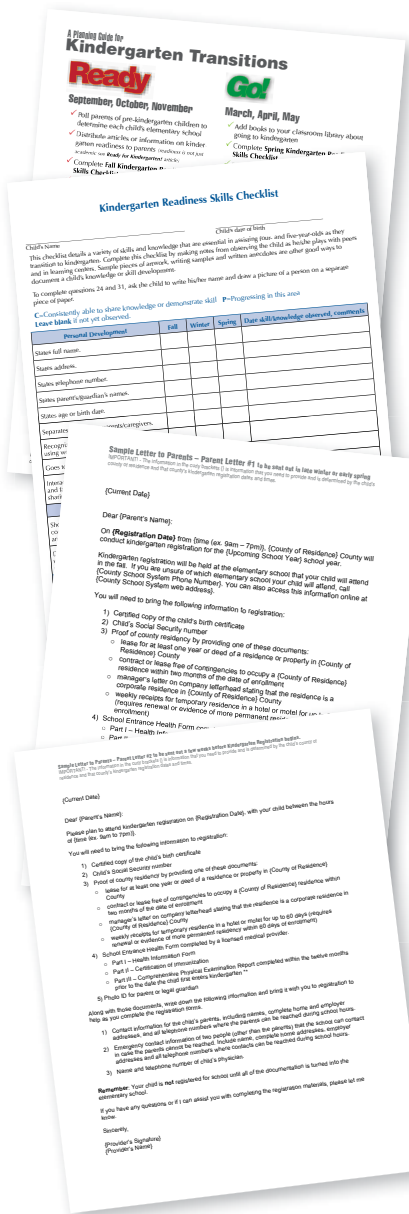
Beyond preparing children for learning when they enter kindergarten, the quality of teacher-child interactions has been associated directly with children's academic and social outcomes in the later school years.<sup>28</sup> Some children may not have access to positive relationship experiences outside of child care, but positive interactions and relationships with child care providers can make a significant difference in children's lives, both socially and academically. Interactions with young children are important for several reasons. Providers can be a source of emotional support for young children, which supports children's development of independence and security. Providers who interact with children in warm, responsive ways are supporting children's social-emotional development and setting a positive role model. When children

feel safe and secure in the family child care home, they are more likely to explore and investigate the materials in their environment, which means they can make the most of the learning opportunities available to them.

When providers focus on giving children learning opportunities in the child care setting, it is very important to consider their interactions with children during these activities. Adults who respond to children's attempts to communicate are encouraging their language development. Interactions that develop into conversations are one of the simplest ways to help children learn. Providers can help promote learning by adding information to conversations, asking questions about the world around them, and encouraging children to try new things or keep working on a difficult task. Learning materials and other toys are not the only important resource that children have in the family child care setting.

Their provider plays an important role as the person who enables children to make the most of the learning opportunities available in the family child care home.

Positive interactions make the difference for children's social-emotional development when teachers are responsive, supportive, and affectionate. These relationships help children learn to regulate their own behavior when the environment is consistent and predictable. The provider has an opportunity to help maximize learning in the family child care home by encouraging language through frequent conversations with the children in their care.<sup>29, 30</sup> Providers who interact with children during their activities and play increase children's learning.







## Sample Forms and Materials for Chapter 4

Infant & Toddler Connection – Child Development Checklist (English and Spanish)

Born Learning – Fun and Games with Songs

A Planning Guide for Kindergarten

Kindergarten Readiness Skills Checklist

Sample Parent Letter #1

Sample Parent Letter #2

Mind in the Making: The Science of Early Learning

The entire toolkit, including all sample forms and materials, is available online and can be printed as needed, visit: [www.smartbeginnings.org/Home/StarQualityInitiative/ForEarlyChildhoodProfessionals.aspx](http://www.smartbeginnings.org/Home/StarQualityInitiative/ForEarlyChildhoodProfessionals.aspx)

# Parents Are Often the First to Know When Their Baby Needs a Helping Hand.



## A Checklist for Your Child's Development from Birth to Age Three

The first three years of your baby's life are very important. Infants and toddlers are learning to walk, talk, recognize people and do many other things. Parents are often the first to notice when their child is not learning or growing like other babies. This brochure outlines what to expect from your child during the ages from birth to three years old.

Please make sure that your child receives well-baby checkups by her doctor every three months for the first year and a half, and every six months after that until she is three years old.

Some infants and toddlers may have trouble developing certain skills. If you have any concerns about your baby, call the Infant & Toddler Connection of Virginia at **1-800-234-1448**. We're here to help.



**Infant & Toddler**  
Connection of Virginia

1-800-234-1448  
TTY/TDD 1-804-771-5877  
[www.infantva.org](http://www.infantva.org)

## Important For All Babies

*Check Yes or No for each question.*

Yes No Does your baby always ride in a car seat  
  when riding in a car?

Yes No Do you have a regular place to go for your  
  baby's health care (pediatrician,  
family doctor, public health clinic)?

**Here's a sample list of what babies are usually able to do at different ages.**

### By 3 Months Old

Yes No Does your baby smile back at you when you  
  smile, talk, or gently touch her face?

Yes No Is your baby making cooing sounds like "ooh"  
  or "aah"?

Yes No Does your baby seem surprised when she  
  hears loud noises?

Yes No Does your baby lift her head and chest when  
  lying on her tummy?

Yes No Does your baby play with her hands by  
  touching them together or putting them in  
her mouth?

Yes No Does your baby watch you when you walk  
  around the room?

Yes No Has your baby seen the doctor at least two  
  times for well-baby checkups?

### By 6 Months Old

Yes No Does your baby laugh and babble, like saying  
  "bababa" or "dadada"?

Yes No Does your baby try to explore toys by putting  
  them in his mouth?

Yes No Does your baby roll from his back to his  
  tummy?

Yes No Does your baby turn his head toward sounds  
  like your voice, radio or TV?

Yes No Does your baby reach for and hold a toy?

Yes No Has your baby had at least one well-baby  
  checkup in the last three months?

### By 9 Months Old

Yes No Does your baby sit by herself without falling?

Yes No Does your baby look for a toy when she sees  
  you drop it?

Yes No Does your baby hold something in each hand  
  at the same time?

Yes No Does your baby scoot or crawl across the floor  
  on her tummy?

Yes No Does your baby pull up to stand by holding  
  on to furniture?

Yes No Does your baby shake her head "No"?

Yes No Has your baby seen the doctor at least one  
  time for a well-baby checkup since she was  
six months old?

## By 12 Months (1 year old)

- Yes No   Does your baby look at the right thing when you say words like “bottle”, “ball” or “cup”?
- Yes No   Does your baby get on his hands and knees to crawl?
- Yes No   Does your baby say “Mama” or “Dada” to the right person?
- Yes No   Does your baby find a toy when he sees you hide it?
- Yes No   Is your baby playing peek-a-boo or waving bye-bye after he sees you do it?
- Yes No   Does your baby look at pictures in a book?
- Yes No   Does your baby take steps when holding on to furniture?
- Yes No   Does your baby pick up finger foods like Cheerios or raisins using the thumb and one finger?
- Yes No   Has your baby seen the doctor at least one time for a well-baby checkup in the last nine months?

## By 15 Months Old

- Yes No   Does your baby point to or ask for things she wants?
- Yes No   Does your baby feed herself with her fingers?
- Yes No   Does your baby walk without help?
- Yes No   Does your baby say any words other than “Mama” or “Dada”?
- Yes No   Does your baby scribble on paper using crayons or pencils?
- Yes No   Has your baby seen the doctor for her 12-month well-baby checkup?

## By 18 Months Old

- Yes No   Does your baby hold and drink from a cup?
- Yes No   Does your baby point to body parts like “eyes”, “nose” and “mouth” when you name them?
- Yes No   Does your baby like to put things in and out of containers?
- Yes No   Does your baby say words to tell you what he wants?
- Yes No   Does your baby like to look at books and turn pages by himself?
- Yes No   Has your baby seen the doctor for a 15-month well-baby checkup?

## By 24 Months (2 years old)

- Yes No   Does your child stack things on top of one another?
- Yes No   Does your child put words together like, “Daddy shoe”, “Go bye-bye”, “See car”?
- Yes No   Does your child point to pictures in a book when you name them?
- Yes No   Does your child take off her sweater, socks or hat by herself?
- Yes No   Has your child had her 18-month well-baby checkup?

## By 30 Months

- Yes No Does your child walk up stairs?
- Yes No Does your child understand simple requests like, "Give me one cracker" or "Bring me one crayon"?
- Yes No Does your child put three words together like, "I want juice"?
- Yes No Does your child make a straight line with a crayon or pencil after you do it?
- Yes No Does your child use pronouns like "I", "you" and "me"?
- Yes No Does your child turn the pages of a book, one at a time?
- Yes No Has your child seen the doctor for a 24-month checkup?

## By 36 Months (3 years old)

- Yes No Can your child tell you her first name?
- Yes No Does your child unbutton buttons?
- Yes No Does your child jump up and down?
- Yes No Does your child ask questions?
- Yes No Does your child understand words like "in", "out" and "behind"?
- Yes No Does your child follow simple two-step directions like, "Go to your room and bring me a diaper"?

## While all infants and toddlers learn at their own pace, some may need a little extra help to develop certain skills.

If you answered "no" to one or more of these questions, or if you have other concerns about your young child's development, the Infant & Toddler Connection of Virginia is here to help!

Please call the toll-free phone number below. You will be given the name and telephone number of someone in your community who will listen to your concerns and offer assistance.



**Infant & Toddler**  
Connection of Virginia

1-800-234-1448

TTY/TDD 1-804-771-5877

[www.infantva.org](http://www.infantva.org)

The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services is grateful to the following people and organizations for their help in preparing and producing this brochure: Virginia families; The Virginia Interagency Coordinating Council (VICC) Public Awareness Workgroup; and the Council Coordinators Association (CoCoA). This brochure was produced with federal funds under Part C of the Individuals with Disabilities Education Act (IDEA) - Early Intervention for Infants and Toddlers with Disabilities.





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*Los servicios del Departamento de Salud Mental, Retraso Mental y Abuso de sustancias de Virginia está agradecida a las siguientes personas y organizaciones por su ayuda en la preparación y edición de este folleto: Virginia families; The Virginia Interagency Coordinating Council (VICC) Public Awareness Workgroup y The Council Coordinators Association (CoCoA). Este folleto fue realizado con fondos federales bajo la Parte C del Acta Educativa de Individuos con Discapacidades (IDEA) – Intervención Temprana para Niños y Bebés con Discapacidades.*

Diseñado por la Oficina de Comunicaciones Gráficas de Virginia, Departamento de Servicios Generales

Los padres son a menudo los primeros en saber cuando su hijo necesita ayuda.



**Infant & Toddler**  
Connection of Virginia



## Una encuesta sobre el desarrollo de su hijo desde el nacimiento hasta los tres años

Los primeros tres años de la vida de su bebe son muy importantes. Los niños y los bebés están aprendiendo a andar, a hablar, a reconocer a la gente y a hacer muchas otras cosas. Los padres son a menudo los primeros en darse cuenta cuando su hijo no está aprendiendo o creciendo como los demás. Este folleto destaca lo que esperar de su hijo durante los tres primeros años de edad.

Por favor asegúrese de que su hijo reciba revisiones médicas cada tres meses durante el primer año y medio y después cada seis meses hasta los tres años.

Algunos niños y bebes pueden tener problemas en el desarrollo de ciertas aptitudes. Si a usted le preocupa alguna cosa de su bebé, llame a the Infant & Toddler Connection of Virginia al **1-800-234-1448**. Estamos aquí para ayudar. \*



## Importante para todos los bebés

Marque Si o No en cada pregunta.

- Si No ¿Su hijo/a va sentado en la sillita para niños siempre que va en carro?
- Si No ¿Acude habitualmente al mismo lugar para temas relacionados con la salud de su hijo/a (pediatra, médico de familia, sala de emergencia)?

## A continuación tiene una lista de acciones que los bebés son capaces de hacer a diferentes edades

### 3 A los 3 meses

- Si No ¿Su hijo/a sonríe cuando usted le sonríe, le habla o le acaricia la cara?
- Si No ¿Su hijo/a hace sonidos básicos como “ooh” o “aah”?
- Si No ¿Su hijo/a parece sorprendido cuando oye ruidos fuertes?
- Si No ¿Su hijo/a levanta la cabeza y el pecho cuando está boca abajo?
- Si No ¿Su hijo/a juega con las manos, juntándolas o metiéndoselas en la boca?
- Si No ¿Su hijo/a le mira cuando usted camina por la habitación?
- Si No ¿Su hijo/a ha ido al médico por lo menos dos veces para revisiones medicas?

# 6

## A los 6 meses

- Si No ¿Su hijo/a ríe y balbucea cosas como  
  “badaba” o “dadada”?
- Si No ¿Su hijo/a trata de explorar los juguetes  
  metiéndoselos en la boca?
- Si No ¿Cuándo está boca  
  arriba su hijo/a se  
 voltea boca abajo?
- Si No ¿Su hijo/a levanta  
  la cabeza y el  
 pecho cuando  
 está boca abajo?
- Si No ¿Su hijo/a gira la  
  cabeza hacia  
 sonidos como su  
 voz, la radio o la TV?
- Si No ¿Su hijo/a alcanza y  
  sostiene un juguete o lo intenta?
- Si No ¿Su hijo/a ha ido al médico por lo menos una  
  vez para una revisión medica desde los 3 meses?



# 12

## A los 12 meses (1 año de edad)

- Si No ¿Su hijo/a mira hacia objetos adecuados cuando usted  
  dice palabras como “botella”, “pelota” o “taza”?
- Si No ¿Su hijo/a se arrodilla y gatea?
- Si No ¿Su hijo/a dice “mama” o “papa” a la persona  
  adecuada?
- Si No ¿Su hijo/a encuentra un juguete cuando le ve  
  esconderlo?
- Si No ¿Su hijo/a juega a “cu-cu” o dice adiós con la mano  
  cuando ve que usted lo hace?
- Si No ¿Su hijo/a mira los dibujos de un libro?
- Si No ¿Su hijo/a da pasitos cuando se sujeta de algún  
  mueble?
- Si No ¿Su hijo/a sujeta comidas como cereal o uvas usando  
  el pulgar y otro dedo?
- Si No ¿Su hijo/a ha ido al médico al menos una vez para  
  una revisión medica desde que cumplió los 9 meses?

# 9

## A los 9 meses

- Si No ¿Su hijo/a se mantiene sentado por si mismo?
- Si No ¿Su hijo/a va a buscar un juguete cuando ve  
  que usted los ha dejado caer?
- Si No ¿Su hijo/a sostiene dos cosas al mismo  
  tiempo, una en cada mano?
- Si No ¿Su hijo/a se arrastra por el suelo o gatea?
- Si No ¿Su hijo/a se pone de pie apoyándose en  
  un mueble?
- Si No ¿Su hijo/a mueve la cabeza para decir “No”?
- Si No ¿Su hijo/a ha ido al médico al menos una  
  vez para una revisión medica, desde que  
 cumplió 6 meses?

# 15

## A los 15 meses

- Si No ¿Su hijo/a señala o pide las cosas que quiere?
- Si No ¿Su hijo/a come solo usando los dedos?
- Si No ¿Su hijo/a camina solo?
- Si No ¿Su hijo/a dice otras palabras además de “mamá”  
  o “papá”?
- Si No ¿Su hijo/a garabatea en un papel usando lápices  
  o lápices de cera?
- Si No ¿Su hijo/a ha ido al médico a la revisión de los  
  12 meses?

# 18

## A los 18 meses

- Si  No  ¿Su hijo/a sostiene un vaso y toma de él?
- Si  No  ¿Su hijo/a señala partes del cuerpo como "ojos", "nariz" y "boca" cuando usted las nombra?
- Si  No  ¿A su hijo/a le gusta poner cosas dentro y fuera de cajas?
- Si  No  ¿Su hijo/a utiliza palabras para decirle lo que quiere?
- Si  No  ¿A su hijo/a le gusta mirar los libros y pasar las páginas por si mismo?
- Si  No  ¿Su hijo/a ha ido al médico a la revisión de los 15 meses?

# 24

## A los 24 meses (2 años de edad)

- Si  No  ¿Su hijo/a apila cosas unas encima de las otras?
- Si  No  ¿Su hijo/a une palabras como "Zapato papá", "Vamos adiós" "Mira coche"?
- Si  No  ¿Su hijo/a señala los dibujos de un libro cuando usted los nombra?
- Si  No  ¿Su hijo/a se quita el suéter, los calcetines o el gorro por si mismo?
- Si  No  ¿Su hijo/a ha ido al médico para la revisión de los 18 meses?

**Mientras todos los bebés y niños aprenden a su propio ritmo, algunos de ellos pueden necesitar un poco de ayuda extra para desarrollar ciertas aptitudes.**

Si Usted. contesta "no" a una o más de estas preguntas, o si Usted. tiene otras preocupaciones sobre el desarrollo de su hijo o hija, ¡el Infant and Toddler Connection of Virginia esta aquí para ayudarle!

Por favor, llame gratis al número al revés de este folleto. La operadora le dará el nombre y número telefónico de alguien en su comunidad que le puede atender.

# 30

## A los 30 meses

- Si  No  ¿Su hijo/a sube las escaleras andando?
- Si  No  ¿Su hijo/a entiende peticiones simples como "Dame una galleta" o "Tráeme un lápiz"?
- Si  No  ¿Su hijo/a une tres palabras para formar una frase como, "Yo quiero zumo"?
- Si  No  ¿Su hijo/a hace una línea recta con un lápiz de cera o un lápiz después de que usted lo haga?
- Si  No  ¿Su hijo/a usa pronombres como "yo", "tu" y "mi"?
- Si  No  ¿Su hijo/a pasar las páginas de un libro una por una?
- Si  No  ¿Su hijo/a ha ido al médico a la revisión de los 24 meses?



# 36

## A los 36 meses (3 años de edad)

- Si  No  ¿Su hijo/a puede decir su propio nombre?
- Si  No  ¿Su hijo/a puede desabrochar botones?
- Si  No  ¿Su hijo/a puede saltar?
- Si  No  ¿Su hijo/a hace preguntas?
- Si  No  ¿Su hijo/a entiende palabras como "dentro", "fuera" y "detrás"?
- Si  No  ¿Su hijo/a sigue indicaciones de dos pasos como "Ve a tu habitación y tráeme el pañal"?



Infant & Toddler  
Connection of Virginia

**Cuanto antes, mejor.**

## Fun and Games with Songs

Singing together is learning together. Songs help your child connect words with their meanings. So, fill your house with songs and music. Here are some of the rhymes and songs that children love best. Learn the words, learn the motions, and sing along with your child.

### This Little Piggy

*(can be done on fingers or toes)*

This little piggy went to market.  
This little piggy stayed home.  
This little piggy had roast beef.  
This little piggy had none.  
And this little piggy cried,  
    "Wee, wee, wee!"  
All the way home.

*touch and wiggle thumb*  
*touch and wiggle index finger*  
*touch and wiggle middle finger*  
*touch and wiggle ring finger*  
  
*touch and wiggle pinky*

### The Itsy, Bitsy Spider

The itsy, bitsy spider  
Went up the water spout.  
Down came the rain  
And washed the spider out.

*put finger to opposite thumb and pretend to crawl up*  
*wiggle fingers from top of "spout" down to lap*  
*move hands/arms across lap;*  
*ie, motion of safe in a baseball game*  
*move hands in large circles to show sun coming out*

Out came the sun  
And dried up all the rain.  
And the itsy, bitsy spider  
Went up the spout again.

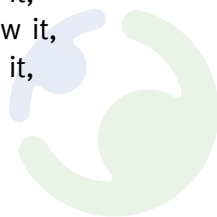
*show spider again going up*

### If You're Happy and You Know It

If you're happy and you know it,  
Clap your hands.  
If you're happy and you know it,  
Clap your hands.  
If you're happy and you know it,  
Then your face will surely show it,  
If you're happy and you know it,  
Clap your hands.

*Suggestions for other verses:*

*stamp your feet*  
*pat your legs*  
*wiggle your ears*



Civitas thanks **Parents as Teachers**, an international early childhood parent education and family support program, for their ongoing support.

## Fun and Games with Songs, page 2

### Teapot

I'm a little teapot, short and stout.  
Here is my handle, here is my spout.

*bend knees*  
*put hand on hip with elbow out;*  
*the other hand should go out to be a spout*

When I get all steamed up,  
Hear me shout,  
“Tip me over and pour me out.”

*pretend to tip over*

### The Wheels on the Bus

The wheels on the bus go round and round,  
Round and round, round and round.  
The wheels on the bus go round and round,  
All through the town.

*bend your arms and make them go around like wheels*

The people on the bus go up and down,  
Up and down, up and down.  
The people on the bus go up and down,  
All through the town.

*sit up and down*

#### Other verses:

The wipers on the bus go swish, swish, swish.

*use your hands as wipers back and forth*

The horn on the bus goes beep, beep, beep.

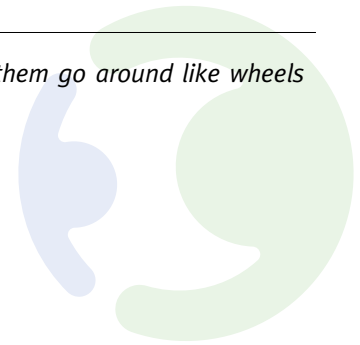
*pretend to beep a horn*

The money on the bus goes clink, clink, clink.

*pretend to put money in*

The driver on the bus says, “Move on back.”

*hand-motion your thumb over your shoulder*  
*to move on back*



*Born Learning*<sup>SM</sup> is a public engagement campaign helping parents, caregivers and communities create early learning opportunities for young children. Designed to support you in your critical role as a child's first teacher, *Born Learning* educational materials are made available through the efforts of United Way, United Way Success By 6 and Civitas. For more information, visit us online at [www.bornlearning.org](http://www.bornlearning.org).



This Civitas tool was adapted for the *Born Learning* campaign. © 2006 Civitas  
PT/E/0506



# Kindergarten Transitions

## Ready

### September, October, November

- ✓ Poll parents of pre-kindergarten children to determine each child's elementary school
- ✓ Distribute articles or information on kindergarten readiness to parents (*readiness is not just academic see **Ready for Kindergarten?** article*)
- ✓ Complete **Fall Kindergarten Readiness Skills Checklist**
- ✓ Host family event viewing the **Ideas to Grow On DVD** (*invite a principal and/or kindergarten teacher to this event*)
- ✓ Distribute the *Family Tip Sheet* from the **Ideas to Grow On DVD**

## Set

### December, January, February

- ✓ Contact a local school principal to schedule a field trip to visit the school in the spring
- ✓ Complete **Winter Kindergarten Readiness Skills Checklist**
- ✓ Contact school to complete *Parent Letter #1* and distribute it 2 months before registration (*provides information about kindergarten requirements/upcoming registration dates*)
- ✓ Host family event viewing the **All Set for School DVD**
- ✓ Distribute the *Family Tip Sheet* from the **All Set for School DVD**
- ✓ Start decreasing the amount of nap time for pre-kindergarten children (*most kindergarten schedules allow children to rest for about 20 minutes*)

## Go!

### March, April, May

- ✓ Add books to your classroom library about going to kindergarten
- ✓ Complete **Spring Kindergarten Readiness Skills Checklist**
- ✓ Distribute *Parent Letter #2* (*one to two weeks before kindergarten registration*)
- ✓ Show the **Making the Move to Kindergarten DVD** to pre-kindergarten class before the field trip to the elementary school
- ✓ Distribute the *Family Tip Sheet* from the **Making the Move to Kindergarten DVD**
- ✓ Take a field trip to the local school using the guide from the **Ready, Set, Go!** Electronic Tool Kit CD under **Making the Move to Kindergarten**

### June, July, August

- ✓ Participate in the Summer Reading Program at your local library
- ✓ Have local elementary school supply lists available for parents
- ✓ Encourage parents to include their child when purchasing back-to-school supplies
- ✓ Encourage families to visit the elementary school before school starts, including attending open houses and/or orientation
- ✓ Encourage parents to bring their child's portfolio with them when they meet their child's kindergarten teacher
- ✓ Show the **Making the Move to Kindergarten DVD** again a few days before school starts

Use this guide to implement a kindergarten transition plan to support children and families in your early childhood program. The DVD's and CD used in this plan are from **Ready, Set, Go! Your Go-To Guide for Kindergarten Transitions**. They can be purchased at [www.readysetk.org](http://www.readysetk.org).

If you have questions about this plan, contact Mickie McInnis, Early Childhood Program Consultant, at 804-874-8195 or [mickie.mcinnis@comcast.net](mailto:mickie.mcinnis@comcast.net).

## Kindergarten Readiness Skills Checklist

Child's Name \_\_\_\_\_

Child's date of birth \_\_\_\_\_

This checklist details a variety of skills and knowledge that are essential in assisting four- and five-year-olds as they transition to kindergarten. Complete this checklist by making notes from observing the child as he/she plays with peers and in learning centers. Sample pieces of artwork, writing samples and written anecdotes are other good ways to document a child's knowledge or skill development.

To complete questions 24 and 31, ask the child to write his/her name and draw a picture of a person on a separate piece of paper.

**C**=Consistently able to share knowledge or demonstrate skill    **P**=Progressing in this area  
**Leave blank** if not yet observed.

Personal Development	Fall	Winter	Spring	Date skill/knowledge observed, comments
States full name.				
States address.				
States telephone number.				
States parent's/guardian's names.				
States age or birth date.				
Separates easily from parents/caregivers.				
Recognizes and expresses own emotions by using words rather than actions.				
Goes to the bathroom independently.				
Interacts appropriately with other children and familiar adults by cooperating, helping, sharing and expressing interest.				
Personal Development	Fall	Winter	Spring	Date skill/knowledge observed, comments
Shows interest and curiosity in learning new concepts and trying new activities and experiences.				
Developing positive responses to challenges while working independently and/or cooperatively to solve problems.				
Physical and Motor Development	Fall	Winter	Spring	Date skill/knowledge observed, comments
Demonstrates progress in performing selected locomotor skills such as jumping, hopping, galloping, and skipping.				

Demonstrates mature forms of walking, running; walks up and down stairs.				
Manipulates small objects using one hand independently, the other hand independently, and both hands working together on the same task; uses large plastic nuts and bolts, cuts with safety scissors.				
Holds and uses pencils, crayons, or markers using a three finger grasp, not in a fist.				
<b>Literacy/Language</b>	<b>Fall</b>	<b>Winter</b>	<b>Spring</b>	<b>Date skill/knowledge observed, comments</b>
Speech is clear, easily understood by adults and peers.				
Uses appropriate language for a variety of purposes, e.g., while asking questions, expressing needs, getting information.				
Follows simple, one-step oral direction.				
Identifies words that rhyme, completes simple rhyming pairs, e.g., ball–tall, cat–bat.				
Identifies 10-18 alphabet (uppercase) letters by name in random order.				
<b>Literacy/Language</b>	<b>Fall</b>	<b>Winter</b>	<b>Spring</b>	<b>Date skill/knowledge observed, comments</b>
Selects a letter to represent a sound (8-10 letters), e.g., s-snake, t-tree.				
Demonstrates directionality of reading left to right on a page.				
Prints first name independently with recognizable letters.				
<b>Mathematics</b>	<b>Fall</b>	<b>Winter</b>	<b>Spring</b>	<b>Date skill/knowledge observed, comments</b>
Counts to 20 or more.				
Describes changes in groups (sets/collections) by combining or separating groups, e.g., using counting bears, adding and taking away amounts.				
Recognizes attributes of length by using terms longer and shorter when comparing objects.				
Recognizes shapes (circle, square, rectangle, triangle) by pointing to appropriate figure when asked the names of the shape.				
Sorts and classifies objects according to one to two attributes (color, size, shape and texture).				

Science	Fall	Winter	Spring	Date skill/knowledge observed, comments
Identifies the body parts that correspond with each of the five senses, e.g., nose – smell, eyes-sight.				
Identifies colors (red, orange, yellow, green, blue, purple, brown) and black and white.				
Describes home and school/child care routines.				
History and Social Science	Fall	Winter	Spring	Date skill/knowledge observed, comments
Draws a picture of a person.				
Engages in pretend play to understand self and others.				
Expresses the difference between past and present using words such as before, after, now and then.				
Uses words to describe features of locations in the environment and man made structures found in stories and seen in everyday experiences, e.g., farm, school, grocery store.				
Identifies pictures of work and name of jobs people do, e.g., doctor, fireman, teacher.				
Demonstrates responsible behaviors in caring for classroom materials.				

Every four months, schedule a time to meet with the parent/guardian to review the child’s progress. Together, discuss/ plan/share activities the program and the parent/guardian can do to support the child’s growth and development.

Fall Review with Parents/Guardian	Name of person completing this checklist: _____
Skills we will focus on for the next couple of months.  	
Things to work on at home.  	
Date reviewed with parents: _____	Comments:  

Winter/Spring Review with Parents/Guardian	Name of person completing this checklist: _____
Skills we will focus on for the next couple of months.	
Things to work on at home.	
_____	Comments:
Date reviewed with parents:	
Spring/Summer Review with Parents/Guardian	Name of person completing this checklist: _____
Skills we will focus on for the next couple of months.	
Things to work on at home.	
_____	Comments:
Date reviewed with parents:	

Note: Every child develops at a different rate and not all children will master all of the skills listed before he/she enters kindergarten. For a complete list of standards for four-year-olds, review Virginia's Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds, Virginia Department of Education, 2007, [www.doe.virginia.gov/instruction/early\\_childhood/preschool\\_initiative/foundationblocks.pdf](http://www.doe.virginia.gov/instruction/early_childhood/preschool_initiative/foundationblocks.pdf).

## Sample Letter to Parents – Parent Letter #1 to be sent out in late winter or early spring

IMPORTANT! - The information in the curly brackets {} is information that you need to provide and is determined by the child's county of residence and that county's kindergarten registration dates and times.

{Current Date}

Dear {Parent's Name}:

On **{Registration Date}** from {time (ex. 9am – 7pm)}, {County of Residence} County will conduct kindergarten registration for the {Upcoming School Year} school year.

Kindergarten registration will be held at the elementary school that your child will attend in the fall. If you are unsure of which elementary school your child will attend, call {County School System Phone Number}. You can also access this information online at {County School System web address}.

You will need to bring the following information to registration:

- 1) Certified copy of the child's birth certificate
- 2) Child's Social Security number
- 3) Proof of county residency by providing one of these documents:
  - lease for at least one year or deed of a residence or property in {County of Residence} County
  - contract or lease free of contingencies to occupy a {County of Residence} residence within two months of the date of enrollment
  - manager's letter on company letterhead stating that the residence is a corporate residence in {County of Residence} County
  - weekly receipts for temporary residence in a hotel or motel for up to 60 days (requires renewal or evidence of more permanent residency within 60 days of enrollment)
- 4) School Entrance Health Form completed by a licensed medical provider.
  - Part I – Health Information Form
  - Part II – Certification of Immunization
  - Part III – Comprehensive Physical Examination Report completed within the twelve months prior to the date the child first enters kindergarten
- 5) Photo ID of parent or legal guardian

Start compiling all of this information now because if needed, it could take several weeks to schedule a doctor's appointment or receive your child's birth certificate or social security card.

Here is a checklist to help you as you collect important information and the documents needed for registration.



## Sample Letter to Parents – Parent Letter #1 to be sent out in late winter or early spring

IMPORTANT! - The information in the curly brackets {} is information that you need to provide and is determined by the child's county of residence and that county's kindergarten registration dates and times.

### Family Checklist:

1. Elementary School Name: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. Telephone Number: \_\_\_\_\_
4. Principal's Name: \_\_\_\_\_
5. Place a check mark by each document when you have it ready to take with you to registration.
  - Child's birth certificate
  - Child's social security card
  - Student Health Form (immunization and physical record completed by a doctor)
  - Proof of current address

***Your child is not registered for school until all of the documentation is submitted.***

Registering on {Registration Date} allows schools time to make plans for purchasing classroom books and materials; and determining class sizes to ensure the appropriate number of trained teachers is in place to support incoming kindergartners.

If you have any questions or if I can assist you with registration, please let me know.

Sincerely,

**{Provider's Signature}**  
**{Provider's Name}**

**Sample Letter to Parents – Parent Letter #2 to be sent out a few weeks before Kindergarten Registration begins.**

IMPORTANT! - The information in the curly brackets {} is information that you need to provide and is determined by the child's county of residence and that county's kindergarten registration dates and times.

{Current Date}

Dear {Parent's Name}:

Please plan to attend kindergarten registration on {Registration Date}, with your child between the hours of {time (ex. 9am to 7pm)}.

You will need to bring the following information to registration:

- 1) Certified copy of the child's birth certificate
- 2) Child's Social Security number
- 3) Proof of county residency by providing one of these documents:
  - o lease for at least one year or deed of a residence or property in {County of Residence} County
  - o contract or lease free of contingencies to occupy a {County of Residence} residence within two months of the date of enrollment
  - o manager's letter on company letterhead stating that the residence is a corporate residence in {County of Residence} County
  - o weekly receipts for temporary residence in a hotel or motel for up to 60 days (requires renewal or evidence of more permanent residency within 60 days of enrollment)
- 4) School Entrance Health Form completed by a licensed medical provider.
  - o Part I – Health Information Form
  - o Part II – Certification of Immunization
  - o Part III – Comprehensive Physical Examination Report completed within the twelve months prior to the date the child first enters kindergarten \*\*
- 5) Photo ID for parent or legal guardian

Along with those documents, write down the following information and bring it with you to registration to help as you complete the registration forms.

- 1) Contact information for the child's parents, including names, complete home and employer addresses, and all telephone numbers where the parents can be reached during school hours.
- 2) Emergency contact information of two people (other than the parents) that the school can contact in case the parents cannot be reached. Include name, complete home addresses, employer addresses and all telephone numbers where contacts can be reached during school hours.
- 3) Name and telephone number of child's physician.

**Remember:** Your child is **not** registered for school until all of the documentation is turned into the elementary school.

If you have any questions or if I can assist you with completing the registration materials, please let me know.

Sincerely,

{Provider's Signature}  
{Provider's Name}

## What is Early Learning?

Research on the development of young children, including their brain development, creates a great deal of interest in early learning, with many positive, but also some negative, repercussions.

On the positive side, studies show that more and more Americans understand that “real” learning doesn’t “wait” until children enter school. The early years are critically important learning years.

On the negative side, interest in early learning sometimes strays far away from the science, leading to some misconceptions:

### **Misconception: Children *begin* learning from the moment of birth on.**

**Science says: Children are born learning and this learning begins even before birth.** Studies in neuroscience by Dr. Charles Nelson of Harvard Medical School, for example, reveal that at birth, a child’s brain patterns are different when hearing a “known” voice (the voice of his or her mother because the child has heard this voice in utero) from the voice of a stranger. Learning is one of the most important human survival skills and all children are born learning.

*Young children from the beginning cannot help but learn—they don’t have to be taught to learn, they are naturally wired up to learn. From the very beginning, children are learning about the world. They are also learning about what learning is about. So everything that is going on is a learning experience.*

Jack P. Shonkoff, MD  
Samuel F. and Rose B. Gingold Professor of Human Development and Social Policy  
Former Dean, Heller School for Social Policy and Management  
Brandeis University

### **Misconception: Children are empty vessels or blank slates to be filled with knowledge.**

**Science says: Children are active learners and the more involved they are in their own learning, the better they learn.** Children’s powerful drive to learn is based on their need to make sense of the world and understand their own experiences. Some researchers have compared children’s learning to that of scientists—children try to figure out what is happening to them and what effect they have on others by testing their ideas and theories, discarding those that don’t fit their experience and building on those that do.

*We used to think of learning as information that you shoved into a vessel and then glued the vessel shut and you would study retention over time, as though learning were the accumulation of facts. Everything we know now about learning says that learning is a moveable, living, vibrating*

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*construct—a set of categories, a set of beliefs, principles in which you are trying to make sense of the universe.*

Patricia K. Kuhl, PhD  
Professor of Speech and Hearing Sciences  
Co-Director, Institute for Learning and Brain Sciences  
University of Washington

*If you think about it, scientists learn mostly the same way children are learning. The way [scien-  
tists] have to learn is by really being driven and going out and trying lots of things, and doing lots  
of experiments and having lots of fun doing it. And then we try to make sense of what we find out.  
And that seems to be the same... literally, the same processes that are involved with children.*

Alison Gopnik, DPhil  
Professor of Psychology  
Institute of Cognitive Science  
University of California, Berkeley

### **Misconception: Social, emotional and intellectual learning are separate, and intellectual or cognitive learning is most important.**

**Science says: Although adults talk about social, emotional and intellectual learning as being different, studies show they are completely interconnected.** Children learn through their important relationships (social learning); they learn when they feel good and are engaged and motivated in what they are learning (emotional learning); and they learn when they are making sense of their world (intellectual learning). One type of learning (such as learning numbers, letters or the like) is not more important than another, since for children to learn—social, emotional and intellectual (SEI) learning all go together.

*The brain is an interdisciplinary device. You can think of language, cognition and social/emotional development as being totally separate, but that is not what the baby provides evidence of. The baby is trying to map how people work, how the world works, and they're doing that as a composite. It's a multimedia event—that's what the world is and the brain maps it as a multimedia event, not separately.*

Patricia K. Kuhl, PhD  
Professor of Speech and Hearing Sciences  
Co-Director, Institute for Learning and Brain Sciences  
University of Washington

*Research tells us that children who make friends easily in kindergarten and are accepted by their classmates are also the ones who work hard in a self-directed way that fosters their academic competence.*

Kathryn A. Hirsh-Pasek, PhD  
Professor of Psychology  
Director, Infant Language Laboratory  
Temple University  
Roberta M. Golinkoff, PhD  
H. Rodney Sharp Professor, School of Education  
Director, Infant Language Project  
University of Delaware



### Misconception: The adult’s role is to “teach” children, making every moment a teaching moment.

**Science says: The adult’s role is to encourage and increase children’s engagement in learning.** The public has been told to read, sing and talk to their children, making every moment a teaching moment. While reading, talking and singing to children are truly important, *how* these activities happen are what’s most important. Adults who bombard children with factual information—like colors or numbers or letters—every moment or who feel that they must entertain children non-stop, are likely to over-stimulate and turn children away from learning, just as much as if they criticize or ignore children’s engagement in learning.

*The motivation to learn comes from the pleasure in learning, the joy in learning. When learning becomes a duty, the child rebels against it or gets bored with it.*

Alicia F. Lieberman, PhD  
The Johns Hopkins University Professor of Medical Psychology  
University of California, San Francisco  
Director, Child Trauma Research Project and Senior Psychologist, Infant-Parent Program  
San Francisco General Hospital

There are, of course, times when direct teaching is crucial. Children do need to learn factual information, colors and numbers and letters. But again, *how* direct teaching occurs is what is most important. At best, direct teaching should be engaging, should build on children’s interests and should extend their learning.

### Principles of Early Learning

Children, like adults, need quiet, “hang around” times and active times to explore, reflect, imagine and learn.

*We’ve learned that you can’t be connected all the time.*

Edward Z. Tronick, PhD  
Chief, Child Development Unit, Children’s Hospital of Boston  
Associate Professor of Pediatrics, Harvard Medical School

Learning for young children should focus on the here and now—as a way of interacting with the world, not just on what learning can do for children in the future. As an early childhood teacher recently said, “Childhood is a journey, not a race.”

*You know, in early childhood there’s always this concept of readiness—they are getting ready for the next thing. They’re getting ready for learning. Well, frankly, they are doing it in the moment. They are in the moment of learning—that’s what is important.*

Suzanne C. Carothers, PhD  
Professor, Department of Teaching and Learning  
The Steinhardt School of Education  
New York University

Learning should be about the child, not about the adult keeping up with other people’s children or proving herself or himself as a perfect parent or caregiver.

Learning should help your child understand his or her experiences, not fill their heads with facts through “drill and kill.” And when children are actively involved in what they are learning in a hands-on way, they remember more.

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*It isn't enough to just tell them [children] what the answer is, they have to in some sense recreate or create that answer for themselves. And that seems to be the fundamental process that's involved in learning.*

Alison Gopnik, PhD  
Professor of Psychology  
Institute of Cognitive Science  
University of California, Berkeley

Learning should include joy. If learning is engaging, children will be motivated to keep learning in the same way that we learn best when the learning is motivating and meaningful. This does not mean that children should not face challenges. That's what learning is all about! The important message is to encourage children's natural drive to overcome challenges.

You can't stop a young child from learning to talk or walk. Nor can you keep a young child from observing what happens when she or he throws something on the floor or experimenting with peek-a-boo and hide-and-seek to understand what happens when things disappear and reappear. Children are born engaged in learning. And adults can either keep this engagement in learning alive or shut it down.

Studies across different scientific fields show that young children are most likely to learn:

- when they are interested and actively engaged;
- when they are connected to the significant adults in their lives; and
- when the adult *follows the child's lead*, extending, elaborating and building what the child is working on.

#### The best ways to promote early learning are to:

- **Connect**—relationships are the “engine of development.” This connection needs to be authentic. We need to connect with children as the people we are, as their family members or caregivers, not in a “role” of super teacher.

*Relationships give a child confidence to go out and explore the world.*

Ross A. Thompson, PhD  
Professor of Psychology  
University of California, Davis

*There is no development without relationships.*

Jack P. Shonkoff, MD  
Samuel F. and Rose B. Ginzburg Professor of Human Development and Social Policy  
Former Dean, Heller School for Social Policy and Management  
Brandeis University

- **Watch and listen**—Look: understanding what children are trying to understand, figure out and do is essential to promoting their learning. See the world through their eyes and notice what they are curious about and are trying to learn and do.
- **Extend**—Furthering children's inquiries and building on their interests are the keys to maintaining their engagement in learning. We all learn more when we are learning something that we care about learning.





*I think every parent, every scientist, every early childhood educator who has looked at a young child sees that curiosity, that wonder and asks themselves, “What can we do to keep this alive in a child, to foster it, to fan the flames of that curiosity—not to dampen them?”*

Andrew N. Meltzoff, PhD  
Job and Gertrud Tamaki Endowed Chair  
Professor of Psychology  
Co-Director, Institute for Learning and Brain Sciences  
University of Washington

*The hope is that parents [and caregivers] will be so excited themselves about learning and teaching that the child will carry that inside of him when he goes into the world on his own.*

Alicia F. Lieberman, PhD  
The Johns Hopkins University Professor of Medical Psychology  
University of California, San Francisco  
Director, Child Trauma Research Project and Senior Psychologist, Infant-Parent Program  
San Francisco General Hospital

**Does this mean that adults don’t “teach?” Of course not.** There are many things that adults need to teach children—from notions like “stoves are hot” and “you can’t hurt your sister” to counting, sorting or learning to read. But keeping children engaged in learning requires a balance between direct teaching and following children’s lead to extend their interests. And we often teach best by example than through directives.

**Does this mean that learning and teaching must always be serious? No.** Being curious and learning about the world should be engaging for you as well as your child.

**Does this mean that learning shouldn’t be challenging? Not at all.** If you watch young children learn, they are always overcoming challenges, such as learning to stand even though they are teetering or learning to walk, talk or roller skate. It is important that adults not try to “fix” problems and make everything too easy, but to acknowledge children’s efforts and provide support when they are trying to do something hard.

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The Procter & Gamble Company  
The Prudential Foundation  
The Robert Wood Johnson Foundation  
Vivendi Universal

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Chapter 5  
**Resources**



# Chapter 5: Resources

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There are resources available for family child care homes, but no easy way to find them all. Although many resources are shared throughout the toolkit, this section includes resources that may have not been previously mentioned. Please note that this is not meant to be an all inclusive list and inclusion of a resource in the toolkit does not indicate quality of service.

## Program Management Resources

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Family child care providers are not only responsible for caring for children, but also responsible for running a small business. Resources available to assist family child care providers in running a successful business include:

### *A Place of Our Own*

A Place of Our Own supports child care providers by recognizing the importance of their role in the way children learn and develop. The series also responds to the needs and workplace realities of people who spend their days caring for children by including topics such as building partnerships with families, reducing stress and completing paperwork. A Place of Our Own is accompanied by comprehensive educational outreach and workforce development plans aimed at expanding the capacity and capabilities of child care providers. When visiting their website you will find resources, activities, and an episode guide. To learn more about this resource or to view previously aired topics visit: [www.aplaceofourown.org/index.php](http://www.aplaceofourown.org/index.php).

### *Business Administration Scale for Family Child Care*

The Business Administration Scale for Family Child Care by Teri N. Talan and Paula Jorde Bloom is designed for family child care providers as a self-improvement tool and for those working with provider's technical assistance and training. The tool is intended to help improve the quality of family child care professional and business practices. Research on family child care indicates that providers who utilize effective professional and business practices are more likely to view family child care as a career.

### *Aspects of business administration assessed by this scale include:*

- Qualifications and Professional Development
- Income and Benefits
- Work Environment
- Fiscal Management
- Recordkeeping
- Risk Management
- Provider-Parent Communication
- Community Resources
- Marketing and Public Relations

### *Redleaf Press Institute*

Since 1971, Redleaf Press Institute has been committed to making child care the best that it can be. Family child care providers can find business-related training, telephone and e-mail support, IRS audit representation, publications, and advocacy by visiting the Business of Child Care section of the website, which is [www.resourcesforchildcaring.org](http://www.resourcesforchildcaring.org).

### *Tom Copeland*

Tom Copeland's Taking Care of Business blog is about running a family child care home with a focus on the business aspects, including record keeping, taxes, contracts, legal issues, insurance, money management and retirement planning. Mr. Copeland has long been considered the family child care guru and is well respected in the family child care community. Tom Copeland's blog can be found at [www.tomcopelandblog.com](http://www.tomcopelandblog.com).

## Resources to Share with Families

Children are not born with a “how to” manual. Families often look to their family child care provider for advice and help in finding community resources. Below are several resources that may help parents and families.

### 1-800-CHILDREN

1-800-CHILDREN is a toll free, statewide helpline that is available Monday through Saturday from 8:00 a.m. to 9:00 p.m. Experienced professionals offer a listening ear and can answer questions about a child’s development and behavior, parenting and other topics.

### 2-1-1 Virginia

Whether you need help or want to provide help, 2-1-1 is the fast, free and confidential way to locate hundreds of services in your community. When you dial 2-1-1, you will be connected to a trained professional, who can provide referrals to health and human services, including:

- **Basic human needs:** food banks, shelters, rent or utility assistance
- **Physical and mental health resources:** Medicaid, Medicare, pre-natal care, children’s health insurance programs, crisis intervention, support groups, counseling, alcohol and drug rehabilitation
- **Work initiatives:** educational and vocational training programs, English as a second language classes, job training, General Educational Development (GED) preparation, financial and transportation assistance
- **Support for seniors and those needing respite care, home health care, transportation and recreation disabilities:** Area Agencies on Aging, independent living centers, adult day care, meals at home, respite care, home health care, transportation and recreation
- **Support for children, youth and families:** After-school programs, tutoring, mentorship programs, family resource centers, protective services, counseling, early childhood learning programs, child care referral centers, and recreation
- **Volunteering in your community:** Volunteer centers, mentorship opportunities, locations to donate food, clothing, furniture, computers and other items

You can access 2-1-1 by dialing 2-1-1 or visiting their website at [www.211virginia.org](http://www.211virginia.org).

### Born Learning

Born Learning educational resources make it simple and easy for parents, grandparents, caregivers and professional child care providers to turn everyday experiences into learning experiences. The material educates parents on how to make learning fun. Parents and caregivers of young children understand that the early years are important, yet many aren’t sure how to encourage early learning, or feel they don’t have time to do what it takes to help their child succeed in school. For more information about Born Learning and to access the free educational resources for families and communities, visit [www.bornlearning.org](http://www.bornlearning.org).

### Child Day Care Assistance for Parents

This program provides funding to enhance the quality, affordability, and supply of child care available to Virginia’s families. Child care services are child-centered, family-focused services that support the family goals of economic self-sufficiency and child development by providing for the supervision, protection, and well-being of a child while the parent is participating in an approved activity. Toward this end, policies and service strategies are designed to meet the following goals:

- Provide low-income families with the financial resources to find and afford quality child care for their children
- Ensure that the family child care program contributes to the broader objective of self-sufficiency by providing child care to parents trying to achieve independence from public assistance
- Promote parental choice in the selection of child care. To empower working parents to make their own decisions on the child care that best suits their family’s needs
- Provide consumer education to help parents make informed choices about child care
- Ensure that subsidy dollars are provided to the neediest families
- Enhance the quality and increase the supply of child care for all families.
- Improve coordination among child care programs and early childhood development programs



Families should contact the Department of Social Services in their locality for more information. To access a complete list of the local offices visit [www.dss.virginia.gov/localagency/](http://www.dss.virginia.gov/localagency/).

### ***Circle of Inclusion***

The Circle of Inclusion website is for early childhood service providers and families of young children. This website offers demonstrations of and information about the effective practices of inclusive educational programs for children from birth through age eight, [www.circleofinclusion.org](http://www.circleofinclusion.org)

### ***Disability Organizations***

The following websites provide information for specific disabilities as indicated.

American Academy of Child and Adolescent Psychiatry, [www.aacap.org](http://www.aacap.org)

American Foundation for the Blind, [www.afb.org](http://www.afb.org)

American Society for Deaf Children, [www.deafchildren.org](http://www.deafchildren.org)

Autism Society of America, [www.autism-society.org](http://www.autism-society.org)

Brain Injury Association of Virginia, [www.biav.net](http://www.biav.net)

Children and Adults with Attention Deficit Disorder, [www.CHADD.org](http://www.CHADD.org)

Epilepsy Foundation, [www.epilepsyfoundation.org](http://www.epilepsyfoundation.org)

Learning Disabilities Association of Virginia, [www.ldavirginia.org](http://www.ldavirginia.org)

Muscular Dystrophy Association, [www.mdausa.org](http://www.mdausa.org)

National Alliance on Mental Illness Virginia, [www.namivirginia.org](http://www.namivirginia.org)

National Down Syndrome Society, [www.ndsccenter.org](http://www.ndsccenter.org)

Speech-Language-Hearing Association of Virginia, [www.shav.org](http://www.shav.org)

Spina Bifida Association, [www.spinabifidaassociation.org](http://www.spinabifidaassociation.org)

The Arc for People with Intellectual and Developmental Disabilities, [www.thearc.org](http://www.thearc.org)

United Cerebral Palsy, [www.ucp.org](http://www.ucp.org)

### ***National Information Center for Children and Youth with Disabilities (NICHCY)***

NICHCY is the national information and referral center that provides information on disabilities and disability related issues for families, educators, and other professionals. NICHCY serves as a central source of information on disabilities in infants, toddlers, children, and youth. NICHCY also provides information on the Individuals with Disabilities Education Act (IDEA), the law authorizing early intervention services and special education. Visit their website for more information, <http://nichcy.org/>

### ***Virginia Home Visiting Programs***

Home visiting programs offer a variety of family-focused services to expectant parents and families with new babies and young children. Programs address issues such as maternal and child health, positive parenting practices, safe home environments, and access to services. Home visiting programs vary by locality, if you think a family might benefit from this resource visit <http://homevisitingva.com/> to find contact information for home visiting programs in your area.

### ***Zero to Three***

Zero to Three is a national, nonprofit organization that informs, trains, and supports professionals, policymakers, and parents in their efforts to improve the lives of infants and toddlers. Their mission is to promote the health and development of infants and toddlers. On the Zero to Three website you will find information, interactive tools, parent handouts, charts, Tip Sheets, FAQ's, articles, and powerpoint slideshows all designed to help you in supporting and nurturing the health and development of babies and toddlers. Visit their website for more information, [www.zerotothree.org](http://www.zerotothree.org).

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