



# Child Care Health Connections

A health and safety newsletter for California child care professionals

Published by the California Childcare Health Program (CCHP),  
a program of the University of California, San Francisco School of Nursing (UCSF)

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## Health and Safety Tip

Studies have shown that contrary to the common belief that “exposure to cold air causes a cold,” fresh air is good and healthy. When children and adults spend a long time together in indoor spaces that are small, overheated and poorly ventilated, germs and illnesses pass easily from one person to another. In fresh, outdoor air, children do not have to rebreathe the germs of the group, and the chance for spreading infection is reduced.

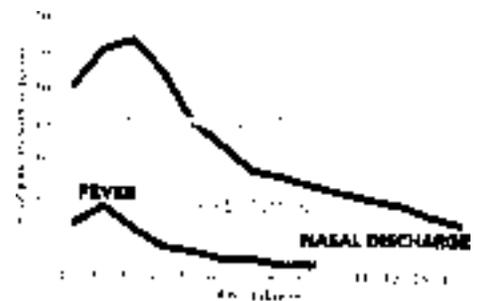
Children of all ages enjoy and benefit from playing outdoors in all except the most extreme weather. Daily outdoor play is healthy and burns energy. Even children who are mildly ill but active should go outside if the weather is not severe. Staff and children alike will feel refreshed when fresh air is part of the daily routine. Taking children outdoors daily, even in winter, can be a healthy part of their schedule, and is safe when clothing is appropriate. So bundle those children up and take them outside to play! You’ll all feel better. ♦



## Sick Season Is Here

by Judy Calder, RN, MS

Rates of illness in child care peak in January and February, with respiratory illnesses such as colds and flu topping the list. Respiratory illnesses can also bring complications such as ear infections, bronchitis, pneumonia, sinus infections and asthma. With lots of sick children on your hands, sometimes it’s hard to know when a cold is normal and does not require exclusion and when exclusion is necessary. Understanding the normal course of colds and flu and when they are contagious helps parents and child care providers make the best decisions on how to manage these common illnesses.



As the chart above describes, typical cold and flu symptoms can last two weeks or more. And when children catch another virus soon after the first, their runny nose may seem to last all winter. Since the average child in child care programs has more than six colds per year, and working families can’t afford to keep their children at home for weeks at a time, it pays to learn all you can about managing colds and flu in a child care setting. Your first line of defense is always proper hand washing and hygiene, but knowing which children are too ill to attend care is also important.

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## Child Care Health Connections®

*Child Care Health Connections* is a bimonthly newsletter published by the California Childcare Health Program (CCHP), a community-based program of the University of California, San Francisco School of Nursing Department of Family Health Care Nursing. The goals of the newsletter are to promote and support a healthy and safe environment for all children in child care reflecting the state's diversity; to recreate linkages and promote collaboration among health and safety and child care professionals; and to be guided by the most up-to-date knowledge of the best practices and concepts of health, wellness and safety.

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Information provided in *Child Care Health Connections* is intended to supplement, not replace, medical advice.

### Visit us on the Web:

[www.ucsfchildcarehealth.org](http://www.ucsfchildcarehealth.org)

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## ASK THE NURSE...

### Infant Feeding: When to Introduce New Foods



by Judith Calder, RN, MS

**Q:** I'm a family child care provider and a parent wants me to give her 5-month-old scrambled eggs for breakfast. That seems too early to me. How should I handle this?

**A:** You are right to be concerned; it is too early to start eggs. To seek guidance on this topic you can look to several sources, beginning with the Healthline at (800) 333-3212 and the Community Care Licensing regulations. There is no mention of infant feeding in the family child care regulations, but the regulations for infant centers provide some excellent guidelines and are based on the American Academy of Pediatrics recommendations:

Birth – 12 months	breast milk or iron fortified formula
At 4-6 months	infant cereal
At 5-7 months	vegetables, fruits and their juices
At 6-8 months	protein foods (cheese, yogurt; cooked beans, meat, fish, and chicken; egg yolk
At 10-12 months	whole egg

Food introduction guidelines have changed over the years. It is now believed that introducing foods too early can trigger food allergies or intolerance. An infant's capacity to digest complex protein foods such as eggs may not be fully developed. I'm concerned that the parent may not have a good source of information and probably needs to discuss nutrition and feeding at her next visit to the child's health care provider, which should occur at 6 months of age. I would encourage the parent to avoid introducing eggs until that visit and advise her to discuss nutrition and feeding. I would also ask the parent for a note from her doctor if the mother still wants to introduce eggs into the infant's diet.

Another source of information on proper nutrition for young children is the Women, Infants and Children (WIC) program, which you can locate through your local health department. They have excellent nutrition information materials in several languages which you can request and pass on to parents. You can find their phone number in the county listings in your phone book. As a child care provider you can also join the Child Care Food Program by calling California Nutrition Services at (800) 952-5609. This program provides financial aid and education to licensed child care centers and family child care homes to improve nutrition and eating habits for young children. ♦

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**Never fear spoiling children by making them too happy. Happiness is the atmosphere in which all good affections grow.**

—Thomas Bray

## Effective Ways to Guide Toddlers' Behavior

by Mardi Lucich, MAEd



Time-outs are a common way to discipline children, but they are not recommended for children younger than age 3 because most toddlers cannot truly make the connections among the behavior that was unacceptable, why it was wrong and why they are sitting separate from the others. Wondering how best to guide toddlers' behavior? Here are some alternative and effective strategies.

### Watch carefully and intervene before a problem occurs

- Redirect a child who is in pursuit of another's toy or having difficulty taking turns by leading her to another area with interesting toys and activities.
- Redirect a child who is hitting to a soft cushion or pillow, saying "It's not okay to hit people. You may hit this instead." Intervene if a child is biting others, and redirect the child to a teething toy or cloth for biting instead.
- Make sure to have several of each popular toy. Temporarily remove toys that continue to cause fights.
- Offer a healthy snack or lunch earlier if children seem to be irritable.

### Change the environment to lessen conflicts or frustration

- Don't overwhelm children with too many toys/materials. Set out a few items, and then rotate them weekly.
- Offer sturdy cardboard and cloth books that resist tearing.
- Provide several private quiet spaces using furniture or a large box with cushions for children who want to be alone or be away from loud activities.
- If mixed-age groups play together, try separating different ages during some parts of the day.

### Keep routines and expectations predictable

- State and restate clear and simple rules. "Feet belong on the floor." Limit rules to what is essential; always state rules positively. "We can run fast outside."
- Maintain a familiar rhythm to the day's activities and use consistent transition cues (songs, charts, bells) to prepare children for the next event.

### Set a good example and emphasize the positive

- Use simple social phrases that children can copy: "Please," "Thank you."
- Avoid power struggles by offering win-win choices. Rather than "You must lay on your cot," ask "Would you like to lay with your head at this end or that end?"
- Teach words that label emotions: *mad, sad, glad, scared*. Give simple sentences for communicating their needs. Instead of saying, "Use your words," explain "If you feel angry, tell me. Say, 'I'm mad!' so I know how to help you."
- Speak in a low, calm voice and address children by their names. Label positive behaviors: "Juan petted the hamster gently" or "Sue shared the trains with Jack."
- Hug, give back rubs, rock, snuggle and hold children on your lap often. ♦

#### References

A. Dombro, L. Colker and D. Dodge. *The Creative Curriculum for Infants and Toddlers*. Teaching Strategies, Inc. Washington, D.C. 1998.

A. Honig. *Behavior Guidance for Infants and Toddlers*. Southern Early Childhood Association. Little Rock, AR. 1996.

## Banishing the Winter Blues

by Judith Kunitz, MA

Many people experience a post-holiday let down after the beginning of the New Year. This can result from disappointments during the preceding holiday months compounded with holiday fatigue and stress. In addition, 10 percent of the population is affected by Seasonal Affective Disorder (SAD), which results from fewer hours of sunlight as the days grow shorter and colder during the winter months.

Tips to help banish those winter blues:

- Get back into a healthy lifestyle—try to exercise daily, get plenty of rest, drink lots of water and practice good eating habits.
- Turn off the television. Read a book, listen to music or take up a hobby.
- Breathe deeply and relax. Find time for yourself. Self-care for child care providers allows us to recharge our often compassion-fatigued batteries.
- Take a bubble bath or a hot tub.
- Call an old friend—pick someone you have not spoken to in a long time and get reacquainted once again.
- Reach out and do something for someone else by volunteering.
- Focus on stress management. Break down large projects into small tasks. Look at what has worked in the past. Remember that you can control how life affects you.
- Be mindful. Be careful of unrealistic "set-ups" such as diets or New Year's resolutions that are not attainable. Set specific and realistic goals for your home life and for your teaching life.
- Find time to have fun with whatever you are doing. Laughter is the best medicine! ♦

For more information: National Mental Health Association, [www.nmha.org](http://www.nmha.org).

## Sudden Infant Death Syndrome (SIDS)

by Joan Murray, RN, MA



Sudden Infant Death Syndrome (SIDS) is the leading cause of death in infants between one month and 12 months of age. In the United States, there are approximately 3,000 such infant deaths per year, a figure reduced by half since the SIDS educational campaign (Back to Sleep) began in 1994. One recent study found that 14 percent of infant deaths in the study occurred while infants were in child care centers or family child care homes. This is because more infants are entering child care than ever before.

Though the causes of SIDS are not clearly understood, it is possible to reduce the incidence by eliminating certain risk factors.

- Place infants to sleep on their backs at all times, even nap times (unless there is a rare medical reason not to do so and parents provide written documentation from their health care provider).
- Keep infants in a smoke-free environment.
- Remove blankets, pillows, sheepskins, comforters, crib bumpers and stuffed toys from the sleep area.
- No bed sharing with other children, even twins or siblings, unless parents provide documentation from their health care provider that they should sleep together.
- No sofa sleeping with or without another person.
- Do not over-dress the infant for sleeping.
- Dress the infant in a sleeper garment instead of using blankets.

Child care staff can help educate parents, grandparents and other caregivers about SIDS risk reduction measures. It is important for child care providers to:

- Attend educational programs on risk reduction, via local SIDS programs.
- Learn and maintain current CPR and first aid training.
- Develop policies regarding correct infant sleep positions (Back to Sleep) and discuss them with parents.
- Do practice drills on emergency procedures for an unresponsive infant.
- Talk with families about your efforts to reduce the risks of SIDS.

The Healthline at (800) 333-3212 can provide materials and local SIDS program contacts, or you can contact some of the resources below. ♦

### Resources

California Sudden Infant Death Syndrome Program at <http://californiasids.com> or (800) 369-SIDS

SIDS Foundation of Southern California: (800) 9-SIDS LA

SIDS Alliance: [www.sidsalliance.org](http://www.sidsalliance.org)

## Blood-Borne Pathogens

by Sharon Ware, RN, EdDc

Managing blood-borne pathogens remains a concern for persons working in child care. Management of blood-borne pathogens is a requirement of the Occupational Safety and Health Administration (OSHA) and involves a clear understanding of what blood-borne pathogens are and when exposure is likely to occur.

Pathogens or germs are organisms that cause disease. Blood-borne pathogens are those which live and thrive in human blood. Although there are many types of blood-borne pathogens, the most notable are Human Immunodeficiency Virus (HIV) and Hepatitis B and C. With all the advancements we have made in medical science, we have yet to find a cure for viruses. However, we can protect ourselves through vaccinations and avoiding exposure. Hepatitis B vaccinations are strongly recommended by the Centers for Disease Control for all persons who could potentially be exposed to blood or body fluids containing blood. Unfortunately, we do not have a vaccination for HIV or Hepatitis C, so avoiding exposure is the primary prevention method.

A blood exposure means the blood of one person gets into the blood stream of another. This can occur whenever there is exposure to blood or body fluids containing blood, such as stool, urine, saliva, nasal drainage and breast milk. In child care, exposure to blood can occur when an injury happens involving broken skin. Children playing on the playground or indoor play area are prone to injuries, even in the best environments. Exposure can also occur when changing diapers, assisting with

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## Poison Treatment at Home Has Changed: Do Not Use Ipecac

by A. Rahman Zamani, MD, MPH

In 2001, 1.2 million children under age 6 swallowed a poisonous substance, according to the American Association of Poison Centers. Because accidental poisonings of young children happen so frequently, in the past few decades the American Academy of Pediatrics (AAP) has recommended that parents keep a bottle of syrup of ipecac in the home to induce vomiting if children swallow something poisonous. In a new policy statement "Poison Treatment in the Home," AAP recommends that syrup of ipecac no longer be used as a home treatment by parents or caregivers to make a child vomit a possible poison he or she has swallowed.

### What is ipecac?

Syrup of ipecac is a medicine made from the dried root of ipecac plant, which is grown in Brazil. When swallowed, ipecac stimulates the central nervous system and the stomach, causing vomiting, usually in about 20 minutes.

### Why did AAP make this new recommendation?

There are several reasons for this decision. The key reason is that ipecac was never proven to be effective in preventing poisoning or in showing benefits for children treated with this medicine. Although it seems to make sense to induce vomiting for treatment of swallowed poison, nevertheless this assumption was never tested or researched. In the past few years, scientific tests and research have shown vomiting will not help children who eat or drink something poisonous.

Research has also shown that ipecac has been improperly administered by

parents and has been abused by people with eating disorders (misuse of ipecac can lead to heart problems and even death). Most emergency rooms have also stopped using ipecac in favor of activated charcoal for a number of reasons. Scientific advisers to the U.S. Food and Drug Administration recommended that over-the-counter sales of ipecac be banned.

#### California Poison Control (800) 876-4766

Free poison control stickers, magnets and other materials are available at [www.calpoison.org](http://www.calpoison.org).

#### American Association of Poison Control Centers (800) 222-1222

For calls outside of California only.

If the victim has collapsed or is not breathing, call 9-1-1.

### What should you do if you still have syrup of ipecac?

**Parents:** Like all unused and no longer needed medications, syrup of ipecac should be disposed of in a safe manner such as flushing it down the toilet.

**Child care providers:** In California, licensing regulations do not require ipecac in first aid supplies. However, some states require child care providers and foster parents to keep syrup of ipecac on hand to be used only on the advice of a physician or poison control center. Child care providers should follow all requirements of state and local agencies, but they should also educate these agencies about the AAP's new recommendation and encourage them to change their policies.

### Tips for protecting your children against poisoning

Prevention is the best defense against unintentional poisoning.

- Keep potential poisons locked out of sight and out of reach of children.
- Select products with child-resistant covers and replace child-resistant caps immediately after use. Remember, nothing is child proof!
- Do not turn your back on a child when a hazardous product is in use.
- Keep all products in their original containers. Never put them into food containers.
- Store hazardous household products and food in separate areas.
- Get rid of old and unused medicines properly (including ipecac).
- Never tell children that medicine or vitamins are candy.
- Keep all toxic plants up high and out of reach of children.
- Poison can look like food or drink. Teach children to ask an adult before eating or drinking anything.

If your child swallows a potentially poisonous substance, do not panic.

- Do not use syrup of ipecac as a poison treatment intervention.
- If a child is in obvious distress (is having convulsions, has lost consciousness or has stopped breathing), call 9-1-1 for help.
- Otherwise call poison control at (800) 876-4766 in California and (800) 222-1222 outside California for help and instructions. ♦

#### References

*American Academy of Pediatrics, Volume 112, November 5, 2003, pp 1182-1185.*

*Health and Safety in the Child Care Setting: Prevention of Injuries, Module 2, 2nd. Edition, California Childcare Health Program, 2001.*



# Hearing Evaluations in Young Children

Good hearing is necessary for a child to learn to talk. Newborn infants can hear a full range of sounds from the moment they are born (and even before)! Infants demonstrate that they hear as they quickly learn to recognize and respond to familiar voices. Hearing children turn to new sounds and their language development generally progresses along a predictable course.

## What causes hearing loss?

Hearing loss is one of the most common birth defects in the United States. Permanent childhood hearing loss can also be due to exposure to loud noise, certain medications, diseases such as meningitis and rubella, head or ear injury, and other causes. Temporary hearing loss can be caused by a build-up of wax in the ear canal, severe colds, sinus infections or ear infections, which can be resolved with medical treatment.

If a permanent hearing loss is discovered, there are treatments and programs that can help a child of any age, including hearing aids (even for infants), sign language classes and support groups.

## What if I think a child has a hearing loss?

An infant or child suspected of having a hearing loss should be evaluated by a trained professional. If a child does not seem to be meeting language development milestones, if there are risk factors for hearing problems, or if a child fails a hearing screening, he or she may be referred for a more complete medical and hearing evaluation.

To arrange for a hearing assessment for a child, parents or guardians should contact their health care provider. The health care provider may want to examine the child before recommending the appropriate hearing test for the developmental age of the child.

Infants or children who fail a hearing screening should be referred for a physical exam and more comprehensive testing as necessary.

## What are the warning signs of hearing loss?

Some factors put a child at risk for a hearing loss. It is recommended that children with one of the following risk factors have a hearing test as early as possible:

- Family member with a permanent childhood hearing loss.
- Serious infection at birth.
- Infection or disorder affecting the brain, such as bacterial meningitis, measles or mumps.
- Mother was exposed to or had infections while pregnant such as cytomegalovirus (CMV), herpes, rubella, syphilis, and/or toxoplasmosis.
- Difficult birth which affected the baby's breathing or APGAR scores (low.)
- Baby required neonatal intensive care for more than two days after birth or required mechanical ventilation.
- Neonatal jaundice (hyperbilirubinemia) which required an exchange transfusion.
- Low birth weight.
- Treatment with drugs, such as certain antibiotics, that can cause damage to hearing.
- Syndromes associated with progressive hearing loss such as neurofibromatosis, neuro-degenerative disorders such as Hunter syndrome, or sensory motor neuropathies such as Charcot-Marie-Tooth syndrome.
- Recurrent or persistent ear infections for at least three months.
- Unusual appearance of child's head, face or ear including cleft lip and/or palate.
- Down's syndrome.
- Head trauma.

## When are infants and children usually tested?

### Infants

In California, a law was passed in 1998 that requires most hospitals (those approved for California Chil-

dren Services funding) to offer hearing screenings to all infants born in their facilities. If a child is diagnosed with a hearing loss, parents should receive information about community resources and appropriate follow-up services.

### Young Children

Many preschools have hearing screening programs. In California, state regulations require hearing screening for each student in kindergarten or first grade, second, fifth, eighth, tenth or eleventh grades and also at first entry to public school. Children in special education services should receive hearing screening tests as part of their individualized plan.

## What are the types of hearing evaluations?

With the help of modern technology hearing tests for newborn infants and children are done with great accuracy. Unlike hearing tests for older children, which require the child to respond to a sound by raising a hand, hearing tests for infants and children measure vibrations produced in the inner ear.

### Otoacoustic Emissions (OAE) Testing

OAE testing is simple, painless, inexpensive and fast. In this test a small microphone resembling an earplug with an attached cord is placed in the ear canal. The infant or child hears a series of rapid clicks or tones about the loudness of a telephone dial tone. The microphone picks up vibrations and sends them to the computer for processing. Results are displayed as a computer graph. This test does not require the child's active participation.

### Auditory Brainstem Response (ABR) or Brainstem Auditory Evoked Response (BAER)

This test involves placing electrodes on the child's head while he or she is very still or sleeping. Clicking sounds are presented to the child through earphones.

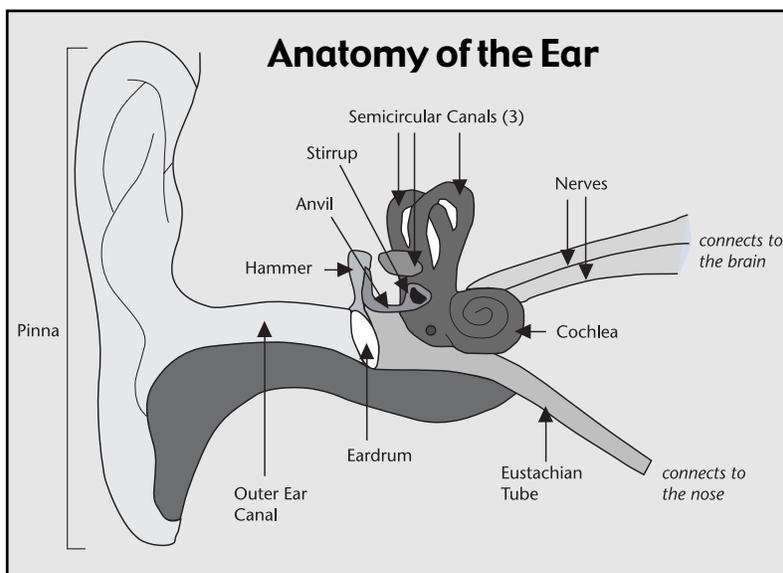
A computer records the brain waves generated by the auditory nerve and auditory brain pathways in response to the clicking sounds. Children who fail the ABR or BSER test are referred for more comprehensive testing.

### Behavioral Hearing Tests

These types of hearing tests are used with children who are able to respond to sounds. These tests measure the degree of hearing loss, assist in locating the

source of problem, and can indicate how the hearing loss will affect the child's ability to communicate. These tests involve observing a child's responses to sound and are useful in infants and those with limited language skills. The behavioral response might be an infant's eye movements, a head-turn by a toddler, placement of a game piece by a

preschooler, or a hand-raise by a school-age child. Very young children can respond to a number of behavioral tests.



### Resources

Developed by a team of professionals at Boys Town National Research Hospital, this Web site contains information about infant hearing screening and infants with hearing loss: [www.babyhearing.org](http://www.babyhearing.org).

The National Campaign for Hearing Health: [www.hearinghealth.net](http://www.hearinghealth.net).

American Speech and Hearing Association: (800) 638-8255, [www.asha.org](http://www.asha.org).

Alexander Graham Bell Association for the Deaf and Hard of Hearing: (202) 337-5220, [www.agbell.org](http://www.agbell.org).

California Department of Health Services Children's Medical Services Branch: (916) 323-8087.

California Department of Education, Special Education Division: (916) 445-4570.

by Lisa Frost, MS, RN, PNP, PHN 05/03

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# Planning for Inclusion

When planning to include a child with a disability or special need into your child care program, begin as you would with any family by meeting the child and parents. Find out as much as you can about what you can do to make them welcome. Talk about the child's strengths as well as weaknesses and begin knowing him or her as a person, not just someone with a disability.

Additional information about the child's disability (obtained from the library, Internet or advocacy group) can be helpful, but remember that children with the same condition can have a broad range of abilities.

After you become familiar with the child's abilities and needs, evaluate your program's environment and make changes as necessary in order to fully include the child. You may not need to make any changes to your program—

often, an environment that suits children with typical needs also suits children with disabilities or special needs. If changes are necessary, staff should work with the child's parents to decide what is needed. Potential changes or issues to address include:

- modifications to the environment, activities, equipment or materials;
- behavior management techniques;
- staff orientation and training to ensure coordinated and supportive inclusion;
- working with the child's therapists/specialists;
- introducing the child to the other children and answering their questions;
- physical needs, such as being lifted, closer supervision, or support at mealtimes;
- caring for specialized equipment, such as hearing aids or braces;

- communicating with the child or helping the child communicate with others;
- accommodations for outdoor play and field trips;
- toileting procedures;
- special diets or feeding techniques;
- additional communication with parents of other children (remember to maintain confidentiality); and
- emergency medical situations.

Just as important is your belief in and acceptance of every child as a unique person with the potential to grow and learn. If you are positive, matter-of-fact, and upbeat about a child's disability, others will follow your lead. ♦

*Adapted from the National Network for Child Care fact sheet: Caring for Children with Special Needs: Feeling Comfortable by D. Greenstein, PhD. (1998). <http://www.ces.ncsu.edu/depts/fcs/human/pubs/nc06.html>.*

## Mentally Healthy Young Children by Mardi Lucich, MAEd

Each child comes into the world wanting to connect with others, to grow and to explore. Social development (our feelings about and expectations of relationships with others) and emotional development (our feelings about and expectations of ourselves) take place in the context of relationships from the very beginning. Newborn infants enter the world ready and wired to be responsive and active partners with the most important people in their lives: family and other primary caregivers. As infants grow and come to know and trust the day-to-day interactions that make up those relationships, they learn that they can have an affect on the world and are worthy of love. The child's feelings of security, confidence and trust blossom.

These early relationships are the foundation of continued mental health and can have a profound affect on how children come to view themselves, and what they expect of others and the world. While there is no one definition of mental health, the following characteristics display healthy social and emotional development in young children:

- Capacity for warm, trusting relationships with other children and adults.

- Positive self-esteem: a feeling that they can be effective and make things happen in the world around them.
- Developmentally appropriate control of impulses and behavior, including an increasing ability to handle assertiveness, curiosity and anger according to the norms of society, the peer group and the particular setting.
- Progressively increasing ability to express needs, feelings and ideas with words.
- Beginnings of empathy and compassion for others; ability to cope (in a developmentally appropriate way) with loss and limitations.
- Acquiring the skills to concentrate, focus and plan as a basis for learning.

A child who has had positive early relationships and experiences that allow and support emotional and social development will flourish, learn and grow. ♦

*Adapted from Training Guides for the Head Start Learning Community: Promoting Mental Health, Module 1(1998). Head Start Bureau. To order a copy or print a PDF version, go to: <http://www.bmcc.edu/Headstart/Trngds/Mentalhe/#mod1>.*

## Five Counties Strut Their Linkages Stuff at Asilomar



by Robert Frank, MEd, Program Specialist

On October 27, 2003, CCHP presented a special program of workshops at the California Child Care Resource & Referral Network's 26th Annual Conference, Asilomar Conference Center, Pacific Grove, California. CCHP offered a block of four workshops:

- *Solutions and Support for Special Situations: Working with Children with Special Needs and Their Families in Child Care*, by Mardi Lucich, MAEd
- *Avoiding Professional Burnout: Health and Wellness in the Early Care and Education Profession*, by Judith Kunitz, MA and Robert Frank, MEd
- *I Am Not a Health Professional, So How Can I Provide the Best Resources?* by A. Rahman Zamani, MD, MPH
- *Roundtable Discussion on High-Quality Health and Safety Models for Child Care Programs*, led by Robert Frank, MEd and Judith Kunitz, MA

CCHP also offered a resource table and one-on-one consultations so that participants could get all their health and safety questions answered. Highlights of the workshops and roundtable included:

- Carol Jones, Child Care Health Consultant (CCHC), along with Michelle Cornejo, Child Care Health Advocate (CCHA), presented as a dynamic duo displaying their home made costumes and children's health and safety gadgets used in teaching the importance of hand washing in the child care environment.
- Amanda Stangis, Program Manager from Sacramento County and Kara Hogue, R&R Manager from Siskiyou County, spoke of the "tricks of the trade" in setting up Child Care Health Linkages Projects in their respective communities.
- Colleen Conley, CCHC, and Ofelia Toledo, her CCHA partner, presented another successful Child Care Health Linkages team on some of their county highlights and community resources used in San Benito. They shared their bilingual community resources binder distributed with an in-depth training to child care providers on its usage.
- Jose Quezada, Program Manager from Humboldt county, presented on accessing medical homes in his county.
- Under the facilitation of Judith Kunitz and Robert Frank a really powerful panel discussion took place on "best practices" challenges, obstacles overcome and sustainability tips. A diverse group of Linkages personnel told attendees how to build successful Child Care Health Linkages Projects in their own communities. Each spoke to their own experiences of implementing their Linkages Project from as far north as Humboldt/Siskiyou counties to as far south as the central California counties of San Benito and San Luis Obispo.

If you would like more information on the Child Care Health Linkages Project, give us a call or check the CCHP Web site at [www.ucsfchildcarehealth.org](http://www.ucsfchildcarehealth.org). ♦

## Keeping Busy

by Abbey Alkon, RN, PhD

CCHP has been very busy these past few months with the development of a new California Training Institute for Child Care Health Advocates and accompanying curriculum. The curriculum is being presented in different regions throughout California over the next five months. Training topics include the history of child care health consultation, common health and safety issues, assessment tools, working with Child Care Health Consultants, oral health, and behavioral health.

The California Training Institute is also offering trainings of Child Care Health Consultants. Module 1 was offered October 13-15, 2003, and Module 2 was offered November 17-19, 2003. Module 3 is scheduled for January 2004. These trainings are open to all health professionals interested in becoming Child Care Health Consultants. For more information about trainings for either Child Care Health Consultants or Child Care Health Advocates, contact Griselda Thomas at (510) 281-7920, or at [gthomas@ucsfchildcarehealth.org](mailto:gthomas@ucsfchildcarehealth.org).

CCHP sponsored a Sustainability Summit October 23, 2003, in Sacramento, California for the 20 Linkages county administrators and colleagues. We discussed how to plan for sustainability and what the Linkages Project has achieved to date. The Child Care Health Linkages Project research staff also presented preliminary findings from the Linkages project at three sessions at the American Public Health Association meeting in San Francisco November 17-19, 2003.

The CCHP staff were sad to say goodbye to Sue Jensen, Healthline nurse, who left CCHP in October 2003. As we go to press, we are recruiting for a new Healthline nurse. ♦

## EVENTS

### January 2004

Jan 22-24

**California Head Start Association Conference.** San Francisco.

CHSA, (916) 444-7760;

[www.ca-headstart.org](http://www.ca-headstart.org) (CCHP will present a special series of workshops.)

Jan 26-30

**Building a Safer World for Children.**

San Diego. Chadwick Center for Children and Families, (858) 966-8572; [www.chadwickcenter.org](http://www.chadwickcenter.org)

Jan 30-Feb 1

**California Teachers Assoc. Good Teaching Conference South.**

Hollywood. CTA, (909) 372-2505; [www.cta.org](http://www.cta.org)

### February 2004

Feb 4-6

**Pilots to Policy Conference — Bold Changes: A Shared Responsibility for Children and Families.**

Glendale, CA. Foundation Consortium, (916) 646-3646;

[www.foundationconsortium.org](http://www.foundationconsortium.org)

Feb 5

**Healthy Communities in the California Heartland: A Call to Action.**

Fresno. College of Health and Human Services, California State University, Fresno, (559) 278-3603

Feb 20-22

**California Association for the Education of Young Children Conference.**

San Diego. CAEYC, (916) 486-7750; [www.caeyc.org](http://www.caeyc.org) (CCHP will present a special series of workshops.)

### March 2004

Mar 5-7

**California Teachers Association Good Teaching Conference North.**

Burlingame, CA. CTA, (909) 372-2505; [www.cta.org](http://www.cta.org)

## PRODUCT WATCH

### Recalls and Product Alerts

Below is a summary of items recalled voluntarily and preventively. As always, take the recalled item out of circulation and contact the appropriate company to find out about replacements, parts, refunds or other instructions.

Recalled Item	Defect	Contact Information
"Chalk To Go...Totally Me!" multi-colored and solid-colored sidewalk chalk	The multi-colored and solid-colored sidewalk chalk contains high levels of lead, posing a risk of poisoning to young children.	Toys "R" Us (866) 274-6340 <a href="http://www.toysrusinc.com">www.toysrusinc.com</a>
"Double Dipp'n Fun" multi-colored sidewalk chalk	The multicolored sidewalk chalk contains high levels of lead, posing a risk of poisoning to young children.	Target Corporation (800) 440-0680 <a href="http://www.target.com">www.target.com</a>
DesignWare® Crazy Bounce Balls	The balls could break apart, posing a choking hazard to young children.	American Greetings Corp. (800) 777-4891
Bear "Jack-In-the-Box" toys	The red bead on the crank of the toy can detach, posing a choking hazard to young children.	Schylling Associates Inc. (800) 767-8697
"Amazing Baby™ Listen and Play" activity books	The hub of the pink dial embedded in the inside back cover can come off during use in some of these books, posing a choking hazard to young children.	Advantage Publishers Group (866) 748-3731 <a href="http://www.advantagebooksonline.com">www.advantagebooksonline.com</a>
Plan Toys Solid Drums	The three rubber feet, which are screwed into the bottom of the drum, could be removed in some cases, posing a choking hazard to young children.	BRIO (888) 274- 6869 <a href="http://www.Briotoy.com">www.Briotoy.com</a>



**CCHP has a set of ten colorful and friendly laminated health and safety "Survival Tips" mini-posters.** The set is available in English or Spanish for only \$10. Topics include morning health checks, hand washing and proper diapering procedures. For more details, call the Healthline at (800) 333-3212 or visit our Web site at [www.ucsfchildcarehealth.org](http://www.ucsfchildcarehealth.org).

## New California Laws

by Mardi Lucich, MAEd



The California Legislature adjourned the 2003 Session on September 12, 2003. Former Governor Davis signed or vetoed all legislation sent to him this year. The following are the 2003 state legislation signed by Governor Davis that affect child care programs. These new laws take effect January 1, 2004:

### AB 1683 (Pavley) Child Care Site Visit Reports

This law requires licensing inspectors visiting a child care facility to post a note near the main door that is to remain there for 30 days, which includes the date of the site visit, whether a citation was issued, the kind of citation issued, and a departmental contact for more information. If a citation reflecting an immediate risk to children was issued, the law requires facilities to post the report near the main door for 30 days. The law also requires a compliance report for correcting the deficiency specified in the citation to be posted for 30 days. The law only requires family child care homes to comply with posting requirements while children are present.

### AB 529 (Mullin) Family Child Care: School Age Children

This law allows one child enrolled in kindergarten (as young as 4 years and 9 months of age) as well as children at least 6 years of age to qualify as school age. Small family child care homes may care for 8 children (instead of 6) and large family child care homes may care for 14 children (instead of 12) if two of them are school age children.

The State Legislature reconvenes on January 5, 2004 and begins with its first major task of working with Governor Schwarzenegger's administration and developing a balanced budget for 2004-05. ♦

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### —Blood-Borne Pathogens, continued from page 4

toileting, handling breast milk, and assisting children in blowing their noses due to the potential of blood being present in the body fluid.

The key to management of blood-borne pathogens is to provide a barrier between the caregiver and the blood or body fluid. The most cost-effective and common barrier is latex gloves; other types of synthetic gloves may be worn if the user is allergic to latex. Gloves must be worn while administering first aid, handling blood-contaminated articles, and while cleaning and sanitizing surfaces contaminated with blood. It is imperative to always follow up with proper hand washing procedures.

Managing blood-borne pathogens is easy when you know what they are and how to avoid exposure. ♦

#### Resource

California Childcare Health Program, *Universal Precautions Health and Safety Note*, 2003, available at [www.ucsfchildcarehealth.org](http://www.ucsfchildcarehealth.org) or from the Healthline at (800) 333-3212.

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### —Sick Season Is Here, continued from page 1

The answer to whether or not children can attend care lies in whether the children are contagious and if they feel well enough to participate. Children aren't necessarily contagious when they are having symptoms—their highest period of communicability occurs before the first day of symptoms and often continues through the period of fever. This means that excluding a child who just has a cough or runny nose won't protect other children from illness. However, there are some specific symptoms that indicate exclusion is advisable:

- Fever (100° F under arm) along with behavior change or other signs of illness such as sore throat, vomiting, diarrhea, earache, etc. A temperature of 99° F in an infant under 4 months of age should be evaluated by a health care professional.
- Symptoms of possible severe illness such as unusual tiredness, uncontrolled coughing or wheezing, continuous crying or difficulty breathing.
- Severe coughing—child gets red or blue in the face, or makes high-pitched whooping sound after coughing.
- Child is unable to participate or requires more care than you can provide.

With lots of hand washing, good hygiene and practical exclusion guidelines, the cold and flu season may just be easier for you this year.

#### References

Chart adapted from Kaiser Pharmacy poster, "How Long Will Your Cold and Flu Symptoms Last," 2002.

*Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs.* Washington, DC: American Public Health Association and Academy of Pediatrics (1992).

#### Resource

Visit [www.ucsfchildcarehealth.org](http://www.ucsfchildcarehealth.org) for detailed handouts on a variety of infectious illnesses or call the Healthline.

# Resources

**Cal-OSHA** offers information and free publications about job safety, including issues such as lifting safely. Call (800) 963-9424 or visit [www.dir.ca.gov/dosh/puborder.asp](http://www.dir.ca.gov/dosh/puborder.asp).

**Lead Poisoning News** provides information about lead poisoning, ways to protect children from lead, and legal resources. [www.lead-poisoning-news.com](http://www.lead-poisoning-news.com).

**Center on the Social and Emotional Foundations for Early Learning** focuses on strengthening the capacity of child care and Head Start programs to improve the social and emotional outcomes of young children. User-friendly information to help early childhood educators meet the needs of the growing number of children with challenging behaviors and mental health challenges. <http://csefel.uiuc.edu>.

**Bullying and What to Do About It** offers statistics and information on bullying, including tips for stopping it. Free. National Mental Health Association, 2001 N Beauregard St, 12th Fl, Alexandria, VA 22311; [www.nmha.org/pbedu/backtoschool/bullying.cfm](http://www.nmha.org/pbedu/backtoschool/bullying.cfm).

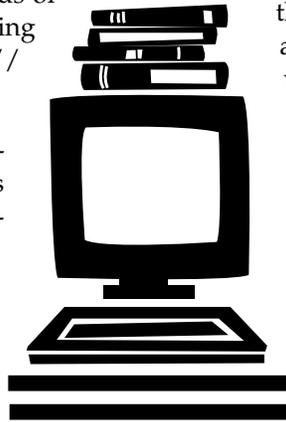
**Center for Social and Emotional Education (CSEE)** works with educators, parents, schools

and communities to develop proactive ways to help children develop the social-emotional skills, knowledge, and beliefs to make healthy decisions and thereby enhance their resiliency. [www.csee.net](http://www.csee.net).

**Geographic Disparities in Children's Mental Health Care** finds that low-income children in California, Texas, and Florida have the least access to mental health care. <http://pediatrics.aappublications.org/cgi/content/full/112/4/e308>.

**New Hope for Preventing Child Abuse and Neglect in California**, from Fight Crime: Invest in Kids, recommends that federal and state governments prevent child abuse and neglect by investing in children's services. [www.fightcrime.org/reports/CANstate2pager/CANca.pdf](http://www.fightcrime.org/reports/CANstate2pager/CANca.pdf).

**Low-Level Ozone Increases Respiratory Risk of Asthmatic Children**, from the October issue of the Journal of the American Medical Association, finds that children with acute asthma are particularly vulnerable to ground-level ozone at levels well below the federal standard. <http://jama.ama-assn.org/cgi/content/abstract/290/14/1859>. ♦



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