



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

Healthy habits can protect you and your children from getting germs or spreading germs at home, work, child care and school. Simple actions can stop germs and prevent illnesses.

Cover your mouth and nose. Use a tissue when you cough or sneeze and drop it in the trash. If you don't have a tissue, cover your mouth and nose as well as possible.

Clean your hands often. Clean your hands every time you cough or sneeze. Hand washing stops germs.

Remind your children to practice healthy habits, too. Germs that cause colds, coughs, flu and pneumonia can spread easily.

Healthy habits help reduce illnesses and sick days. Feel good about doing the right things to stay well.

Source:

The Centers for Disease Control and Prevention and the Department of Health and Human Services. To learn more, please visit www.cdc.gov/germstopper.

**Need a free
telephone consultation
on health and safety
in child care?
Call the Healthline at
(800) 333-3212**

Putting the Brakes on a Silent Epidemic

If a new epidemic occurred that caused the deaths of hundreds of children each year, we'd hear about it every day in the news. But a kind of silent epidemic does take the lives of far too many of our children. In 2002, more than 1,500 children ages 14 and younger died in car accidents. It's a national tragedy, especially because so many of those deaths are preventable.

Awareness of car safety has increased greatly over the years (many of us can remember the days when almost no one wore seat belts, and infants rode home from the hospital in their mothers' arms rather than car seats). In fact, according to the National Highway Traffic Safety Administration, child safety seat use has increased from 50 percent to over 70 percent in the past decade. But there's still more we can do. That same study found, for example, that four out of five children who should be riding in booster seats are not.



Child care providers, who are in an excellent position to be role models and educators for parents, have an important role to play in reducing deaths through car

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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.

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ASK THE NURSE...

Food Fight! Conflict Over Food Issues



by Judith Calder, RN, MS

Q: As a child care provider, I get into disagreements with parents over food all the time. Some of the disagreements are related to culture and some are caused by a lack of good nutrition information. How can I resolve these differences?

A: This issue comes up very frequently. Last month we addressed a specific food concern of whether it is appropriate to offer eggs to a 5-month-old. But food issues are so common that we've had requests to cover the topic more generally as well.

When differences come up, it's often useful to explore the reasons why a parent has made a request with which you disagree. They may hold a very strong cultural belief, or are following child-raising advice passed on to them by older adults in their family. It's very important that you honor the family's cultural practices and respect their right to make decisions about their child.

However, as a child care provider you are also responsible for following best practices and making sure the children in your care are safe. Ask yourself: will the behavior in question cause harm? If you believe it will, then share written materials with the family which support your perspective, and ask for advice from the family's medical care provider. If not, it is probably preferable to abide by the family's wishes. While you may believe the current feeding recommendations are best, if the behavior is not going to cause the child any harm, the family's wishes must be understood or at least negotiated.

One food issue that comes up very frequently is when to introduce solid foods to an infant, so let's use that as an example. Some parents believe that a child sleeps better with early introduction of solid foods, or will be hungry without solids. However, the American Academy of Pediatrics recommends breast feeding exclusively until a baby is 6 months old and for at least one year with the gradual introduction of solids. This schedule reduces the risk of food allergies and ensures that the baby is physically ready to digest solid foods. So what should you do if a family requests that you feed the baby cereal at 4 months of age?

After reviewing your materials, you could sit down with the family and discuss your concerns. In this instance, developmental readiness and food allergies are the biggest issues. If babies are not developmentally ready for the introduction of solid foods they may be at risk for choking. Babies' swallowing and digestive systems are not developmentally ready to handle solid foods until they are 4 to 6 months old. Ask the family to help you assess whether the baby is ready. Have they observed signs of physical readiness for solid food? The baby should be able to hold her neck steady and sit with support. She should be able to draw in her lower lip as a spoon is removed from her mouth, and swallow the food rather than push it back out.

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Family-Centered Child Care: What Does it Look Like?



Adapted from Promoting Family-Centered Child Care

Family-centered child care is flexible by definition and may look different in different settings. However, there are some common characteristics:

- Family-centered settings support connections between children and their families. They honor the primary role families have in the lives of their children and recognize that children draw their identities from their family. A basic belief in the value of families permeates program planning, policies and practices. All family members are included and treated with respect and warmth.
- Family-centered settings speak the languages and respect the cultures of the families in the program, and staff members are drawn from the community.
- Family-centered settings support and build on family strengths. Programs recognize various stages of development in family members and work with them to meet their individual needs. There is a natural give-and-take that empowers families to make meaningful contributions.
- Family-centered settings support and train caregivers and teachers. Pre-service and in-service training, peer coaching and mentoring opportunities are provided on a continuous basis on topics such as relationship building and communication skills. Joint training is also provided for staff and families.
- Family-centered settings meet the basic requirements of families, meaning that families have real choices when it comes to child care—care that is affordable, accessible and consistent with their working hours. Programs are inclusive of all children, regardless of abilities.
- Family-centered settings forge true partnerships with families—families know that their feedback will effect change. Parents are in a creative role in program design, establishing goals and making decisions. Efforts are made to build inclusiveness and to welcome all family members as partners in the program.

Partnership is the heart of family-centered child care. The family is valued as part of the program and likewise the program is valued as part of the family's life. This reciprocal relationship is based on cooperation, respect and the mutual goal of everyone doing their best for the children in their care. ♦

Adapted from Promoting Family-Centered Child Care brochure, U.S. Department of Health and Human Services, Administration for Children and Families, Child Care Bureau. Available from National Child Care Information Center at <http://nccic.org/pubs/famcent/fam-toc.html>.

Recommended readings

Diffily, D. & Morrison, K. (eds.). (1996). *Family-friendly communication for early-childhood programs*. Washington, DC: National Association for the Education of Young Children.

Lopez, M. E. (1996). *Quality in family and child care partnerships*. Cambridge, MA: Harvard Family Research Project.

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Picky, Finicky Eaters!

by Judith Kunitz, MA

Caregivers play a very important role in helping young children develop their attitudes about food and eating. The nutritional messages given to young children will stay with them for the rest of their lives. You can help turn a picky eater into a healthy eater by providing safe and pleasant eating experiences, role modeling healthy eating habits, and providing a variety and balance of delicious and nutritious foods.

Most young children do not eat a balanced diet every day, but over the course of a week their diet will usually end up being well balanced. Children have their own internal signals for hunger, appetite and nutritional needs. Young children may be hesitant to try new foods, but try to offer small amounts once or twice a week. Most children will try a new food only after being offered that food item 10 to 15 times!

Use food as nutrition, not for control as a bribe or reward for desired behaviors. Encourage mealtime conversations in a family style manner that allows for children to serve themselves. A relaxed and pleasant eating environment allows for a social and interactive meal or snack time.

Here are some suggestions on how to introduce a wider variety of new foods to picky, finicky eaters:

- Serve new foods when children are hungry.
- Serve small amounts of the new food.
- Introduce one new food at a time.
- Expose young children to culturally diverse foods.

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Respiratory Hygiene in Child Care

by Sharon D. Ware, RN, EdDc



Your program may be doing a great job of keeping surfaces clean and free of germs this winter. But are you keeping the air clean also? Although germs can be spread through physical contact, such as touching a contaminated toy, they are also spread when people cough or sneeze into the air and their germs are breathed by other people. The air can be full of germs just like a dirty play surface can be!

During cold and flu season, child care programs should make special efforts to reduce the amount of germs in the air. The germs we breathe can cause respiratory illnesses like colds, influenza, respiratory syncytial virus (RSV), whooping cough and pneumonia, and these are more prevalent during the winter, when bad weather keeps people crowded indoors. A clean fresh environment triggers fewer allergies, generates fewer respiratory illnesses and is very pleasant to work and play in.

It's not hard to practice good "respiratory hygiene" in your child care program. A few simple precautions will assure that the air is as free from germs as possible.

- Open the windows in every room every day to circulate fresh air, even during winter. Make sure the windows are screened and not opened wider than four inches so that children cannot fall out.
- If you use an air conditioner, be sure that it is cleaned and serviced regularly.
- Never allow smoking in or near your facility.
- Teach children to cover their mouth and nose with a tissue when coughing or sneezing. When a tissue is not available, have them cough or sneeze into the sleeve of their clothing to prevent germs from going airborne.
- The dry, hot air of an overheated room takes moisture from the skin and mucous membranes, leaving children and adults more vulnerable to colds. If the air in your program is very dry, consider using a cool air humidifier or cool air vaporizer to add moisture to the air (do *not* use a steam vaporizer).
- Consider purchasing fans with HEPA filters, which can reduce the number of germs in the air. Make certain that the fans are used and cleaned properly and that they are the right size for the room.

Good respiratory hygiene, in combination with regular hand washing, cleaning and disinfecting of surfaces, immunization updates, and sensible exclusion policies, can make a significant impact on the rate of infection in child care. With a little work, your program can stop the spread of germs before they make everyone sick. ♦

References

Centers for Disease Control at www.cdc.gov.

California Childcare Health Program. (2001). *Health and Safety in the Child Care Setting: Prevention of Infectious Disease*. CCHP: Oakland, CA.

School Entry Physical Exams

by Judith Calder, RN, MS

Do you have children in your child care program who are going off to school in September? Now is the time to alert parents that school entry exams are due on their child's birthday or any time between now and September. The school health physical is very important to assure that children are ready for school in the areas of health. The important tests that get done at the 4- to 5-year-old exam are:

- a dental assessment and referral for dental care if indicated and not done at age 3;
- a vision test, done using a Snellen eye chart;
- a hearing test using an audiometer;
- a Tb screening test;
- nutritional assessment;
- height and weight graphing;
- blood test for anemia;
- urine test for diabetes or infection;
- a general physical exam;
- a developmental assessment; and
- an immunization update.

As you can see this is a very important exam. It assures that when young children go off to school they are healthy and ready to learn, and if they have conditions that may interfere with learning and development, those conditions can be identified and treated early.

Child care programs can prepare children for these exams in a number of ways so that they won't be afraid of their trip to the doctor. Read books about going to the doctor or dentist. Talk about what happens when you get an eye test or hearing test. Give children a chance

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Can Parents of Children with AD/HD Pay Attention?

by A. Rahman Zamani, MD, MPH

The authors of a new study, conducted by the University of Maryland¹, conclude that parents of children with Attention Deficit Hyperactivity Disorder (AD/HD) should be tested for the condition themselves. This new study reinforces the importance of testing parents of children with AD/HD. These parents are over 20 times more likely to have AD/HD than parents whose children do not have AD/HD.

How common is AD/HD?

Approximately 7 percent of school-age children have AD/HD, which can continue into adulthood. AD/HD, previously called Attention Deficit Disorder or ADD, is the name of a group of behaviors found in many children and adults. AD/HD in adults is sometimes considered a "hidden disorder" because the symptoms are often covered by other problems such as relationships, organizational skills, mood disorders, substance abuse, employment issues and other psychological difficulties. Even with increased awareness that the disorder exists in adults, many remain unidentified and untreated. Some adults only recognize that they may have AD/HD after their own child is diagnosed.

What causes AD/HD?

Although the exact causes of AD/HD remain unclear, there is little question that genetics makes the largest contribution. Other risk factors include difficulties during pregnancy, prenatal exposure to alcohol and tobacco, premature delivery, significantly low birth weight, excessively high body lead levels, and postnatal injury to the brain.

Contrary to popular opinion, AD/HD *is not caused* by excessive sugar intake, food additives, excessive viewing of

television, poor child management by parents, or social and environmental factors such as poverty or family chaos.

How is AD/HD diagnosed?

AD/HD does not have obvious physical signs and there are no simple tests such as a blood test, x-ray or a short written test to conclude whether someone has this disorder. Therefore, a comprehensive evaluation and a series of interviews with the individual (child or adult) and other key persons in their lives (parents, spouse, teachers, etc.) is necessary to rule out other causes, establish a diagnosis, and determine the presence or absence of co-existing conditions.

What are the symptoms?

According to the Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV), there are three patterns of behavior that indicate AD/HD: inattention, hyperactivity, and impulsivity.

Signs of *inattention* include becoming easily distracted, failing to pay attention to details and making careless mistakes, rarely following instructions, and losing or forgetting things needed for a task.

Some signs of *hyperactivity* and *impulsivity* include feeling restless, often fidgeting with hands or feet, or squirming, running, climbing, or leaving a seat, in situations where sitting or quiet behavior is expected, blurting out answers before hearing the whole question and having difficulty waiting in line or for a turn.

Since now and then everyone shows some of these behaviors, the DSM has very specific guidelines for determining when they indicate AD/HD.

Why should parents of children with AD/HD be tested?

Treatment for children with AD/HD requires a lot of support from parents, so for children to perform at their best, it is important that their parents are also performing as well as possible. The identification and treatment of adults with AD/HD may be an important component of the treatment plan of children with AD/HD. Parents who are unable to organize and pay attention can miss their child's medical appointments, forget to give medications and fail to follow a treatment plan.

What is the treatment for AD/HD?

Although there is no cure for AD/HD, treatment plans which combine medication, education, behavioral skill building (using lists, day planners and filing systems), and psychosocial treatments can be very effective in reducing the effects of AD/HD. ♦

¹*Journal of the American Child & Adolescent Psychiatry, December 2003, Volume 42, Issue 12.*

Resources

American Child & Adolescent Psychiatry at www.aacap.org.

California Childcare Health Program at www.ucsfchildcarehealth.org/webpages/specialneeds.htm.

CHADD (Children and Adults with Attention-Deficit/Hyperactivity Disorder), at www.chadd.org, offers an online directory of AD/HD professionals.



Stimulating Language Development

Most children begin to speak around the age of 10 to 18 months. However, their understanding of words starts long before that. Hearing word sounds stimulates children's brains to grow so that they can remember and repeat these sounds. Children also begin to understand the rhythms and patterns of speech.

As children listen, watch and participate in the world around them, they begin to master language. Their experiences in child care are an important part of language development. An interesting, enriched environment makes a difference. There are many things you can do to help children build a solid foundation for a lifetime of self expression.

Meet the Match Developmentally

Pay attention to where children are developmentally and move forward as they do, using more complicated language as they are ready for it. Repeat and match words and sounds from the child. Always answer children's questions patiently and fully.

Tie Words to Actions

Self-talk. Describe what you are doing and how you are doing it, including new words and ideas. *"I am using my hands to mix the color violet into the playdough."*

Parallel talk. Describe the child's actions as she does them. *"You're pulling the long train down the windy track."*

Imitation. Encourage children to imitate your words or phrases if they want to.

Expanding. Expand on things children say. For example, if a child says *"kitty nice,"* you could follow with, *"Yes, the kitty is soft and gray."*

Prompting. If a child doesn't answer a question, change your question. For example, if you said, *"Where did you go?"* you could restate it as *"You went where?"*

Make Language Clear

Use simple, clear speech and speak to children directly. Make eye contact, and give them time to respond. Be very specific when you give directions, such as *"Please put these crayons with the other crayons on the green shelf."*

Describe and Label

Introduce new words in a meaningful way, such as talking about what you are seeing and doing. Have children describe and label things, encouraging them to make connections themselves. For example, have them taste sugar and salt and then have them describe the differences. Use real objects to teach new words, and let children feel the object when you name it.

Communicate Without Words

Act out stories or situations and meanings of words without words. *"Pretend you are carrying the biggest log you ever saw."* *"Show me 'sad' with your face."*

Thinking in Sequences

Teach children that things are often done in a certain order. *"What happens if we put our shoes on before our socks?"* You can also ask children to do things in order, as in *"Jonathan, please push in your chair, put your trash in the garbage, and wash your hands."*

Ask Open-Ended Questions

Offer choices that get more than a "yes" or "no" answer. *"What would happen if...?"* *"Can you tell me how you made your sand castle?"*

Help Children Reason

Encourage children to talk about **why** they do things in a certain way. Ask questions that encourage problem-solving skills. For example, if together you see a person fixing a fence, you could ask the child, *"How do you think the fence became broken?"* and *"How is the man going to solve the problem of a broken fence?"*

Teach Time and Space Words

Use objects found in the child care setting (blocks, dolls, etc.) to talk about space relationships such as *in front of, behind, over, under, next to*, etc. You can also use objects to talk about comparisons: *Which is bigger, tallest, widest*, etc. Use time and space words like *nearer, soon, later, and after*.

Activate Children's Listening Skills

Make "silly" mistakes on purpose, such as "*Airplanes fly under water.*" "*Is this my (point to knee) nose?*" Play games where mistakes are obvious, such as "*The wheels on the bus go oink, oink, oink.*" Give different instructions than normal, and see if the children catch the difference.

Make Connections Between Written and Spoken Language

Help children sign their own work—even if it's only a letter or an attempt at writing their name.

Read in Groups and Individually

Read to the children every day. Go through books and talk about the pictures: discuss the names of objects seen in the pictures, describe the actions taking place and the feelings and emotions on the character's faces, and ask children questions about what is happening in the stories. Create a comfortable book corner with a variety of reading materials available within children's reach.

Help Children Make Up and Retell Stories

Ask children to tell you a story about what they are doing or have done, such as "*T.J., tell me about what you are drawing.*" Make up stories and/or poetry and share, or have children make up stories and/or poetry that you write down and read back to them.

Help Children Learn Positive Social Skills

Teach and model courteous ways of speaking with others, such as using "*please*" and "*thank you.*" Help children understand the variety of emotions they feel by reading and telling stories about characters that express emotions, encouraging discussions about feelings, and showing children that you understand and appreciate their feelings.

Keep Talk/Attitudes Toward Language Positive

Use praise and encouraging words, but be specific, such as "*Thank you for helping me clear the table.*"

Accept word mistakes as part of the developmental process. Do **not** correct children; instead, model proper usage. For example, if the child said, "*dog run,*" you could say, "*Yes, the dog is running.*"

Use Music

Make up songs and chants, including rhymes, and sing them repeatedly.

Listen to and Talk with Children

Encourage children to communicate verbally by paying attention to all communication attempts, and by taking special time to be with, talk to and listen to each child daily.

Remember that there is great variation in when children will begin to speak. Language can develop smoothly and continuously, or in jumps and spurts. And because the development of speech varies, it is important *not* to compare one child's language development to another's. If you suspect a child is having a delay in either understanding or using language, discuss your concerns with the child's parents and encourage them to talk with their family health care provider. He or she may evaluate the child, or refer the family to professionals who specialize in speech and language evaluation. The parents may also contact their local school district to request a speech and language assessment for their child.

If you have additional questions or concerns, contact the Healthline at 800-333-3212.

Resources

Honig, A.S. (1989) "*Talk, read, joke, make friends: Language powers for children.*" *Day Care and Early Education*, 16(4), 14-17.

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Martin, Katherine L. (1997). *Does My Child Have a Speech Problem?* Chicago, IL; Chicago Review Press, Inc.

Golinkoff, Roberta M. and Hirsh-Pasek, Kathryn. (1999). *How Babies Talk: The Magic and Mystery of Language in the First Three Years of Life*. New York, NY; Dutton/Plume Publishing.

by Mardi Lucich, MAEd (07/03)

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What is Occupational Therapy?

by Mardi Lucich, MA

Occupational therapy (OT) is the science of using “occupation,” meaning activities with specific goals, in helping people of all ages prevent, lessen or overcome disabilities. As a treatment it focuses on helping people achieve independence in all areas of their lives, giving people the “skills for the job of living” necessary for independent and satisfying lives. Some people may think that occupational therapy is only for adults; children, after all, do not have occupations. But the true “occupation” of children is learning through play and school.

For children, occupational therapy can provide intervention that helps the development of appropriate social, play and learning skills. The therapy can aid a child in achieving and maintaining normal daily tasks such as getting dressed and playing with other children. Generally, therapy is provided through purposeful activities working on fine motor skills and hand-eye coordination, focusing on the child’s ability to master skills for greater independence.

This can include:

- self-care skills such as feeding, dressing and grooming
- skills related to school performance such as writing and cutting
- play and leisure activities such as climbing

Every day, children and adults have or develop health conditions that significantly affect their ability to manage their daily lives. With the help of occupational therapy, many can achieve or regain a higher level of independence.

Who are occupational therapists (OTs)?

Occupational therapy practitioners are skilled professionals whose education includes the study of human growth and development with specific emphasis on the social, emotional and physiological effects of illness and injury. An occupational therapist can have a bachelor’s, master’s or doctoral degree, must complete supervised clinical internships in a variety of health care settings, and must pass a national examination. The California Board of Occupational Therapy (www.bot.ca.gov) regulates occupational therapy practice in California. Practitioners must be licensed or certified by the Board.

What’s the difference between physical therapy and occupational therapy?

Both types of therapy help people improve the quality of their lives. However, physical therapy deals with the issues of pain, strength, joint range of motion, endurance, and gross motor functioning, while occupational therapy deals with fine motors skills, visual-perceptual skills, strength, cognitive skills, and sensory-processing deficits.

If you suspect that a child could benefit from occupational therapy, encourage the family to talk with their health care provider for a referral for services. In addition, if the child is under 3 years old, families can be referred for an evaluation through the California Early Start Program at (800) 515-2229. If the child is 3 years or older, families should be referred to their local school district for an evaluation. ♦

Resource

The American Occupational Therapy Association (AOTA) at www.aota.org.

Strengthening Self-Esteem

When we talk about the need for good self-esteem, we mean that children should have good feelings about themselves. Children with healthy self-esteem feel that the people who most matter in their life accept, care about and protect them. How children feel about themselves affects the way they act. Keep these tips in mind for strengthening your child’s self-esteem.

- As they grow, children become increasingly sensitive to evaluations of their peers and need support to build healthy peer relationships.
- Children do not acquire self-esteem at once nor do they always feel good about themselves in every situation. Children may feel self-confident and accepted at home but not in preschool, or feel liked one moment but not the next. Reassure them that you support and accept them.
- Respond to children’s interests and efforts with appreciation rather than just praise.
- Offer tasks and activities that present a real challenge to stretch children’s abilities and give a sense of accomplishment.
- Self-esteem is fostered when children are esteemed by the adults important to them. Treat children respectfully, consider their views and opinions, and give them meaningful feedback.
- Help children cope with defeats and disappointments. Let them know your love and support remain unchanged and help them reflect on what went wrong. ♦

Adapted from “How Can We Strengthen Children’s Self-Esteem?” by Lilian Katz. (Summer 1995). ERIC Clearinghouse on Elementary and Early Childhood Education.

Health Screenings Make a Difference in San Francisco



by Robert Frank, MEd and Peter Vaernet, RN

Screening preschoolers to identify vision, hearing and dental deficits is one of the many functions of the San Francisco Child Care Health Linkages Team, which serves the city's lowest-income families who send their children to child care centers and family child care homes.

These screenings have been an effective means of catching and intervening with problems early, so young children are not only ready for kindergarten, but have a healthy start in life. Identifying crucial health issues while children are still in child care will enable them to get the help they need before minor problems become major roadblocks to their educational and developmental success.

Recently, a special case occurred which provides a clear example of the value of health consultation services. A 3-year-old child from Nepal who was screened by a Linkages staff member at a child care center was found to have massive decay of 16 of her 18 teeth. The child was obviously in pain and in need of dental treatment.

The Child Care Health Consultant realized that the family did not speak English, so he went to work on finding a Nepalese interpreter in the local community. He was able to arrange for an interpreter to accompany the family to UCSF, where the child was treated at the pediatric dental clinic. The child's tooth decay was so severe that she had to be placed under general anesthesia for surgery. Subsequently, a county public health nurse made a home follow-up visit with the family to ensure post-surgery instructions were followed and to explore what types of food, snacks and oral hygiene this family practiced.

Child Care Health Linkages made all the difference for this family, but screenings that find less dramatic problems can be crucial as well. By identifying health issues early, screenings help families in addressing health issues so their children can learn, grow and achieve their full potential. ♦

—Picky, Finicky Eaters, continued from page 3

- Let the children try all kinds of foods, even the ones you don't like!
- Involve the children in the fun process of preparing and serving the food.
- Encourage mealtime conversations.
- Communicate with parents and fellow staff about the healthy eating and cooking activities taking place in your program. ♦

Resources:

Making Food Healthy & Safe for Children: How to Meet the National Health & Safety Performance Standards – Guidelines for Out-of-Home Child Care Programs, National Center for Education in Maternal and Child Health.

Funding and Training News

by Abbey Alkon, RN, PhD

CCHP is pleased to announce that we were granted another year of funding for the Healthy Child Care California Project. This will be the last year of funding for this project, which is supported by the Federal Maternal and Child Health Bureau. The Healthy Child Care America project is working with a new federal initiative, the State Early Childhood Comprehensive Systems (SECCS) projects.

The California Maternal and Child Health (MCH) Department was awarded the SECCS grant and UCSF School of Nursing's California Child-care Health Program is a subcontract agency. We will work collaboratively with the MCH department to achieve the project goal of intergrating health into the state's comprehensive early childhood systems. This is a two-year planning grant that will be followed by a five-year implementation grant. ♦

Vaccination: An Act of Love

National Infant Immunization Week is April 25 – May 1, 2004, a time for child care programs to review the immunization records (blue cards) of children in care to make sure they are current. Infants and young children are particularly vulnerable to infectious diseases, so it is critical that they be protected through immunization. For information on materials and low-cost immunization clinics, contact your local Health Department's Immunization Coordinator, visit www.cdc.gov, or call Healthline at (800) 333-3212.

EVENTS

March

March 6

Annual School-Age Care Conference.

Gavilan Hills, CA. CalSAC;
www.calsac.org.

March 9-11

Tenth Annual Special Education Early Childhood Administrators Project Symposia.

Anaheim, CA. (760) 471-8208 x228;
www.sdcoe.k12.ca.us/seecap.

March 10-12

2004 CCDAA Annual Statewide Conference.

Pasadena, CA. (626) 967-7848.

March 18

Protecting Priorities in Uncertain Times.

Sacramento, CA. California Budget Project, (916) 444-0500; www.cbpp.org

April

April 15-17

Riding the Waves to Quality School-Age Care.

Pasadena, CA. California School-Age Consortium, (415) 957-9775;
www.calsac.org.

April 21

California Association for the Education of Young Children Public Policy Symposium.

Sacramento. CAEYC; Debi Badger, (805) 730-1126; www.caeyc.org.

April 21-23

California Children and Families Association (First Five) State Conference.

Burlingame, CA. CCAFA, (650) 347-1234; www.ccafa.org.

April 23-25

2004 CA Association for Family Child Care's 2004 Annual Conference.

San Francisco. (510) 536-9273;
www.cafcc.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
PlayWell Crayola® Activity Cube	Small parts can detach from the cube, posing a choking hazard to small children.	PlayWell Toy Company (800) 836-7928 www.regcen.com/activitycube
Lily Pad Clacker Instruments	The green coating on the Lily Pad Clacker instruments contain high levels of lead, posing a risk of poisoning.	Kindermusik (800) 628-5687 www.drmy.com lilypad@kindermusik.com.
Bumble Bee Toys with blue antennae sold with Graco high chairs, Graco mobile entertainers and separately.	The blue antennae on the Bumble Bee toy can break, posing a choking hazard to young children.	Graco (800) 258-3213
Swing-N-Slide "Mega Rider" Swings	The plastic handle on the swing could crack at the seat connection allowing the metal connecting rod to pull out.	Swing-N-Slide (800) 888-1232 www.swing-n-slide.com

—School Entry Physical Exams, continued from page 4

to role-play about going to the doctor to demystify the health exam. Set up the dramatic play area as a doctor or dentist office. Include pictures of an eye chart for pretend vision screening, and provide old ear muffs or head phones for pretend hearing tests. Set out other tools health care providers use, such as stethoscopes, pretend immunization syringes, and pretend doctor clothes.

Parents should be reminded to bring the child's immunization record to be updated and should ask for a copy of the exam results to take to the grade school when they enroll their child.

If parents do not have a regular health care provider or health insurance they can call their local Child Health Disability Prevention (CHDP) service located in the health department to find out if they are eligible for temporary Medi-Cal and a free CHDP health physical. The CHDP office can also refer parents to a local health care provider, a dentist or to on-going health insurance resources. Some CHDP offices also have coloring books that prepare children for physical exams.

The Healthline, at (800) 333-3212, maintains a list of local CHDP offices, sample eye charts for dramatic play and suggestions for books about doctor and dentist visits that are appropriate for young children. ♦

More on New California Laws

by Mardi Lucich, MA



AB 529 (Mullin): Family Child Care Home Capacity

Allows two additional children in family child care home settings. Small family child care homes can now have up to eight children without an assistant; large family child care homes can now have up to 14 children with an assistant provider, as long as one of the two additional children is enrolled in and attending kindergarten or elementary school, and a second child is at least 6 years of age. Family child care home licensees counting a child who is currently enrolled in and attending kindergarten or elementary school as one of the additional children in their capacity of eight or 14 children are required to:

1. Obtain the parent or authorized representative's written, signed statement that the child is currently enrolled in and attending kindergarten or elementary school.
2. Maintain the parent's/representative's written statement in the child's file.

Failure to take these steps before admitting the child into care could result in a citation for overcapacity.

AB 1752: License Fee Increases, Fingerprinting Fees and Facility Visits

Increased license and annual fees effective August 4, 2003, include the elimination of aggregate fees for licensees with multiple facilities. In addition, a fee will be charged by the Department of Justice for processing FBI fingerprints of any applicant serving six or fewer children, including applicants for a family child care license, or for obtaining a criminal record history of an applicant. Also, triennial visits are no longer made to family child care homes or annual visits to child care centers. Instead, annual visits will be made to facilities in which legal or compliance problems have been identified. Annual visits will also be made to 10 percent of the total number of licensed child care facilities identified using a random sample methodology.

AB 1697 (Pavley): Car Seat Law

Effective January 1, 2005, a child under the age of 6 years old who weighs less than 60 pounds must ride in the rear seat of a motor vehicle, except if:

- There is no rear seat.
- The rear seats are side-facing jump seats or are rear-facing seats.
- A child passenger restraint system cannot be properly installed in the rear seat.
- All rear seats are already occupied by children under the age of 12 years old.
- Medical reasons (not specified in the law) require that the child not ride in the rear seat. The court may require proof of the child's medical condition.

This law applies to parents, legal guardians and any driver transporting a child in a motor vehicle, including child care providers, unless the parent/legal guardian is also present in the car. ♦

New License Fee Schedules

Child Care Centers

capacity	fee
1-30	\$200
31-60	\$400
61-75	\$500
76-90	\$600
91-120	\$800
121+	\$1,000

Family Child Care Homes

capacity	fee
1-8	\$50
9-14	\$100

—Putting the Brakes on a Silent Epidemic, continued from page 1

accidents. Here are just a few tips:

- Always transport children in appropriate safety seats that have been properly installed.
- Teach children songs about car safety and the need to buckle up.
- Sponsor a car seat safety workshop at your child care program where parents can make sure they're using their seats properly.
- Place car safety posters around your program, especially by the doors where parents will see them as they leave.
- Find out about programs in your community where parents can get low-cost or free safety seats. ♦

Resources

Call the Healthline at (800) 333-3212, or visit www.cdc.gov/injury, www.nhtsa.dot.gov, or www.nsc.org for car seat safety resources.

—Food Fight! continued from page 2

Then there is the issue of food allergies. Solid foods should not be introduced into the diet of allergy-prone infants until 6 months of age, with dairy products delayed until 1 year, eggs until 2 years, and nuts and fish until 3 years of age. Infants with a family history of allergy may be two to four times more likely to develop a food allergy by the age of 2. Discuss with parents whether there is a family history of food allergies to help them determine whether a child is allergy-prone and caution about food introduction is indicated.

If a baby is developmentally ready, there is no history of family allergies and after discussion the family still wants you to feed their baby cereal—go ahead. ♦

Resources

To find out more about food allergies check out the Food Allergy & Anaphylaxis Network, (800) 929-4040, www.foodallergy.org or call Healthline at (800) 333-3212.

Resources

Guide to Advocacy for Parents of Children with Learning Disabilities, from the National Center for Learning Disabilities, describes ways parents can become involved in advocacy efforts and strategies for working with policymakers and the media. Information on learning disabilities and an online action center. www.nclld.org/advocacy/tutorial.cfm.

Pre-Primary Assessments: What the Experts Think, from the Erikson Institute, finds that experts and state preschool programs agree on the importance of developmentally appropriate, informal assessment techniques for children in child care. However, only 39 percent of states connect their assessment with the curriculum being taught and only 25 percent include parent evaluations and teacher meetings. www.erikson.edu/files/nonimages/horton-bowman.pdf.

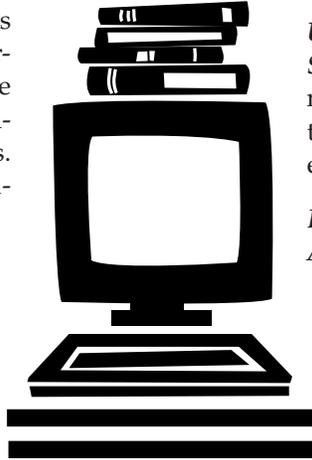
Union Advantage in Child Care, from Child Care Connection, discusses how the unionization of child care workers in Canada was a key factor in improving recruitment and retention of staff. www.childcarecanada.org/research/complete/CCAACUnion.html.

Geographic Disparities in Children's Mental Health Care, from the October issue of *Pediatrics*, 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>.

Lead Poisoning News provides information about lead poisoning, ways to protect children, and news about lead poisoning from selected states. Includes legal resources. Online at www.lead-poisoning-news.com.

Understanding Fathering: The Early Head Start Study of Fathers of Newborns, from *Mathematica*, makes recommendations to help fathers bond with their infants. www.mathematica-mpr.com/PDFs/ehsnewborns.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. Online at <http://jama.ama-assn.org/cgi/content/abstract/290/14/1859>. ♦



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