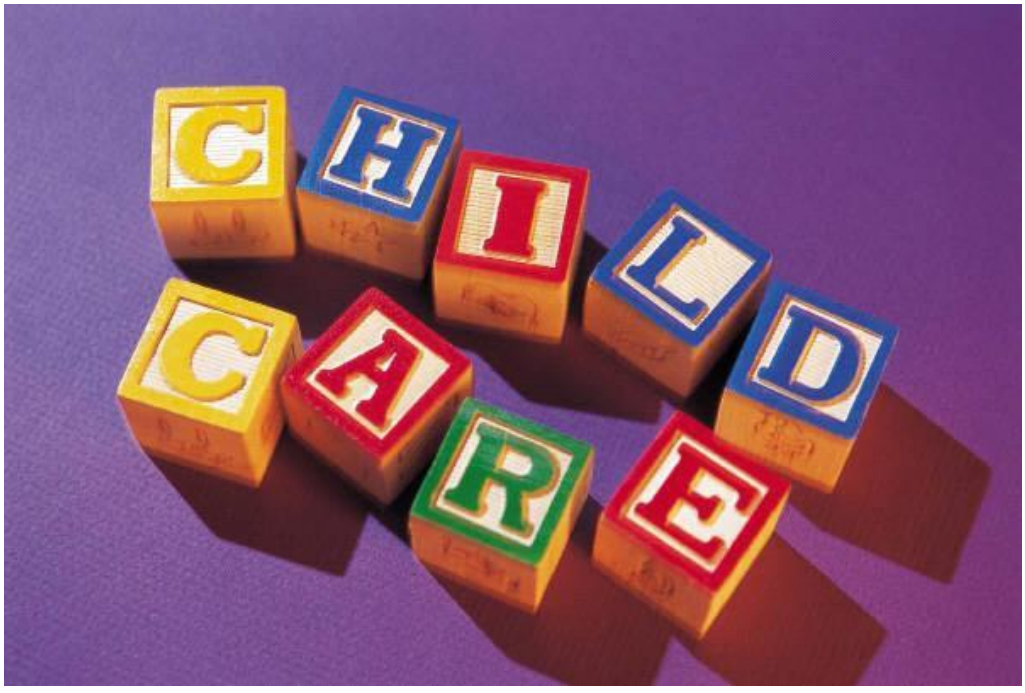
Illness and Reportable Diseases in Child Care

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

Resource Guide



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ILLNESS AND REPORTABLE DISEASES

According to the AAP Managing Infectious Diseases in Child Care and Schools: "Staff and child care providers must decide whether children are too ill to participate in care or require more care than can be reasonably be provided without compromising care of the others in the group." An exclusion decision by a responsible adult is always required when a decision to exclude would apply to children in care and the adults responsible for that care.

Requirements for exclusion related to "an acute illness" should be based on the requirements of The Maryland State Department of Education Office of Child Care (OCC) COMAR regulations 13.16-18.08.01 Individualized Attention to Care, and COMAR 13A.15.11.02 (Family) Health and 13A.16-18.11.01Center (Health) Exclusion for Acute illness regulations. An additional resource is the Department of Health and Mental Hygiene (DHMH) Communicable Disease Guideline information related to acute illness (fever, vomiting, and diarrhea) exclusion and required reporting to the local or state health department. These resources provide helpful information to inform the child care provider, the parent/guardian, and/or the health care provider when making the final determination about an acutely ill child or reporting a potential infectious disease exposure in a child or staff to the local health department. A partial list of Signs of Illness in Children may be found at Appendix **A** of this document, and will assist in making critical observations about the status of a child receiving care.

Caring for Our Children Standard 3.6.1.1 Inclusion/Exclusion Due to Illness recommends that caregivers /teachers should:

(a) Develop written exclusions policies and criteria that "promote consistency and aid to diffuse disagreements between parents/legal guardians and program/school staff members about the handling of children who are ill.

(b) Encourage all families to have a backup plan for child care in the event of short or long term exclusion;

(c) Review with families the inclusion/exclusion criteria and clarify that the program staff (not families) will make the final decision about whether children who are ill may stay based on the program's inclusion/exclusion criteria and their ability to care for the child who is ill without compromising the care of other children in the program;

(d) Develop policies and procedures for handling children's illnesses, medication/treatment authorizations (including care plans and inclusion/exclusion policies).

(e) Request a primary health care provider's note to readmit a child if the primary care provider's advice is needed to determine whether the child is a health risk to other, or if the primary care provider's guidance is needed about any special care the child requires;

(f) Rely on the family's description of the child's behavior to determine whether the child is well enough to return, unless the child's status is unclear from the parent's report.

(g) Notify the parent/guardian when a child develops new signs or symptoms of illness. Parent/guardian notification should be immediate for emergency or urgent issues. Staff should notify parents/guardians of children who have symptoms that require exclusion and parents/guardians should remove the child from the child care setting as soon as possible. Most conditions that require exclusion do not require a primary care provider visit before reentering care.

(h) For children whose symptoms do not require exclusion, verbal or written notification to the parent/guardian at the end of the day is acceptable.

When it is Necessary to Exclude Sick Children from Care

A child may be excluded from care if:

The child's illness prevents the child from participating comfortably in activities that the facility routinely offers for well children or mildly ill children.

1) The child is displaying any of the signs and symptoms that require an evaluation from a health care provider as indicated by the child's age and condition. In this situation the parent is notified of the need for immediate emergent or urgent issues.

2) The illness requires more care than the child care staff is able to provide without compromising the needs of the other children in the group.

3) The child exhibits an acute change in behavior, and examples include lethargy/lack of responsiveness, irritability, persistent crying, difficult breathing, or having a quickly spreading rash

4) The child with fever: Temperature at or above 100.0◦ F orally, 101 ◦ F rectally or temporally (Temporal Artery Forehead scan), or 99.5◦ F axillary (armpit). Exclusion due to fever should be based on disease-specific guidelines or other clinical guidance from the child's health care provider.

5) The child with Diarrhea: Loose or watery stools of increased frequency that is not associated with change in diet. Stools that is not able to be contained by a diaper or be controlled /contained by usual toileting practices. Exclude until diarrhea has resolved and child is diarrhea-free for at least 24 hours; or until cleared by medical provider.

6) The child with Vomiting: Two or more episodes of vomiting in a 24 hour period. The child should be excluded until vomiting resolves or until a health care provider clears for return.

7) The child mouth sores with drooling unless the child's primary care provider or local health department authority states that the child is noninfectious.

8) The child with rash with fever or behavioral changes, until the primary care provider has determined that the illness is not an infectious disease.

9) The child with Impetigo/Scabies, until treatment has been started.

10) The Child with Hand, Foot and Mouth Disease: Fever, uncontrollable "hand to mouth" behavior, not able to contain their secretions, such as ulcers in the mouth and the child is drooling, or draining sores that cannot be covered.

If child care staff is uncertain about whether the child's illness poses an increased risk to others, exclude the child until a health care provider notifies the child care program that the child may attend. If a child's illness does not meet any of the above criteria or infectious disease criteria for exclusion as listed in the DHMH Communicable Disease Summary, the child should not be excluded.

Follow These Procedures for a Child Who Requires Exclusion

The caregiver/teacher must:

a) Provide care in a place where the child will be comfortable and supervised by someone who knows the child well and who will continue to observe the child for new or worsening symptoms. A potentially contagious child should be separated from other children by at least three feet.
b) Ask the parent/guardian to pick up the child as soon as possible
c) Discuss the signs and symptoms of illness with the parent/guardian or primary care provider
d) Follow the advice of the primary care provider
e) Contact the local health department if there is a question of a reportable (harmful) infectious disease in a child or staff member in the facility. The Health Department has the legal authority to make a final determination
f) Document actions in the child's file with date, time, symptoms actions taken (and by whom); sign and date the document.

g) Develop a procedure for parent/staff information and share it with your assigned licensing specialist. Update it as needed.
h) Follow general cleaning and sanitation procedure

Conditions/Symptoms That Do Not Require Exclusion

a) Common colds, runny noses (regardless of color or consistency of nasal discharge);
b) A cough not associated with an infectious disease or fever;
c) Fever: Temperature up-to 100.0°F orally, 101° rectally or temporally or (99.5F axillary) without any signs or symptoms of illness in children older than six months regardless of whether acetaminophen or Ibruprofen was given; ***Remember children, younger than 6 months of age, with a fever requires a parent to contact a health care provider for an evaluation and recommendations for treatment.
d) Rash without fever and behavioral changes;
e) Lice or nits (exclusion for treatment may be delayed until the end of the day);
f) Ringworm (exclusion may be delayed until the end of the day. Lesions must be covered. If there is a possibility of high contact sports or other skin to skin activity the child should be excluded from the activity).

References:

Caring for Our Children (2013).National Health and Safety Performance Standards, Guidelines for Early Care and Education Programs,3rd(ed).

Communicable Disease Summary:
http://phpa.dhmh.maryland.gov/IDEHASharedDocuments/guidelines/CDSummary_FINAL_2011_Nov.pdf

Communicable Disease Fact Sheets:
http://phpa.dhmh.maryland.gov/SitePages/fact-sheets.aspx

SIGNS OF ILLNESS IN CHILDREN

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

General Appearance

- Excessive crying, clinginess, fussiness
- Doubled over in pain, unable to move
- Listless, lethargic, unresponsive
- Vomiting, diarrhea
- Feverish
- Seizure (although child has no history of seizure disorder)

Breathing

- Fast, shallow, gasping breaths
- Difficulty breathing, wheezing
- Sucking in around ribs
- Flaring nostrils
- Persistent or uncontrollable coughing

Skin

- Pale, grayish, flushed, yellowish skin
- Hot or cold and clammy skin
- Skin rashes, sores, swelling, or bruising
- Scratching at skin or scalp
- Skin doesn't spring back when pinched

Eyes, Nose, Ears, and Mouth

- Eyes swollen, red, crusty, watery, yellowish, or sunken
- Nose congested or runny
- Ears draining pus or blood
- Pulling at ears
- Mouth or lips with sores
- Sore throat, difficulty swallowing
- Excessive drooling

Appearance of Urine/Stool

- Gray or white stool
- Black or blood-flecked stool
- Unusually dark or tea-colored urine

Excerpts from COMAR 10.06.01 - For Informational Purposes Only

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Subtitle 06 DISEASES
Chapter 01 Communicable Diseases and Related Conditions of Public Health Importance

Authority: Health-General Article, §§2-104(b), 18-102, 18-105, 18-202, 18-307, and 24-101—24-110, Annotated Code of Maryland

.2 Definitions.

B. Terms Defined.

(5) Child Care Facility.

(a) "Child care facility" means a licensed, registered, or unlicensed facility, institution, establishment, or home where children receive care or supervision for which money is paid when the child's parent has given the child's care over to another on a regular basis for some portion of a 24-hour day as a supplement to the parent's primary care of the child.
(b)"Child care facility" includes child care center, day care center, nursery, family day care home, and babysitter.

Diseases, Conditions, Outbreaks, & Unusual Manifestations Reportable by Maryland Health Care Providers

The regulations governing reporting were last updated effective October 1, 2008. Table 1, below, copied from the Code of Maryland Regulations (COMAR) 10.06.01.03 C, details the diseases, conditions, outbreaks, and unusual manifestations that are reportable in Maryland. The table has been altered from the exact COMAR version by the addition of information about the reporting of AIDS, arboviral infections and HIV. This document is intended to provide guidance about reporting to physicians and other health care providers, hospitals and other health care institutions, and certain other groups specified below. For simplicity, the use of "health care providers" in this document refers to all those groups that are required to report, except laboratories, which have a separate guidance document for their use. In addition to the list of reportable conditions, Table 1 also indicates the timeframe for reporting. Several footnotes to the table elaborate on specific details, as do the following sections of this document: Legal Authority, Who Should Report, What to Report, How to Report, When to Report, and Where to Report. The full text of the regulations can be found in COMAR (online at www.dsd.state.md.us/comar/).

Who Should Report: The following persons and establishments shall report:

1. Health care providers (for example, physician, physician's assistant, dentist, chiropractor, nurse practitioner, nurse, medical examiner, administrator of a hospital, clinic, nursing home, or any other licensed health care provider)
2. Public, private, or parochial school and child care facility personnel (teacher, principal, school nurse, superintendent, assistant superintendent or designee).
3. Masters or person in charge of vessels or aircraft within the territory of Maryland.
4. Owners or operators of food establishments.
5. Any individual having knowledge of an animal bite.

What to Report: Diseases, Conditions, etc. Health care providers must report those diseases and conditions as indicated in Table 1. Reporting by laboratories does not nullify the health care provider's or institution's obligation to report these diseases and conditions, nor does reporting by health care providers nullify the laboratory's obligation to report.

When to Report: Health care providers should report according to the "Timeframe for Reporting" shown in Table1. There are two timeframe categories: "immediate" and "within one working day." When an immediate report is required, the person making the report should communicate directly with an individual and not leave a message on an answering device.

Where to Report: Each jurisdiction in Maryland has its own health department. Health care providers must submit a report in writing of diagnosed or suspected cases of the specified diseases and conditions to the Commissioner of Health in Baltimore City or the health officer in the county where the provider cares for that person. See Table 3 for addresses and telephone numbers for local health departments, including numbers for after hours or weekend reporting.

Additional Information Should the health department needs to contact the patient, the advice and assistance of the reporting health care provider will ordinarily be sought first. Health departments offer medical and epidemiological consultation and laboratory assistance to physicians and other health care providers.

HIPAA: The HIPAA Privacy Rule permits physicians and other covered entities to disclose protected health information, without a patient's written authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease. This includes conducting public health surveillance, investigations, or interventions. (For more about the privacy rule and public health see: http://dhmh.maryland.gov/hipaa/SitePages/Home.aspx and http://www.cdc.gov/mmwr/preview/mmwrhtml/su5201a1.htm.)

Getting Up-to-Date Information

Requirements for reporting diseases and other important information will change with time. Please call your local health department or the Maryland Department of Health and Mental Hygiene - Division of Infectious Disease Surveillance (410-767-6709), or visit one of the following Internet sites to obtain the most current information.

HEALTH CARE PROVIDERS, INSTITUTIONS, & OTHERS[1]	Reporting Time Period	
Diseases and Conditions	**Immediate**	**Within One Working Day**
Arboviral infections including, but not limited to: Chikungunya virus infection Dengue fever Eastern equine encephalitis LaCrosse virus infection St. Louis encephalitis Western equine encephalitis West Nile virus infection Yellow fever Zika virus disease	X	
Babesiosis		X
Botulism	X	
Brucellosis	X	
Campylobacteriosis		X
Chancroid		X
Chlamydia trachomatis, including lymphogranuloma venereum (LGV)		X
Cholera	X	
Coccidioidomycosis		X
Creutzfeldt-Jakob disease		X
Cryptosporidiosis		X
Cyclosporiasis		X
Diphtheria	X	
Ehrlichiosis		X
Encephalitis, infectious		X
Epsilon toxin of Clostridium perfringens	X	
Escherichia coli O157:H7 infection	X	
Giardiasis		X
Glanders	X	
Gonococcal infection		X

HEALTH CARE PROVIDERS INSTITUTIONS, & OTHERS[1]	Reporting Time Period	
Diseases and Conditions	**Immediate**	**Within One Working Day**
Haemophilus influenzae invasive disease	X	
Hantavirus infection	X	
Harmful algal bloom related illness		X
Hemolytic uremic syndrome, post- diarrheal		X
Hepatitis A acute infection	X	
Hepatitis, viral (B, C, D, E, G, all other types and undetermined)		X
Human immunodeficiency virus (HIV) infection[5]	x(physicians)	With in 48hours for institutions)
Human immunodeficiency virus (HIV) perinatal exposure (infant whose mother has tested positive for HIV)		(within 48 hours of birth, for physicians)
Influenza-associated pediatric mortality		
Influenza: novel influenza A virus infection	X	
Isosporiasis		X
Kawasaki syndrome		X
Legionellosis	X	
Leprosy		X
Leptospirosis		X
Listeriosis		X
Lyme disease		X
Malaria		X
Measles (rubeola)	X	
Melioidosis	X	

HEALTH CARE PROVIDERS, INSTITUTIONS, & OTHERS[1]	Reporting Time Period	
Diseases and Conditions	**Immediate**	**Within One Working Day**
Meningitis, infectious		X
Meningococcal invasive disease	X	
Microsporidiosis		X
Mumps (infectious parotitis)		X
Mycobacteriosis, other than tuberculosis and leprosy		X
Pertussis	X	
Pertussis vaccine adverse reactions		X
Pesticide related illness		X
Plague	X	
Pneumonia in a health care worker resulting in hospitalization		X
Poliomyelitis	X	
Psittacosis		X
Q fever	X	
Rabies (human)	X	
Ricin toxin poisoning	X	
Rocky Mountain spotted fever		X
Rubella (German measles) and congenital rubella syndrome	X	
Salmonellosis (nontyphoidal)		X
Severe acute respiratory syndrome (SARS)	X	

HEALTH CARE PROVIDERS, INSTITUTIONS, & OTHERS[1]	Reporting Time Period	
Diseases and Conditions	**Immediate**	**Within One Working Day**
Shiga-like toxin producing enteric bacterial infections	X	
Shigellosis		X
Smallpox and other orthopoxvirus infections	X	
Staphylococcal enterotoxin B poisoning	X	
Streptococcal invasive disease, Group A		X
Streptococcal invasive disease, Group B		X
Streptococcus pneumoniae invasive disease		X
Syphilis		X
Tetanus		X
Trichinosis		X
Tuberculosis and suspected tuberculosis[6]	X	
Tularemia	X	
Typhoid fever (case, carrier, or both, of Salmonella Typhi)	X	
Vancomycin-intermediate *Staphylococcus aureus* (VISA) infection or colonization		X
Vancomycin-resistant *Staphylococcus aureus* (VRSA) infection or colonization		X
Varicella (chickenpox), fatal cases only		X
Vibriosis, non-cholera[7]		X
Viral hemorrhagic fevers (all types)	X	
Yersiniosis		X

Outbreak Reporting

Outbreak means:

- A **foodborne** disease outbreak, defined as two or more epidemiologically related cases of illness following consumption of a common food item or items, or **one case** of the following:

  - Botulism
  - Cholera
  - Mushroom poisoning
  - Trichinosis
  - Fish poisoning such as Ciguatera poisoning
  - Scombroid poisoning
  - Paralytic shellfish poisoning
  - Any other neurotoxic shellfish poisoning

- Three or more cases of a disease or illness that is not a foodborne outbreak and that occurs in individuals who are not living in the same household, but who are epidemiologically linked;
- An increase in the number of infections in a facility, such as a hospital, long-term care facility, assisted living facility, school, or child care center, over the baseline rate usually found in that facility;
- A situation designated by the Secretary as an outbreak; or
- One case of:

  - Anthrax
  - Plague
  - Rabies (human)
  - Smallpox
  - Any of the single cases defined as a foodborne disease outbreak above

An outbreak of a disease of known or unknown etiology that may be a danger to the public health should be reported to your local health department immediately.

MARYLAND LOCAL HEALTH DEPARTMENTS

Addresses & Telephone Numbers for Infectious Disease Reporting

Telephone (**T**) or Pager (**P**) Number for After Hours and Weekend Reporting

JURISDICTION	ADDRESS	JURISDICTION	ADDRESS
ALLEGANY Ph. 301-759-5112 Fax 301-777-5669 •**T** 301-759-5000	PO Box 1745 12501 Willowbrook Road SE Cumberland MD 21501-	**HARFORD** Ph. 410-612-1774 Fax 410-612-9185 •**T** 443-243-5726	1321 Woodbridge Station Way Edgewood MD 21040
ANNE ARUNDEL Ph. 410-222-7256 Fax 410-222-7490 •**T** 443-481-3140	Communicable Disease & Epi. 1 Harry S. Truman Parkway Room 231 Annapolis MD 21401	**HOWARD** Ph. 410-313-1412 Fax 410-313-6108 •**T** 410-313-2929	8930 Stanford Blvd Columbia MD 21045
BALTIMORE CITY Ph. 410-396-4436 Fax 410-625-0688 •**T** 410-396-3100	1001 E. Fayette Street Baltimore MD 21202	**KENT** Ph. 410-778-1350 Fax 410-778-7913 •**T**(410) 708-5611	125 S. Lynchburg Street Chestertown MD 21620
BALTIMORE CO. Ph. 410-887-6011 Fax 410-377-5397 •**T** 410-832-7182	Communicable Disease, 3rd Floor 6401 York Road Baltimore MD 21212	**MONTGOMERY** Ph. 240-777-1755 Fax 240-777-4680 •**T** 240-777-4000	2000 Dennis Avenue Suite 238 Silver Spring MD 20902
CALVERT Ph. 410-535-5400 Fax 410-414-2057 •**P** 443-532-5973	PO Box 980 975 Solomon's Island Road Prince Frederick MD 20678	**PR. GEORGE'S** Ph. 301-583-3750 Fax 301-583-3794 •**T** 240-508-5774	3003 Hospital Drive Suite 1066 Cheverly MD 20785-1194
CAROLINE Ph. 410-479-8000 Fax 410-479-4864 •T 443-786-1398	403 South 7th Street Denton MD 21629	**QUEEN ANNE'S** Ph. 410-758-0720 Fax 410-758-8151 •**T** 410-758-3476	206 N. Commerce Street Centreville MD 21617
CARROLL Ph. 410-876-4900 Fax 410-876-4959 •**T** 410-876-4900	290 S. Center Street Westminster MD 21158-0845	**ST. MARY'S** Ph. 301-475-4316 Fax 301-475-4308 •**T** 301-475-8016	PO Box 316 21580 Peabody Street Leonardtown MD 20650
CECIL Ph. 410-996-5100 Fax 410-996-1019 •**T** 410-392-2008	John M. Byers Health Center 401 Bow Street Elkton MD 21921	**SOMERSET** Ph. 443-523-1740 Fax 410-651-5699 •**T** 443-614-6708	Attn: Communicable Disease 7920 Crisfield Highway Westover MD 21871
CHARLES Ph. 301-609-6810 Fax 301-934-7048 •T 301-932-2222	PO Box 1050 White Plains MD 20695	**TALBOT** Ph. 410-819-5600 Fax 410-819-5693 •**T** 410-819-5600	100 S. Hanson Street Easton MD 21601
DORCHESTER Ph. 410-228-3223 Fax 410-901-8180 •**P** 410-221-3362	3 Cedar Street Cambridge MD 21613	**WASHINGTON** Ph. 240-313-3210 Fax 240-313-3334 •T 240-313-3290	1302 Pennsylvania Avenue Hagerstown MD 21742
FREDERICK Ph. 301-600-3342 Fax 301-600-1403 •**T** 301-600-1603	350 Montevue Lane Frederick MD 21702	**WICOMICO** Ph. 410-543-6943 Fax 410-548-5151 •**T** 410-543-6996	Attn: Communicable Disease 108 E. Main Street Salisbury MD 21801-4921
GARRETT Ph. 301-334-7777 Fax 301-334-7771 Fax 301-334-7717 •**T** 301-334-1930	Garrett Co. Community Health Ctr. 1025 Memorial Drive Oakland MD 21550-4343 (Fax for use during emergencies)	**WORCESTER** Ph. 410-632-1100 Fax 410-632-0906 •**T** 443-614-2258	PO Box 249 Snow Hill MD 21863

Sample Emergency Numbers Form

Post this information by each telephone or accessible to staff	
Center and Other Emergency Numbers	
Center/Family Home Care Name	
License /Registration Number	
Center/Family Home Care Address	
Center Phone Number	
Available Staff Name/Names	
Emergency Number	
Poison Control	
Law enforcement	
DSS-Child Protective Service	
Health Department Communicable Diseases Division Number	
Licensing Office Number	
Licensing Specialist Number	
Health/Nurse Consultant Number	
Other Useful Information- Emergency Exit :	

Recommendations adapted from

1.Aronson, S.S., T.R. Shope, eds. 2013 the American Academy of Pediatrics (AAP) Managing Infectious Diseases in Child Care and Schools Managing Infectious Diseases in Child Care and Schools 3rd Edition© 2013

2.Instructions for Maryland Infectious Disease Morbidity Reporting (DHMH 1140)

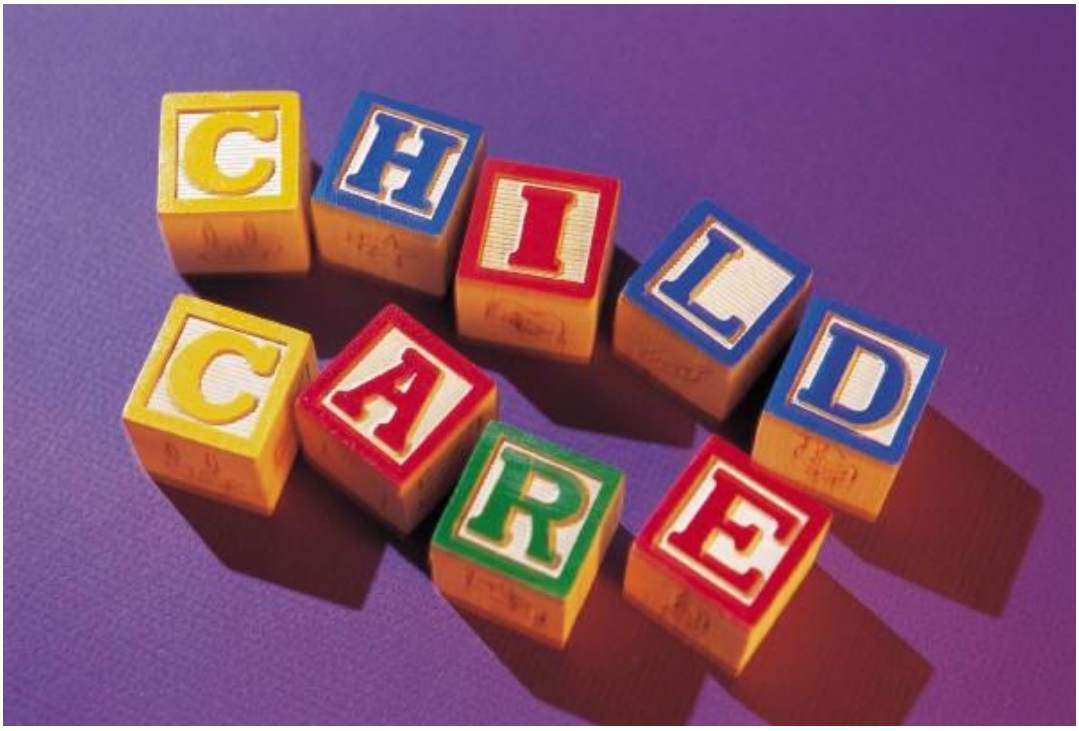
3..The AAP Model Health Care Policies 5th Edition & Caring for Our Children: National Health and Safety Performance Standards Guidelines for Early Care and Education 3rd Edition.

ASTHMA AND ALLERGIES

Caring for Children with Asthma and Allergies in Child Care Facilities

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

Resource Guide



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CARING FOR CHILDREN WITH ASTHMA AND ALLERGIES IN CHILD CARE FACILITIES

Introduction

There are many children in child care facilities with a diagnosis of asthma, have serious reactions to allergens, and may need emergency medical attention. Allergic reactions (anaphylaxis) are an immune system hypersensitivity to a particular substance called an allergen. For many allergic individuals, exposure to an allergen results in mild symptoms. However, for some, allergic reactions can be severe and result in potentially life-threatening medical conditions. The most dangerous symptoms include breathing difficulty and a drop in blood pressure or shock, both of which are potentially fatal. Anaphylaxis refers to this type of severe allergic reaction. Anaphylaxis may affect children with both known allergies and those without known allergies.

Asthma is a chronic lung disease that lasts for long periods of time and involves ongoing management of the disease. Asthma may require periodic treatment to lessen the severity of inflammation and irritation to the lungs and affects the child's ability to breathe effectively. The level of severity of the disease and adherence to prescribed medication prior to and in response to symptoms can prevent life threatening breathing difficulties.

The Office of Child Care requires early education and child care providers to take great care in administering and storing medications as indicated in the Code of Maryland Regulations **(COMAR) 13A.15-18.11.04** Medication Administration and Storage. The regulations allow school-age children to self-carry and self–administer their medications for asthma and anaphylaxis emergencies in accordance with **COMAR 13A.15-18.11.04H**. It is important for child care providers to understand and follow regulations and health care provider instructions when caring for children with asthma and allergies.

Purpose

The purpose of this document is to provide guidance to early child care providers when caring for children with asthma and allergies. These guidelines will also help in planning for and managing school age children permitted to self-carry and self-administer emergency medications. Child care providers responsible for children with life-threatening allergies must plan and provide for five key activities: 1) allergy awareness training, 2) emergency planning, 3) allergen exposure avoidance measures in the environment, 4) treatment to control symptoms and 5) training of staff. Child care providers, the school-age child allowed to self-carry and self-administer medications for allergy and asthma treatment, child care staff, and parents all have responsibilities within each of these key areas. Managing allergies and asthma in child care is a team effort among the health care provider, family, child, and authorized caretakers.

KEY ACTIVITIES REQUIRED FOR ASTHMA AND ALLERGY EMERGENCY RESPONSE PREPAREDNESS

Training

Training for child care staff and children attending the child care program should be a major priority for the management and prevention of asthma and allergic reactions in the child care setting. While **COMAR 13A.16.11.04F** mandates medication to be administered to a child in care only by an employee who has completed approved medication administration training, general training should be provided to all child care staff involving the care and management of children with asthma and allergies. The priorities should include:

- General training for all child care staff and children;
- In depth training to staff who have frequent contact with children diagnosed with asthma and/or allergies;
- Specialized training to include signs of symptoms specific to asthma or allergies, medications and the associated medication delivery device;
- Guidance and direction for all staff in how to follow special health care plans specific to the child's needs; and
- Environmental factors related to controlling asthma symptoms and avoiding allergens in the child care setting.

Note: *You may contact your local Child Care Resource Center for Asthma and Allergy/Medication Administration training resources.*

Emergency Planning

All programs providing care to children, no matter the setting should have emergency procedures in place to respond effectively to an emergency. Emergency planning should include:

- Ensuring that children with known asthma and/or allergies have Asthma Allergy Action Plans;
- Developing and using specific procedures to identify children with food or other allergies;
- Developing a plan for managing or reducing environmental risks for exposure to allergens and triggers for asthma symptoms;

- Setting up communication systems that are easy to use during an emergency situation;

- Making sure staff can get to auto-injectors or asthma medications quickly and easily;

- Making sure that children and staff are aware of how to access emergency medical services; and

- Documenting the response to the emergency related to an exposure to an allergen or a child with increased asthma symptoms.

Maintaining an Allergen and Asthma Trigger Free Environment

Each child care facility should provide a healthy and safe child care environment. This includes a clean and hygienic environment. To manage asthma and allergies this includes limiting the presence of known and unknown substances that may trigger or increase the severity of a medical condition. Program staff should be responsible for:

- Creating and maintaining a clean and safe child care environment;

- Using nonfood items for rewards or incentives;

- Creating ways for children with asthma and allergies to participate in activities;

- Eliminating or preventing the presence of known allergens or triggers, such as dust, use of household chemicals, and fragrances;

- Maintaining the prescribed food service procedures that prevents contact with other food to known allergens;

- Instructing the staff and monitoring for safe food handling practices; and

- Maintaining good hand washing procedures for staff and children throughout the day.

Parental and Staff Responsibilities in Managing and Maintaining Asthma & Allergy Plans Parental Responsibilities

- Upon enrollment, parents must provide to the child care provider, health information at registration, or upon diagnosis, of all health issues unique to the child. The diagnosis of asthma allergy must be confirmed by the health care provider upon completion and submission of the OCC 1215 Health Inventory, along with an OCC 1216 Medication Administration Authorization Form for medications to be administered, and an asthma and/or allergy action plan detailing activities to be provided by the child care staff specific to the needs of the child. **(Forms OCC 1215 and OCC 1216 may be found at www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms)**

- Parents must provide accurate information about the child's medical status and condition at all times.

- Parents must advise the child care provider of any changes in health care provider treatment goals and medications at all times.

- Parents must supply all prescribed medication and/or medication delivery devices.

- Parents must sign, along with the health care provider, the OCC 1216 Medication Administration Authorization Form, and if appropriate, sign the self carry/self administration section verifying that the child is capable of carrying out the self carry/self administration activity without supervision.

- In cooperation with the child care provider, parents must establish an agreement to contact the health care provider to obtain missing information, medications and/or for clarification of any instruction or necessary information to carry out the care plan if all information, medications and/or equipment is not provided.

Staff Responsibilities

- Staff must ensure that the Asthma Action Plan or Allergy Action Plan is current and not dated more than one year prior to the date of the day the care is delivered;

- Staff must frequently review and monitor records to ensure the care plan remains consistent with the licensed health care provider's authorized plan of care;

- Staff must conduct an annual Asthma/Allergy Self-Carry Action plan review or more often as indicated by the content of the plan of care;

- Staff must ensure that all medications have a current expiration date or is returned to the parent (or discarded) as indicated by the date on the medication;

- Staff must ensure that assigned staff receiving and reviewing the care plan, signs the medication authorization form verifying the receipt of and an understanding of the care plan's contents; and

- Staff must ensure that the child care staff person documents in the record each instance of the administration of medication to a child, and a school-age child's self-administration of medication, on the OCC 1216 Medication Administration Authorization Form. Staff should always document the date, time and reason the medication was administered.

Emergency Management of an Allergy or Anaphylaxis Episode

Anaphylaxis usually occurs immediately (seconds or minutes), but also may occur several hours after allergen exposure. Symptoms can progress rapidly, making it a medical emergency. Any combination of signs and symptoms of an anaphylactic reaction may be present. Any one or combination of signs and symptoms are an indication for action. ***Not all signs and symptoms need be present in anaphylaxis***.

Follow the procedures for the administration of a prescribed medication and/or the administration of an auto-injector prescribed by the child's health care provider in the child's Allergy Action Plan (**Attachment 1**).

(The Allergy Action Plan document may also be found at www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/res_docs.)

Follow this emergency procedure when training and supporting child care staff about the management of a child during an anaphylaxis episode while in a child care program regulated by the Maryland State Department of Education, Office of Child Care.

1. Rapidly assess Airway, Breathing, and Circulation (ABC's) and begin CPR as necessary;

2. Follow the allergy action plan completed by the child's health care provider. This may include the administration of prescribed medication and/or auto-injector.

3. If administering an auto-injector, follow directions found on the device.

4. Call 911 after administering prescribed medication and/or auto-injector notifying the dispatcher of the type of medication administered to the child for an anaphylactic reaction, and informing them that paramedics are needed to provide continued care.

5. Contact the parent or guardian.

6. Assist the child into a comfortable position.

7. Loosen restrictive clothing and keep the child calm;

8. When EMS responds, turn the care over to them along with the child care health record to go with the child to the emergency room; and

9. If there is no parent or guardian available, send a staff person with the child.

Emergency Management of an Asthma Episode

Asthma is a chronic lung disease that lasts for long periods of time and involves ongoing management of the disease. Asthma may require periodic treatment to lessen the severity of inflammation and irritation to the lungs and affects the child's ability to breathe effectively. The level of severity of the disease and adherence to prescribed medication prior to and in response to symptoms can prevent life threatening breathing difficulties.

Follow this emergency procedure when training and supporting child care staff about the management of a child with any asthma symptoms while in a child care program regulated by the Maryland State Department of Education, Office of Child Care.

1. Observe asthma symptoms - the child reports difficulty with breathing, has difficulty speaking or is drowsy and not participating in activities.

2. Follow the Asthma Action Plan to administer the quick acting inhaler or nebulizer treatment. (**Attachment 2**)**.**

   (The Asthma Action Plan document may also be found at www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/res_docs.)

3. Contact the parent or guardian.

4. Restrict activity and allow the child to rest.

5. Place child in an area where there is quiet and little activity and can be observed by child care staff.

6. If child is not responding appropriately- call 911 and contact the parent again letting them know the child's status and that 911 has been called.

7. When EMS responds, turn the care over to them along with the child care health record to go with child to the emergency room.

8. If there is no parent or guardian available send a staff person with the child**.**

School-Age Children Who Self Carry/Self Administer Emergency Medication for Asthma and Allergies

When a school-age child is authorized and found to be capable of self-carrying and self-administer a quick relief medication, responsibilities must be met by all parties as indicated below:

School-Age Children Authorized to Self-Carry Must:

- Understand what condition the medication is to treat;
- Safely handle the medication at all times;
- Report symptoms of not feeling well to staff;
- Safely administer the medication with or without supervision; and
- Report each occurrence of self-administration of the medication to a staff person.

Parents Must:

- Upon enrollment, provide health information at registration, or upon diagnosis, of all health issues unique to the child to the child care provider. The diagnosis of asthma allergy must be confirmed by the health care provider upon completion and submission of the OCC 1215 Health Inventory, along with an OCC 1216 Medication Administration Authorization Form for medications to be administered, and an asthma and/or allergy action plan detailing activities to be provided by the child care staff specific to the needs of the child. **(Forms OCC 1215 and OCC 1216 may be found at www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms)**

- Provide accurate information about the child's medical status and condition at all times.

- Advise the child care provider of any changes in health care provider treatment goals and medications at all times.

- Supply all prescribed medication and/or medication delivery devices.

- Sign, along with the health care provider, the self-carry/self-administration section of the OCC 1216 Medication Administration Authorization Form verifying that the child is capable of carrying out the self-carry/self-administration activity without supervision.

- In cooperation with the child care provider, establish an agreement to contact the health care provider to obtain missing information, medications and/or for clarification of any instruction or necessary information to carry out the care plan if all information, medications and/or equipment is not provided.

Child Care Center Staff Must:

- Ensure that the Asthma Action Plan or Allergy Action Plan is current and not dated more than one year prior to the date of the day the care is delivered;

- Frequently review and monitor records to ensure the care plan remains consistent with the licensed health care provider's authorized plan of care;

- Conduct an annual Asthma/Allergy Self-Carry Action plan review or more often as indicated by the content of the plan of care;

- Ensure that all medications have a current expiration date or is returned to the parent (or discarded) as indicated by the date on the medication;

- Ensure that assigned staff receiving and reviewing the care plan, signs the medication authorization form verifying the receipt of and an understanding of care plan's contents; and

- Ensure that the child care staff person documents in the record each instance of the child self-administering medication on the OCC 1216 Medication Administration Authorization Form. Staff should always document the date, time and reason the medication was administered.

Note: Child care staff assigned to a child with an allergy/asthma self-carry self-administration plan should have successfully completed an approved OCC Medication Administration training curriculum.

Evidenced Based Resources to Support Activities

This policy incorporates the recommendations and standards as outlined in the: American Academy of Pediatrics and the American Public Health Association Caring for Our Children: National Health and Safety Standards for the preferred required actions, responsible parties and how information is communicated.

Contacts

For questions regarding information contained herein, contact **Cheryl Hall, Nurse Consultant**, Office of Child Care, Licensing Branch at **410-332-0815** or via email at Cheryl.Hall@msde.state.md.us **or**
Paula Johnson, Chief, Licensing Branch, Office of Child Care at **410-569-8071** or via email at Paula.Johnson@msde.state.md.us

Allergy Action Plan
Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

TREATMENT

Symptoms: The child has ingested a food allergen or exposed to an allergy trigger:	**Give this Medication** Epinephrine	Antihistamine
But is ***not*** exhibiting or complaining of any symptoms		
Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progressing (several of the above areas affected)		

*Potentially life-threatening. The severity of symptoms can quickly change.
*__IMPORTANT:__ Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Medication		**Dose:**
Epinephrine:		
Antihistamine:		
Other:		

_____ _____
Doctor's Signature Date

EMERGENCY CALLS

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name:_____ Phone Number:_____

Contact(s)	Name/Relationship	Phone Number(s) Daytime Number	Cell
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

*EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.

Health Care Provider and Parent Authorization for Self/Carry Self Administration
I authorize the child care provider to administer the above medications as indicated. **Students may self carry/self administer [school-aged only] ☐ yes ☐ No**

_____ _____
Parent/Guardian's Signature Date

Allergy Action Plan
(Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

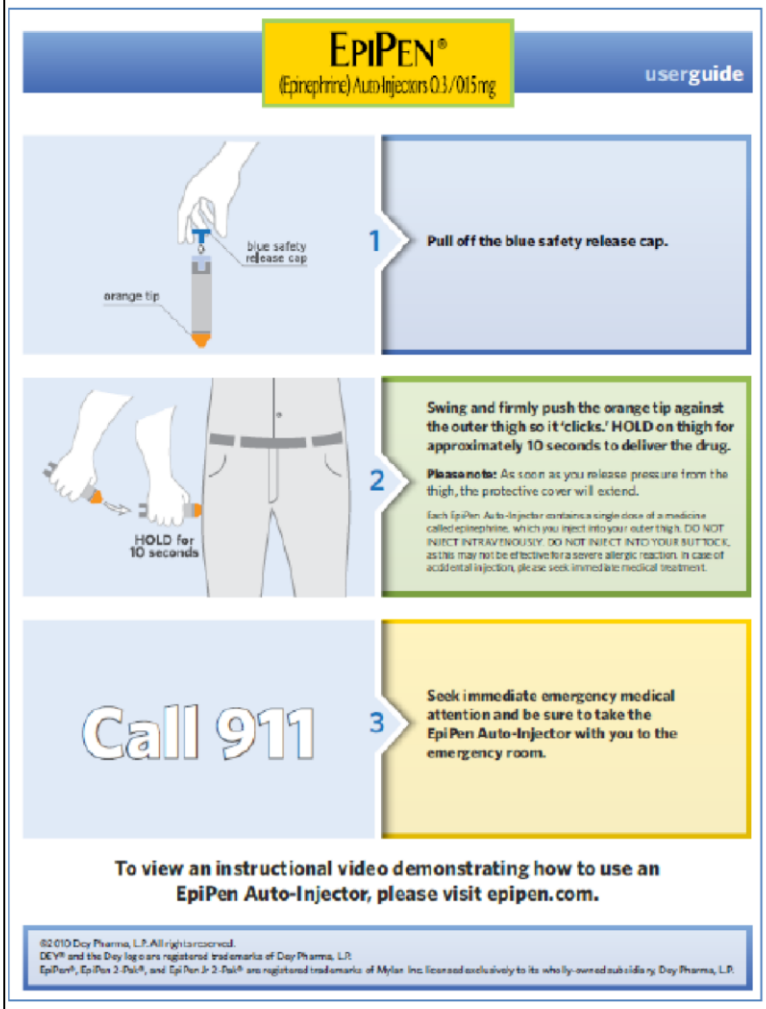
CHILD'S NAME: _____ **Date of Birth**: _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

The Child Care Facility will:

- ☐ Reduce exposure to allergen(s) by: (no sharing food,
- ☐ Ensure proper hand washing procedures are followed.
- ☐ Observe and monitor child for any signs of allergic reaction(s).
- ☐ Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.)
- ☐ Ensure that a person trained in Medication Administration accompanies child on any off-site activity.
- ☐



The Parent/Guardian will:

- ☐ Ensure the child care facility has a sufficient supply of emergency medication.
- ☐ Replace medication prior to the expiration date
- ☐ Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- ☐

Attachment 2

Maryland State Child Care/Nursery School
Asthma Medication Administration Authorization Form
ASTHMA ACTION PLAN for ___/___/__ to ___/___/___ (not to exceed 12 months)

MARYLAND STATE DEPARTMENT OF EDUCATION
PREPARING WORLD CLASS STUDENTS

Triggers (list)
_____
_____
_____
_____
_____
_____
_____

Student's
Name:_____ **DOB:**_____ **PEAK FLOW PERSONAL BEST:**_____

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE : Long Term Control Medication — use daily at home unless otherwise indicated

☐ Breathing is good ☐ No cough or wheeze ☐ Can work, exercise, play ☐ Other: _____ ☐ Peak flow greater than _____ (80% personal best)	Medication	Dose	Route	Frequency
☐ Prior to exercise/sports/ physical education	(Rescue Medication)			
	If using more than twice per week for exercise, notify the health care provider and parent/guardian.			

YELLOW ZONE: Quick Relief Medications — to be added to Green zone medications for symptoms

☐ Cough or cold symptoms ☐ Wheezing ☐ Tight chest or shortness of breath ☐ Cough at night ☐ Other: _____	Medication	Dose	Route	Frequency
☐ Peak flow between _____ and _____ (50%-79% personal best)	If symptoms do not improve in _____ minutes, notify the health care provider and parent/guardian. If using more than twice per week, notify the health care provider and parent/guardian.			

RED ZONE: Emergency Medications— Take these medications and call 911

☐ Medication is not helping within 15-20 mins ☐ Breathing is hard and fast ☐ Nasal flaring or skin retracts between ribs ☐ Lips or fingernails blue ☐ Trouble walking or talking ☐ Other:_____ ☐ Peak flow less than _____ (50% personal best)	Medication	Dose	Route	Frequency
	Contact the parent/guardian after calling 911.			

Health Care Provider and Parent Authorization

I authorize the child care provider to administer the above medications as indicated. By signing below, I authorize to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs. Student may self-carry medications:

[School-age children) ☐Yes ☐No

Prescriber signature: _____ **Date:** _____ **Parent / Guardian Signature:** _____ **Date:** _____

Reviewed by Child Care Provider: Name: _____ **Signature:** _____ **Date:** _____

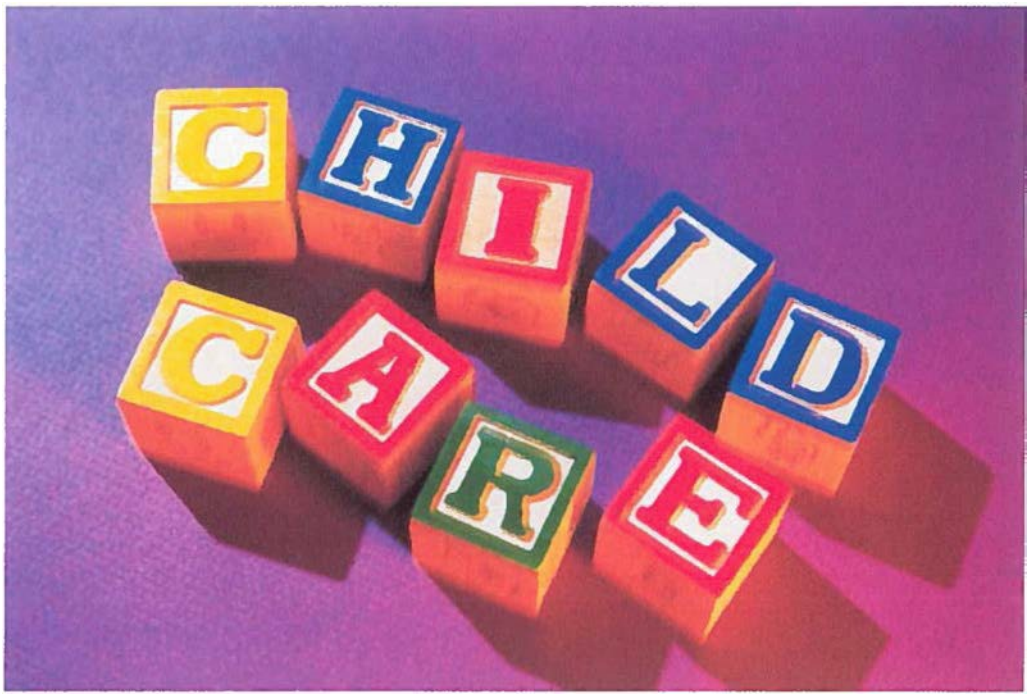
3/20/2014

Safe Sleep Practices and Swaddling

With Excerpts from CDC, AAP & CCDF Health and Safety Standards

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

Resource Guide



February 15, 2017

Safe Sleep Practices and Swaddling in Child Care

Sudden Infant Death Syndrome (SIDS)

Sudden Infant Death Syndrome (SIDS) is the leading cause of deaths in infants between one month and one year of age. Most SIDS deaths happen when the babies are between 1 month and 4 months of age. Each year about 4000 infants die unexpectedly during sleep time. The causes of Sudden Infant Death Syndrome-SIDS (sleep related deaths) include suffocation, asphyxia, entrapment, strangulation, and other unspecified causes.

The leading cause of death of infants aged One to Twelve months include;

1. Unknown Cause

2. Accidental Suffocation and Strangulation in Bed (ASSB). The causes include Suffocation by soft bedding (pillow, sheet/bed linen covering an infant's mouth and nose), overlay due to another person rolling on top or against the infant, Wedging or entrapment compressing the infant with mattress, wall, bed frame or furniture, and strangulation when an infant's head and neck caught between crib railings

Swaddling

There is no evidence to recommend swaddling as a strategy to reduce the risk of SIDS. Swaddling, or wrapping the infant in a light blanket, is often used as a strategy to calm the infant. If swaddled, baby should be on the back and STOP swaddling as soon as the baby starts turning/rolling .There is a high risk of death if a swaddled infant is placed- in or rolls to the prone position(on stomach ,face down).

Decisions about swaddling should be recommended by a Health Care Provider.

Safe Sleep Practices

Safe sleep practices reduce SIDS risks and promote protective effects against SIDS. The recommended safe sleep practices include:

Sleep Position: Always place babies on their backs when putting them to sleep or naps.

Sleep Surface: Infants should sleep in a Safety-Approved Crib, or Portable Crib. Cribs should be with no pillows, pillow like toys, crib bumper, stuffed animals, quilts, comforters, sheepskins, loose bedding, and other loose items. Blankets are not allowed instead layered baby clothing (one additional layer) may be allowed to keep the baby warm.

Bedding: Infants sleep on a FIRM SURFACE. Bed should be firm with well and tightly fitted sheet. Bedding should meet safety standards. Bedding should be without any soft or loose bedding. Pillows, quilts, and comforters should never be in the infant's sleep environment.

Wedges /Position Devices/Bumper Pads: These devices cause suffocation and not approved in infant's crib.

Smoking: Smoking is prohibited in an infant's room or child care area.

Breast Feeding: Breastfeeding reduces the vulnerability to SIDS and promote protective factors.

Immunization: Vaccination may have a protective effect against SIDS.

Swaddling: Swaddling is not recommended in Child Care. Swaddling is prohibited unless it is part of a medical plan for a special reason and must have Health Care Provider's written order.

Pacifiers: Pacifier use at nap time promotes a protective effect against SIDS.

Overheating and Ventilation: Babies should be dressed in sleep clothing, such as a wearable blanket designed to keep him or her warm without the need for loose blankets in the sleep area. Caregivers should watch for signs of overheating, such as sweating or the baby's chest feeling hot to the touch.

Reference Resources:

1.AAP (2016). SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment TASK FORCE ON SUDDEN INFANT DEATH SYNDROME. PEDIATRICS, 138(5),November 2016: e 20162938

2.AAP (2011). SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment. pediatrics.aappublications.org/Volume 128,November 5.

3.APHA (2017). Updated recommendations aimed at keeping infants safe from SIDS. The Nation's Health January 2017 vol. 46 no. 10 E59

4.Caring for our Children : National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Third Edition. Chapter 3: Health Promotion and Protection 3.1.4 Safe Sleep and STANDARD 3.1.4.2: Swaddling

5.CCDF Health and Safety Requirements Brief #4: Reducing the Risk of Sudden Infant Death Syndrome and Using Safe Sleeping Practices

6.CDC: PEDIATRICS, 138 (5), November, 2016.

7.CDC: Sudden Infant Death Syndrome (SIDS) from SUID and SIDS from CDC's Division of Reproductive Health @https://www.cdc.gov/features/sidsawarenessmonth/

8.NIH : Safe to Sleep Public Education Campaign .

Chapter 3: Health Promotion and Protection

3.1 Health Promotion in Child Care

SafeSleep

Standard 3.1.4.2: Swaddling

In child care settings, swaddling is not necessary or recommended.

RATIONALE:

There is evidence that swaddling can increase the risk of serious health outcomes, especially in certain situations. The risk of sudden infant death is increased if an infant is swaddled and placed on his/her stomach to sleep (1,2) or if the infant can roll over from back to stomach. Loose blankets around the head can be a risk factor for sudden infant death syndrome (SIDS) (3). With swaddling, there is an increased risk of developmental dysplasia of the hip, a hip condition that can result in long-term disability (4,5). Hip dysplasia is felt to be more common with swaddling because infants' legs can be forcibly extended. With excessive swaddling, infants may overheat (i.e., hyperthermia) (6).

COMMENTS:

Most infants in child care centers are at least six-weeks-old. Even with newborns, research does not provide conclusive data about whether swaddling should or should not be used. Benefits of swaddling may include decreased crying, increased sleep periods, and improved temperature control. However, temperature can be maintained with appropriate infant clothing and/or an infant sleeping bag. Although swaddling may decrease crying, there are other, more serious health concerns to consider, including SIDS and hip disease. If swaddling is used, it should be used less and less over the course of the first few weeks and months of an infant's life.

TYPE OF FACILITY:

Small Family Child Care Home, Center, Large Family Child Care Home

RELATED STANDARDS:

3.1.4.1 Safe Sleep Practices and Sudden Unexpected Infant Death (SUID)/SIDS Risk Reduction

REFERENCES:

1. Pease AS, Fleming PJ, Hauck FR, et al. 2016. Swaddling and the risk of sudden infant death syndrome: A Meta-analysis. *Pediatrics*;137(6):e20153275.

2. Richardson, H. L., A. M. Walker, R. S. Horne. 2010. Influence of swaddling experience on spontaneous arousal patterns and autonomic control in sleeping infants. *J Pediatrics* 157:85-91.

3. Contemporary Pediatrics. 2004. *Guide for parents: Swaddling 101*. http://www.aap.org/sections/scan/practicingsafety/Toolkit_Resources/Module1/swadling.pdf.

4. Van Sleuwen, B. E., A. C. Engelberts, M. M. Boere-Boonekamp, W. Kuis, T. W. J. Schulpen, M. P. L'Hoir. 2007. Swaddling: A systematic review. *Pediatrics* 120:e1097-e1106.

5. Mahan, S. T., Kasser J. R. 2008. Does swaddling influence developmental dysplasia of the Hip? *Pediatric Pediatrics*121:177-78.

6. Franco, P., N. Seret, J. N. Van Hees, S. Scaillet, J. Groswasser, A. Kahn. 2005. Influence of swaddling on sleep and arousal characteristics of healthy infants.*Pediatrics* 115:1307-11.

Child Abuse, Neglect, and Mental Injury

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

Resource Guide

Amended **2015**

Table of Contents

CHILD ABUSE, NEGLECT AND MENTAL INJURY

Reporting Child Abuse, Neglect, or Mental Injury

Each child care facility should have a written policy for reporting child abuse and neglect. Caregivers/teachers are mandated reporters of child abuse and neglect and **must** report to the child abuse reporting hotline, department of social services, child protective services, or police as required by state and local laws, any instance where there is a reasonable cause to believe that child abuse and neglect has occurred. Every staff person should be oriented to what and how to report. A staff member does not have to seek permission from the Director of the child care facility to report suspicions of child abuse, neglect, and/or mental injury. Emergency numbers must be posted for easy access by staff.

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

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

Possible indicators of <u>CHILD PHYSICAL ABUSE</u> include Physical Indicators and/or Behavioral Indicators. For Example:

- Unexplained welts or bruises (especially facial bruises on infants), burns, fractures, lacerations, abrasions, human bite marks.
- Appearance of injuries after school absence, weekend, or vacation.
- Absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair pulling.
- Cigar or cigarette burns, especially on feet, hands, or buttocks.
- Burns or cuts patterned like an electric burner, iron, belt buckle, etc.

- Immersion burns indicating dunking in a hot liquid (glove-like or sock-like burns on hands or feet, doughnut-shaped burns on buttocks).
- Rope burns that indicate confinement (on arms, legs, neck, and torso).
- Easily frightened or fearful of adults and parents.
- Wary of physical contact initiated by parents or anyone else.
- Apprehensive when adults approach another crying child.
- Constantly on the alert for danger, is guarded and distrustful.
- Destructive to self or others.
- Extremes of behavior – aggressive and withdrawn.
- Runaway or delinquent behavior.
- Reporting unbelievable reasons for injuries.
- Cautious when asked about the sudden appearance of an injury, looks at parent for an answer.
- Wears clothing that is clearly meant to cover the body when not appropriate.
- Seems afraid or reluctant to go home.

Possible indicators of <u>CHILD SEXUAL ABUSE</u> include Physical Indicators and/or Behavioral Indicators. For Example:

- Difficulty in walking or sitting.
- Torn, stained or bloody underwear.
- Genital/anal itching, pain, swelling or bleeding or burning.
- Frequent urinary tract or yeast infections.
- Venereal disease.
- Pregnancy.
- Frequent psychosomatic illnesses.
- Extreme fear for no apparent reason.
- Inability to trust.
- Anger and hostility.
- Inappropriate sexual behavior.
- Depression.

- Guilt or shame.
- Sudden drop in school performance.
- Somatic complaints.
- Sleep disturbances (nightmares, bed wetting, sleeping in clothing)
- Eating disorders.
- Withdrawal, fantasy, or infantile behavior.
- Suicidal gestures or statements.
- Running away (especially for females).
- Fire setting; fascination with fire.

Possible indicators of <u>CHILD NEGLECT</u> include Physical Indicators and/or Behavioral Indicators. For Example:

- Poor growth pattern.
- Constant hunger, malnutrition.
- Poor hygiene, body odor, or lice.
- Clothing inappropriate or inadequate for weather condition.
- Constant fatigue.
- Consistent lack of supervision, especially for long periods or in dangerous conditions.
- Unexplained bruises or injuries as a result of poor supervision.
- Unattended physical problems or medical needs such as lack of proper immunizations, gross dental problems, need glasses/hearing aids.
- Developmental lags.
- Begs or steals food, forages through garbage; always hungry.
- Destructive to self and/or others.
- Extremes in behavior-- aggressive and withdrawn.

- Assumes adult responsibilities.
- Exhibits infantile behavior.
- Delinquent behavior.
- Depressed/apathetic; states "no one cares."
- Frequent school absences or chronic tardiness.
- Seeks attention and/or attention.
- Hypochondria.

Possible indicators of <u>CHILD MENTAL INJURY</u> include Physical Indicators and/or Behavioral Indicators. For Example:

- Non-organic failure to thrive.
- Accident prone.
- Small abrasions on limbs that heal slowly.
- Self-destructive both physically and socially.
- Eating disorders, anorexia, bulimia, obesity.
- Gastrointestinal and bowel problems.
- Reduced energy level, lethargy.
- Extreme fear for no apparent reason.
- Inability to trust.
- Anger and hostility, tantrums.
- Inappropriate sexual behavior.
- Depression.
- Guilt or shame.
- School learning problems.
- Lack of exploration and curiosity.
- Lying for no apparent reason, stealing, cheating.

Sample Emergency Numbers Form

Post this information by each telephone or where easily accessible to staff.	
	Center and Other emergency numbers
Emergency	**911**
Center Name	
Center Address	
Center Phone Number	
Poison Control Center	
Available Adult Name (Substitute)	
Phone Number	
Child Protective Services	
Office of Child Care Licensing Office Number	
Health Consultant Name	
Phone Number	
Other important numbers:	

MARYLAND STATE DEPARTMENT OF EDUCATION

Achievement Matters Most

PLAYGROUND AND WATER SAFETY GUIDELINES

Division of Early Childhood Development
Office of Child Care

MARYLAND STATE BOARD OF EDUCATION

For more information about the contents of this document, contact 410.767.0335.

FOREWORD

The Maryland State Department of Education (MSDE) is pleased to provide the Playground and Water Safety Guidelines which provide a framework for medically and scientifically based Safety education for providers responsible for the safety of children and youth.

These Guidelines were developed by the Playground and Water Safety Workgroup which included representation from MSDE, the Maryland Department of Health and Mental Hygiene, Baltimore City Department of Recreation and Parks, National Child Care Information and Technical Assistance Center, National Resource Center for Health and Safety in Child Care and Early Education, Maryland Committee for Children, Maryland State Child Care Association, Baltimore County YMCA Head Start, Maryland School Age Child Care Alliance, and many others. They reflect the current federal and state standards and refer to practices which have been recommended by national associations.

These guidelines are designed for practitioners and administrators who work with young children and should be used as guidance in ensuring safety at playgrounds and swimming pools while children enjoy the excitement and pleasures of play and learning.

The Guidelines are available online at
www.MarylandPublicSchools.org

PLAYGROUND AND WATER SAFETY WORKGROUP

Barbara Bice
Maryland State Department of Education
School Facilities Branch

Tiffany Brewington
Maryland Committee for Children

Anna Byrd-Jones
Baltimore County YMCA Head Start

Lori Congleton
Department of Health and Mental Hygiene
Community Services

Lori Connors-Tadros
National Child Care Information and
Technical Assistance Center

Susan Copsey
Maryland State Department of Education
Office of Child Care

Mona Criswell
Maryland School Age Child Care Alliance

Amy Dapasuki
Maryland Committee for Children

Vanessa Diggs
Maryland Sate Department of Education
Division of Student and Family Support
School Health Services

Pamela Engle
Department of Health and Mental Hygiene
Community Services

Kathy Foster
Maryland State Child Care Association

Donna Fowler
Maryland State Family Child Care Association

Cheryl Hall
Maryland State Department of Education
Office of Child Care

Barbara Hamilton
National Resource Center for Health and
Safety in Child Care and Early Learning

Rose Marie Hayes
Maryland State Department of Education
Office of Child Care

Paula Johnson
Maryland State Department of Education
Office of Child Care

Elizabeth Kelley
Maryland State Department of Education
Office of Child Care

Michael Mason
Maryland State Department of Education
Division of Instruction

Valerie McGuire
Baltimore City Department of Recreation
and Parks

Alicia Mezu
Maryland State Department of Education
Division of Student and Family Support

Mary Nielsen
Maryland Child Care Association

Jennifer Nizer
Maryland State Child Care Association

Lorna Ochs
Maryland State Department of Education
Office of Child Care

Mary Porter
Baltimore City Department of Recreation
and Parks

Steve Rohde
Maryland Committee for Children

Barbara Tayman
National Child Care Information and
Technical Assistance Center

Sandy Trent
Maryland State Department of Natural
Resources

Patricia Tyler
Maryland State Department of Education
Adult Education

Linda Zang
Maryland State Department of Education
Head Start State Collaboration Project

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INTRODUCTION

Outdoor play is considered an essential component of the total educational experience for children. Whether at home, schools, community parks, apartment complexes, churches, child care facilities, or at other public gatherings, children have an opportunity to interact with various types of outdoor play equipment on playgrounds, often under the supervision of child care providers. The U.S. Consumer Product Safety Commission (CPSC) estimates that over 200,000 children suffer serious injuries each year that require medical treatment when this equipment is used improperly.[1] The Division of Early Childhood Development (DECD), Office of Child Care (OCC) has developed playground and water safety guidelines to emphasize the importance of supervising children and the maintenance of safe physical development and learning environments while children are engaged in outdoor play.

Playground facilities created, maintained, and renovated with the CPSC home and public playground safety guidelines support children's healthy development and safety. The safety guidelines contained in this document are based on the National Program for Playground Safety's (NPPS) research-based S.A.F.E. playground safety model.[2] This model incorporates six components: Supervision, Developmentally-Appropriate Play Areas, Accessible Play Spaces, Playground Equipment, Playground Fall Surfacing, and Equipment Maintenance. These guidelines are intended to help protect children using any type of playground environment.

Also included in this document are recommendations for water safety taken from CPSC "Safety Barrier Guidelines for Home Pools" handbook.[3] MSDE seeks to encourage activities that help to develop physical strength and endurance. Child care providers are also encouraged to follow the CPSC recommendations contained in "Safety Barrier Guidelines for Home Pools" handbook. The guidelines for pool barriers can help to prevent drowning and near-drowning of young children.

This document is intended to serve as a resource for child care providers and other adults who supervise children in outdoor play. Current local or state regulation supersedes the recommended practice listed in this document. This document includes self-assessment checklists for playground and water safety, quick tips for sun safety, suggestions for purchasing and maintaining safe equipment, and other helpful information.

[1] *CPSC Handbook for Playground Safety Pub. No. 325 (1997) www.cpsc.gov*
[2] *S.A.F.E. Play Areas Creation, Maintenance, and Renovation*
[3] *CPSC Pub. 362 Safety Barriers for Home Pools*

DEFINITIONS

The following definitions clarify the language used in these guidelines.

American Society for Testing Materials (ASTM) - a standards development organization that serves as an open forum for the development of international standards.

Caring For Our Children: National Health and Safety Performance Standards 2nd Edition (CFOC) - a comprehensive set of uniform health and safety standards intended to improve the quality of child care.

Division of Early Childhood Development (DECD) - a division of The Maryland State Department of Education responsible for early care and education in Maryland. The Division houses the Office of Child Care and the Early Learning Branch.

Guideline - a statement of policy or procedure.

Lifeguard - an expert swimmer who holds approved lifegaurd certification employed to safe-gaurd swimmers.

Maryland State Department of Education (MSDE) - responsible for providing leadership, support, and accountability for effective systems of public education, library services, and rehabilitation services in Maryland.

Maryland State Department of Health and Mental Hygiene (DHMH) - responsible for protecting, promoting and improving the health and well being of all Maryland citizens. Approving public and private swimming pools is one of its many functions.

National Program for Playground Safety (NPPS) - a non-profit organization who is a leader in research, training and development of S.A.F.E. play areas.

Natural Swimming Area - lakes, beaches, bodies of water that meet Maryland Beach Regulations as verified by a local health department permit.

Office of Child Care (OCC) - the office in the Division of Early Childhood Development responsible for licensing and monitoring all child care centers and family child care providers, and approving nonpublic nursery schools in Maryland. The Office also administers Maryland's subsidized child care program for working families, administers the state's Child Care Credentialing System, and issues contracts and grants to child care providers to improve the quality of early care.

Plan - a detailed scheme, program, or method worked out beforehand for the accomplishment of a goal or an objective.

Playground - an outdoor area set aside for recreation and play.

Definitions con't.

Policy - a plan or course of action, as of a government, political party, or business designed to influence and determine decisions, actions and other matters.

Regulation - a governmental order having the force of law.

Requirement - something that is required.

Standard - an accepted measure of comparison for quantitative or qualitative value or criterion which is a commonly used and accepted authority.

Supervision - the action, process, or occupation of critical watching and directing (as of activities or course of action).

Swimming Pool - a pool constructed for swimming that meets Maryland's Public Pool and Spa Regulations as verified by a local health department permit.

U.S. Consumer Product Safety Commission (CPSC) - federal agency responsible for promoting greater safety awareness among those who purchase, install, and maintain public playground equipment and other consumer products.

SUPERVISION

Because children will use playground equipment in ways for which the equipment is not intended, close supervision of children is necessary while they are at play. Supervision matters because we have a responsibility to keep children safe. Supervision saves lives, prevents injuries, avoids litigation and complies with national guidelines and standards.

Supervision is the action, process, or occupation of critical watching and directing (as of activities or course of action).[4]

Playgrounds that are designed, installed, and maintained in accordance with safety guidelines and standards can still present hazards to children in the absence of adequate supervision. The quality of the supervision depends on the quality of the supervisor's knowledge of safe play behavior. Recognize that preschool-age children require more attentive supervision on playgrounds than older children. Supervision encompasses anticipation, behavior, and context. The application and practice of all three factors are necessary for providing optimal oversight of children during any outdoor activity.

ANTICIPATION

Anticipation includes program or classroom staff making an assessment of the location of the play environment and making a determination of whether the facility is accessible to children with disabling physical conditions or special health care needs. If there are roads and parking lots nearby, the supervisor should be responsible for preventing children from running into the street or into the path of oncoming traffic.

The following are items to consider when making the assessment:

- Outdoor equipment should be divided into equipment that is appropriate for children aged birth to 23 months, 2 to 4 years, and 5 to 12 years. Schools may want to separate their play areas for children into areas for preschool, kindergarten through second grade, third and fourth grades, and fifth and sixth grades.

- If unsafe conditions exist, a report should immediately be made to the owner or operator of the playground which should expedite the repair or removal of the hazard if it cannot be handled by the staff supervising the children.

[4] *Merriam-Webster Online Dictionary*

BEHAVIOR

Supervision, when done appropriately, focuses on keeping children safe, and it involves taking the necessary precautions that save lives, prevent injuries, avoid litigation and comply with safety guidelines and standards. It is important that supervisors recognize **unsafe play behaviors** and **unsafe equipment use.**

Supervisors' Behaviors include practices of movement, observation, and interaction to produce a safe play environment. Important actions by supervisors that help to prevent playground injuries include:

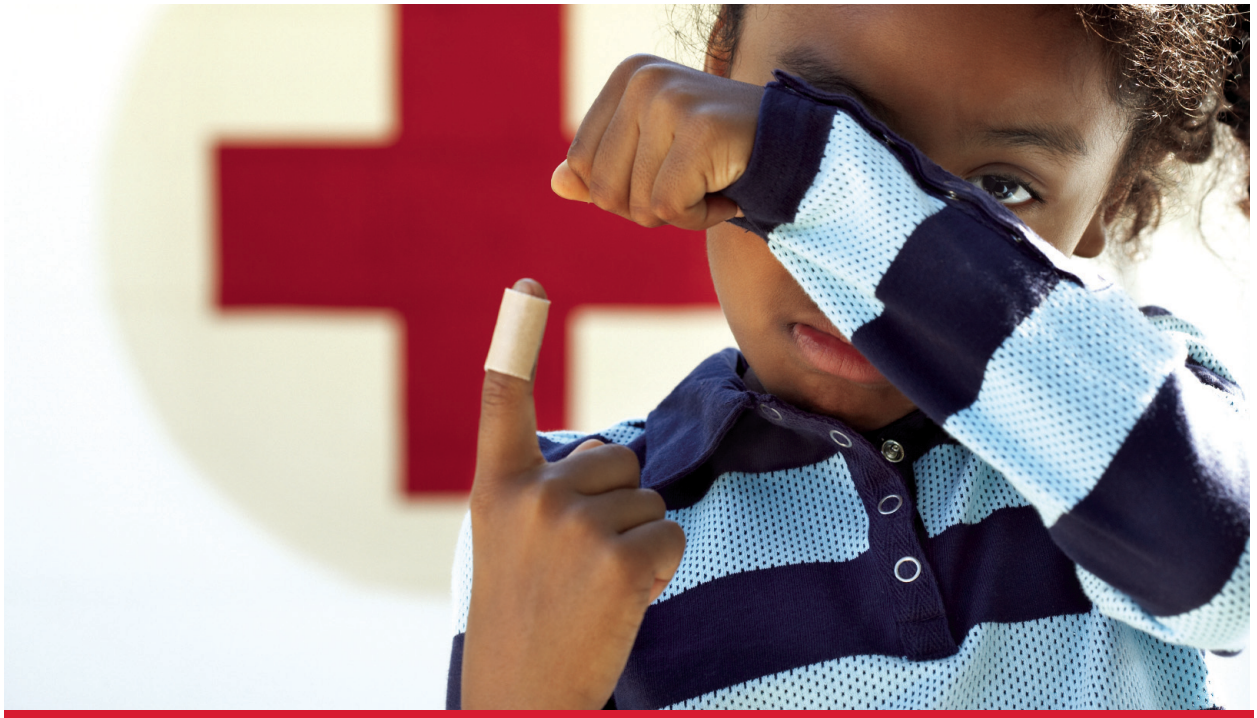
- Assessing play area prior to allowing children to use equipment
- Identifying broken equipment, trash, and vandalism
- Providing active supervision, active monitoring, scanning, interacting with others
- Watching and directing children's activities within a designated area
- Responding to each child's needs
- Positioning oneself in the outdoor play area so all children can be observed
- Minimizing conversations not related to direct supervision among caregivers

CONTEXT: HOW THE PLAY AREA IS BEING USED

How the outdoor play environment is used in the community, school, and child care plays a vital role in keeping the play environment safe. Child care administrators and staff should look at who, what, when, and where with respect to providing a safe environment. Administrators should understand that there are essential things that should be considered while playgrounds and swimming areas are in use:

- Emergency Care and First Aid
- Universal Need for Shade and Sun Protection
- Developmentally Appropriate Play Areas
- Accessible Play Spaces
- Age Appropriate Equipment
- Playground Fall Surfacing
- Water Safety

When communities, schools and child care facilities offer opportunities for children to play on equipment, they have a duty to provide a safe environment and provide appropriate interventions to prevent serious injury should an accident occur. Supervisors or teachers should be reasonable and prudent while providing supervision.



EMERGENCY CARE AND FIRST AID

Playground accidents are to be expected and playground supervisors should know basic first aid procedures. Most playground accidents result in bumps, abrasions, cuts, sprains, and an occasional broken bone. If an injury occurs on the playground, the following steps serve as a guideline for the playground supervisor on duty:

- Stay calm and don't panic
- Analyze the situation completely and quickly
- If basic first aid is required, begin at once using universal precautions
- Stay with the child and seek assistance from support staff
- Unless the situation is serious, the individual on duty should not leave the playground
- If a broken bone is suspected, treat as a fracture
- Do not move child if a fracture of the back, neck, leg or skull is suspected
- Call or send for help immediately
- Know your physical limitations when trying to help an injured child

Any good emergency plan should include practice and drill. When a physical injury does occur, or is suspected, a procedure should be in place to contact parents/caregivers, emergency medical services, or to transport the injured child to the local hospital emergency department. Injuries should be cared for following basic first aid rules, using recommended first aid supplies, documented and reported to parents by the end of the day. (See Appendix for a copy of the OCC First Aid Supply List.)

SUN PROTECTION AND THE WEATHER

A common problem that appears during the hot weather months is over-heating, causing fainting spells. If this happens, have the child:

- Rest in the shade, perhaps 10 minutes or more
- Sit down and bend forward at the waist, bringing the head between the knees, or lie down with the feet slightly elevated

Apply cool compresses and have water available for those alert enough to drink. Follow emergency procedures by calling 911 and contact parents/guardians.

It is recommended that children of all ages and abilities have shade available at child care facilities, schools and parks. Shade prevents the children, the equipment, and the surfacing from getting too hot. It is also recommended that children play outdoors daily when weather and air quality conditions permit according to conditions defined by the National Weather Service forecast and alerts. The following tips should be considered when planning for outdoor activities:

- Protect yourself and children from the sun by using shade, sun-protective clothing, and sunscreen with UVB-ray and UVA-ray protection of SPF-15 or higher, with permission from the parents, as described in CPSC Standard 3.081, during outdoor play

- Before prolonged physical activity in warm weather, provide water to aid with hydration and encourage children to drink water during any activity

- Make sure children wear sun-protective clothing, such as hats, long- sleeved shirts and pants, when playing outdoors between the hours of 10 a.m. and 3 p.m.

Include shade covering in the design of playground equipment and recreational areas
The American Cancer Society's "Sun Basics for Kids" recommends that adults and children:

"Slip on a shirt
Slop on some sunscreen
Slap on a hat
Slide on a pair of sunglasses, and
Shade yourself"

Shade is especially important for children under 2 years of age, who have more sensitive skin, wear less clothing, and often have bare feet. If the play area has any dark rubber surfacing, be sure to keep it cool by providing shade. All equipment should be tested with the back of the hand to ensure that is not too hot before a child uses it.

WEATHER

Children should play outdoors daily when weather and air quality conditions do not pose a significant health risk. Outdoor play for infants may include riding in a carriage or stroller; however, infants should be offered opportunities for gross motor play outdoors, as well.[5] When weather is predicted to be uncomfortably hot during the summer months, we recommend you adjust your schedule to allow outdoor activities before noon.

Dress children appropriately for weather that poses a significant health risk such as wind chill at or below 15 degrees F. or a heat index at or above 90 degrees F. Please be aware of advisories and notices of poor air quality conditions as identified by the National Weather Service. These recommendations should be followed as advised. [6]

[5] *Caring for Our Children Standard 2.009*
[6] *National Weather Service www.nws.noaa.gov*

DEVELOPMENTALLY APPROPRIATE PLAY AREAS

Developmentally appropriate play areas should be designed for children aged birth to 23 months, 2 to 4 years, and 5 to 12 years, both in school settings and in the park setting. The maximum group size will be determined by the age of youngest child in your group. (For further information please refer to the CPSC guidelines.)

Infants and toddlers need opportunities of creeping, crawling, and walking. Soft surfacing (such as rubber tiles or poured in place materials) should be provided for pathways from the door of the building to other surfaces in play setting. Separate play areas are recommended for children in the birth to 23 months developmental category.

Adults need to heed signs and labels provided by manufacturers, in early childhood settings, schools, and parks that inform the public about the age ranges appropriate for the equipment. Play areas for children ages 2-4 should offer areas with smaller steps and crawl spaces. Hands require smaller grips, and bodies require appropriately placed railings on platforms. Appropriate play areas for children ages 2-4 could include:

- Areas to crawl
- Low platforms with multiple access such as ramps and ladders
- Ramps with pieces attached for grasping
- Low tables for sand, water and manipulation of materials
- Tricycle paths with various textures
- Flexible spring rockers; sand areas with covers; and shorter slides (usually no taller than 4 feet)

ACCESSIBLE PLAY SPACES AND THE ADA

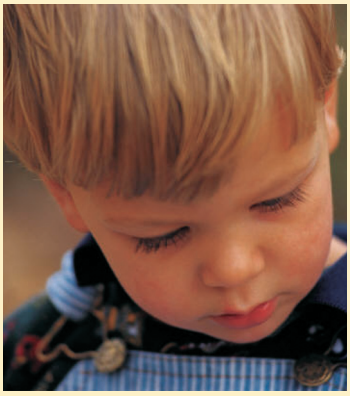
The Americans with Disability Act (ADA) Accessibility Guidelines explain how indoor and outdoor playgrounds can be made accessible for children with disabilities. The Access Board (a federal agency responsible for the development of design guidelines for accessibility) submitted a plan to the Justice Department that determined how the ADA should be implemented in children's play environments. The plan states that children must have access to playgrounds and equipment as well as opportunities to play with children who do not have disabilities. For more information visit www.access-board.gov.

Playground accommodations need to meet the needs of children with mobility impairments, cognitive delays, and sensory dysfunctions. It is critical to provide an opportunity for children with special needs to use play areas that allow children to:

- Get from the edge of the playground to the equipment
- Be able to play with other children
- Get onto equipment
- Get from the equipment to the edge of the playground and into a parking lot or building

DEVELOPMENTALLY APPROPRIATE PLAY EQUIPMENT

The following table shows the appropriate age ranges for various pieces of playground equipment. This is not an all-comprehensive list and, therefore, should not limit inclusion of current or newly designed equipment that is not specifically mentioned. For equipment listed in more than one group, there may be some modifications or restrictions based on age, so consult the specific recommendations in CPSC Handbook for Playground Safety.

Toddler Under 2	**Preschool Ages 2-5**	**Grade School Ages 6-12**
Ramps Stairways Single file stepladders Slides Climbing equipment under 32" high Spring rockers 	Spring rockers Straight slides Spiral slides up to 360° Certain climbers** Merry-go-rounds Rung ladders Single file stepladders Stairways Ramps Horizontal ladders under 60" high for ages 4 and 5 	Chain or cable walks Free standing arch climbers Ladders – Arch; Rung Free standing climbing events with flexible parts Fulcrum seesaws Log rolls Long spiral slides (more than one 360° turn) Overhead rings*** Horizontal ladders Merry-go-rounds Track rides Vertical sliding poles Single-axis belt swings Slides Ring treks Stepladders Stairways Ramps Rotating tire swings
	** See CPSC §5.3.1	*** See CPSC §5.3.1.5

If a child care center or pre-school is located at an elementary school and the program does not have age appropriate equipment, it is recommended that children not play on the elementary school equipment, which is designed for children 5 to 12 years. If a separate area has been designed for preschool children then that is the only area that should be used.

Designate a separate area for preschool children. Make sure signs are conspicuously placed to inform adults about the two different playground settings, including appropriate age categories and notification of the need for adult supervision.

Within the elementary school setting it is reasonable to provide several different areas for play equipment because one size does not fit all. Playground facilities are equipped by grade levels such as:

- Kindergarten: areas to develop motor actions, climbing, and arm strength
- Grades 1 and 2: areas that continue to develop upper body strength, opportunities to develop understanding of level, range, direction, pathway, time, and force
- Grades 3 and 4: areas that encourage continued development of balance between upper body and lower body. Areas should also promote socialization with peers, and opportunities to make decisions
- Grades 5 and 6: areas that continue to develop strength and problem solving

AVOIDING PLAYGROUND HAZARDS

Outdoor activity space should be accessible to all children and free from conditions that may be dangerous to the health and safety of children in care. The outdoor play space for child care centers is recommended to be 75 square feet (22.9 square meters) allocated per child. The equipment and play areas should be free from general hazards such as entrapment, pinch, crush, and shearing points as well as:

- Entanglement
- Impact with moving equipment or a moving vehicle
- Impact from tip over or failure
- Poisonous snakes, insects, or plants
- A natural or man-made hazard specific to the site or any condition or situation that poses a risk of injury to a child or staff member

ENTANGLEMENT AND ENTRAPMENT

A playground part or group of parts should not form openings that could trap a child's head. An opening presents an entrapment hazard if the distance between any interior opposing surfaces is greater than 3.5 inches and less than 9 inches. Additionally:

- Drawstrings should be removed from hoods and necks of clothing to avoid entanglement and strangulation
- All fasteners, connectors and covering devices should not loosen or be able to be removed without the use of tools
- Lock washers, self-locking nuts and bolts should be provided to protect from detachment
- All hooks, including S-hooks, should be closed. There should be no gap or space greater than 0.04 inches, or a space that will not admit a dime.

PINCH, CRUSH, AND SHEARING POINTS

The CPSC advises that "anything that could crush or shear limbs should not be accessible to children on a playground." Crush and shear points can be caused by parts moving relative to each other or to a fixed part during a normal use cycle. Further:

- There should be no sharp points, corners, and edges on any components and all components should be smooth and free from splinters
- All corners should be rounded or capped to avoid sharp edges (warning: children have died when hood or neck drawstrings on their jackets or sweatshirts caught on slides and other playground equipment)
- Protrusions, projections, pinch points, crush and shearing points should be eliminated from all playground equipment

TRIPPING

Play areas should be free of trip hazards to children who may be running through a playground. The two most common trip hazards are anchoring devices for playground equipment and containment walls for loose-fill surfacing materials. All anchoring devices for playground equipment, such as concrete footings or horizontal bars at the bottom of flexible climbers, should be installed:

- Below ground level
- Beneath the base of the protective surfacing material, to eliminate the hazard of tripping

For information on stairways, ladders, and handrails go to section 10 of the CPSC guidelines. Specifications for major types of playground equipment are contained in section 12, Major Types of Playground Equipment in the CPSC Handbook for Public Playground Safety. You may obtain this document online at www.cpsc.gov.

PLAYGROUND FALL SURFACING

The CPSC recommends the installation and maintenance of shock-absorbing surfaces around the play equipment. There should be a minimum of 9 inches of wood chips, mulch, or shredded rubber for play equipment up to 7 feet high. If sand or pea gravel is used, install at least a 9-inch layer for play equipment up to 5 feet high. Or, use surfacing mats made of safety-tested rubber or rubber like materials.

The CPSC (Standard 4.5) states that "hard surfacing materials, such as asphalt or cement are unsuitable for use under and around playground equipment of any height unless they are the required base for a shock absorbing unitary material such as a rubber mat. Earth surfaces such as soils and hard packed dirt are also not recommended because they have poor shock absorbing properties. Similarly, grass and turf are not recommended because wear and environmental conditions can reduce their effectiveness in absorbing shock during a fall."

Frequently, child care centers have playground equipment inside. Therefore, if playground equipment is installed inside, the acceptable surfacing materials should be specifically designed and ASTM F.1292 tested. To access this information go to www.cpsc.gov for more manufacturing standards for different types of materials.

SURFACING MATERIALS

There are two types of surfacing available for use under and around outdoor playground equipment: loose fill and unitary. These surfacing materials may be made of organic or inorganic materials.

Loose Fill Materials - made up of multiple particles that are not bonded together with glue or other adhesives. Because these materials are easily displaced and migrate with use, they should never be installed over an existing hard surface (e.g. asphalt or concrete). These materials need a method of containment (e.g. retaining barrier or excavated pit). There should also be good drainage underneath the material to prevent pooling and migration of the particles.

- **Organic Materials** - such as wood chips, bark mulch, and engineered wood fiber get compacted and decompose over time and should be replaced on a regular basis. Signs of microbial growth or the presence of weeds or other plant growth will require some replacement or removal of the material.

- **Inorganic Materials** - such as sand, pea gravel, or shredded rubber may need to be loosened from time to time because they become compacted, or in the case of gravel, they can turn into "hardpan." Gravel is not recommended for preschoolers because they place the small pea stones in various body cavities.

Recycled tires in multi-colors are available. Note that those materials with the primary color of black could make the rubber surfaces too hot in some climates. Care should be taken in extremely high temperatures to avoid burn injuries.

Unitary Materials - have materials that are bonded together either through heating or cooling or with the use of a bonding agent or adhesive. Common unitary synthetic materials are rubber tiles or mats, urethane poured in place, and rubber compositions. When unitary surfacing materials develop holes or cracks they need to be repaired or replaced. Unitary materials should be ASTM approved.

USE ZONES

Other than the equipment itself, the use zone should be free of obstacles that children could run into or fall on top of and thus be injured. It is also recommended that protective surfacing be installed 6 feet in all directions from play equipment. For swings, the surfacing should extend in back and front, twice the height of the suspending bar.

The CPSC defines use zones and outlines their requirements in the *Handbook for Public Playground Safety, 1997 as:*

- Stationary equipment: 6 feet (1.8 meters) on all sides of the equipment
- Slides: 6 feet (1.8 meters) on all sides; 4 feet (1.2 meters plus the height of the slide in front of the slide chute
- Swings: 6 feet (1.8 meters); twice the height of the swing beam in front and back of the swing

EQUIPMENT MAINTENANCE

An equipment maintenance policy provides a basis for what types of inspections will be performed, who will perform the inspections and how often the inspections will be performed. The following constitutes an important series of activities when a standard of care for the playground is to be maintained:

- Include the development of maintenance policies that set forth standards for the ongoing care of equipment and playground surfacing
- Carry out training in identifying different types of hazards and common problems for current and new staff or persons assuming supervision responsibilities
- Document hazards found on the playground enabling agencies to provide remedial training and maintenance
- Assign responsibility to an individual or group of individuals to identify maintenance activities, perform the maintenance, and to keep a maintenance record
- Provide training for maintenance supervisors and maintenance personnel (or designated staff) to look for hazards
- Establish a schedule for inspection and maintenance based on manufacturers' recommendations, frequency of use, equipment age and frequency of repairs, materials used, vandalism and accidents that occur on a piece of equipment

WATER SAFETY

Each year, nationwide, about 300 children under 5 years old drown in swimming pools, usually a pool owned by their family. In addition, more than 2,000 children in that age group are treated in hospital emergency rooms for submersion injuries.[7] A child can drown in the time it takes to answer a phone. Seventy-seven percent of the victims had been missing from sight for 5 minutes or less. There is no splashing to alert anyone that the child is in trouble.

The following are recommendations for actions necessary to ensure the safest swim or water play activity possible.

SWIMMING SAFETY RECOMMENDATIONS

Use Only:

- Facilities that comply with Maryland's Public Pool and Spa Regulations, COMAR 10.17.01 (Verified by a local health department permit)
- Natural swimming areas that meet the requirements of the Maryland Beach Regulations COMAR 26.08.09.00 (Verified by a local health department permit)
- Facilities that are maintained to protect the health and safety of children and staff members

Establish a swimming activity and swimming safety plan that includes:

- ✓ Supervision rules of behavior for children and supervisors assigned to the care of children permitted to be in the water
- ✓ Each child should have a signed permission slip from a parent or guardian before participating in water activity
- ✓ Lifeguard, family child care and child care center staff surveillance zones should be determined in the swimming area
- ✓ Designate safe swim areas based on the children's size and swimming ability
- ✓ Establish and maintain clear communication and emergency procedures that every staff member receives at the time of orientation
- ✓ Have clear provisions for a child with a special need

[7] *CPSC Pub. 359 How to Plan for the Unexpected-Preventing Child Drowning*

MSDE recommends that all local, state, and federal regulations that apply to water safety be followed. Please note the following items are not permitted:

- A pool such as a fill and drain molded plastic or inflatable pool or slide, which does not have a filtration and disinfection system approved by the local health department
- Pool toys, floatation devices (not meeting U.S. Coast Guard specifications), and swim aids are not recommended in home or public pools
- Hot tubs, spas and saunas are not recommended (Caring For Our Children Standard 5.211)[8]

[8] *Caring for Our Children: National Health and Safety Standards*

WATER SAFETY REQUIREMENTS

✓ Obtain prior written approval from a child's parent to take the child wading or swimming
✓ Approved child care staff in centers and family child care homes should provide continuous supervision for all children during any water activity
✓ When using pools, lakes, or any bodies of water available to children for swimming, a lifeguard must be present who holds current approved lifeguard certification. During the swimming activity the qualified lifeguard is at waterside and is not included in the required staff/child ratio
✓ When water is over a child's chest and the child cannot swim, a one-to-one staff/child ratio for each child who cannot swim should be maintained in the water. This standard does not apply to swimming lessons approved by the American Red Cross
✓ Only swimming facilities meeting applicable local standards of health, sanitation, and safety may be used
✓ Maintain child/staff ratios for infants and toddlers (See CFOC Standard 1.005)

BARRIERS

When a body of water, pool or spa is onsite or in close proximity to the child care center or family day care home a barrier must be installed that:

- Meets the requirements of the Office of Child Care Circular Letter #97-06 Barriers for Swimming Pools and Spas in Child Care Centers
- Prevents a child from getting over, under, around or through the barrier and keeps a child from gaining access to the water

During a swimming activity, it is recommended that there be on duty at all times:

- At least two individuals who are certified in both CPR and First Aid
- A lifeguard, who is currently certified by a national organization
- An adult staff person, in addition to the lifeguard who is on duty to provide active supervision
- One staff member actively supervising not more than 2 children who are 2 years old
- One staff member actively supervising not more than 5 children who are 5 years old
- One staff member actively supervising not more than 10 children who are 6 years old or older
- If the child is a non-swimmer the ratio of staff to child should be one-to-one

Department of Health and Mental Hygiene Public Pool and Spa Regulations (10.17.01) require supervision, for mixed age groups, to be at a ratio based on the age of the youngest child. When water is over a child's chest and the child cannot swim, a one-to-one staff member to child ratio shall be maintained in the water.

APPENDICES

FREQUENTLY ASKED QUESTIONS

✓ **For whom was the U.S. Consumer Product Safety Commission (CPSC) Handbook for Public Playground Safety guidelines written?**

The handbook is intended for use by parks and recreation personnel, school officials, equipment purchasers and installers, and any other members of the general public concerned with public playground safety such as parents and school groups.

✓ **Public playground refers to which areas?**

"Public play areas are considered parks, schools, child care facilities, institutions, playgrounds for multiple family dwellings, restaurants, resorts and recreational developments, and other areas of public use. They are not intended for use with soft contained play equipment, equipment found in water play facilities, or home playgrounds."

✓ **Are there CPSC guidelines for home playground equipment?**

Yes. The Outdoor Home Playground Safety Handbook is the CPSC guidance intended for homes and residential child care facilities. There are also the American Society for Testing Materials (ASTM) technical provisions for the performance and design of home playground equipment.

✓ **Are the MSDE Playground and Water Safety Guidelines formal regulations to be adhered to for licensed and registered child care providers in the state of Maryland?**

No. The Playground and Water Safety Guidelines have been developed to help child care providers and other early education staff to voluntarily provide for increased safety of children while on a playground or participating in a water activity. The guidelines condense existing Office of Child Care (OCC) child care licensing regulations, CPSC standards, ASTM standards, Maryland Department of Health and Mental Hygiene regulations and other agency guidelines into one document to be used as an easy training or reference tool for child care providers and parents.

✓ **If we use a community park or swimming pool and have notified the appropriate agency of a hazard without success, what should our next course of action be?**

If you are a licensed or registered child care provider, the next step would be to enlist the help of your OCC Licensing Specialist to help communicate with the agency responsible for the maintenance of the playground. The Office of Child Care has established many cooperative relationships that can help improve the quality of these facilities. MSDE is committed to providing this type of support with help from parents, child care providers, and other early education providers.

✓ **How do these recommendations apply to me as a family child care provider?**

The MSDE Playground and Water Safety Guidelines contain recommendations based upon the CPSC document "Outdoor Home Playground Safety Handbook" and serve as a guide for the development and maintenance of home playgrounds.

✓ **How do I address creating separate play environments for a family child care home serving mixed age groups?**

When you look at playground design and equipment consider the developmental characteristics of children. ASTM has provided manufacturing standards for equipment for children of differing age ranges. The MSDE strongly recommends that family child care providers use products from reputable manufactures following these standards when designing and constructing a playground.

✓ **How do I address creating play environments for children with health or other special needs?**

Children with special needs receive the same positive benefits from exercise and exploration while at play. Again, some activities may need to be modified to fit each child's needs and limitations.

DEVELOPMENTALLY APPROPRIATE PLAY ACTIVITIES

Children in child care and pre-school learning environments benefit from early care and education providers encouraging activities that are developmentally age appropriate. The curricular objectives for Physical Education and Development included in the Maryland Model for School Readiness (MMSR) standards may act as guidelines for assessing children's performance. The physical development and health objectives and activities may be found online at www.MarylandPublicSchools.org/MSDE/divisions/child_care.

ACTIVITIES THAT ENHANCE GROSS MOTOR DEVELOPMENT

The following activities will help children to coordinate movements to perform simple tasks:

MOVING WITH BALANCE AND CONTROL

- Maintaining balance on a 2 x 4 balance beam that is close to the ground
- Moving around objects on narrow paths without bumping into things
- Developing mastery over running (such as quick stops, full circle turns, short 180 degree turns, speeding up and slowing down)
- Going up and down stairs using alternating feet without holding onto the rail or wall
- Walking and jumping
- Hopping several times on each foot
- Galloping with a smooth gait and relative ease

COORDINATING MOVEMENT TO PERFORM SIMPLE TASKS

- Throwing a ball in the right direction, aiming at a target with reasonable accuracy
- Catching a ball by moving arms or bodies to adjust for the direction the ball is traveling
- Kicking a large ball with a two step start
- Riding a tricycle on a path around a playground
- Using the slide, seesaw, or swings
- Hitting a stationary target with an overhand throw
- Attempting hopscotch or jumping rope
- Climbing on a play structure

ACTIVITIES THAT ENHANCE FINE MOTOR DEVELOPMENT

- Block building
- Throwing and catching balls
- Use of sand/water tables

EXERCISES AND ACTIVITIES FOR BIRTH TO SIX MONTHS

CHEST STRETCH TO STRETCH AND RELAX ARMS

Action: Put baby flat on back on the carpet or a covered pad on a table. Place your forefingers in the baby's hand to encourage grip. If baby does not hold his/her forearms, slowly stretch open the arms side-wards and gently close arms across the chest. At the same time, give a "snug hug."

MASSAGE TO RELAX ARMS, SHOULDERS AND HANDS

Action: Put baby flat on back on the carpet or on a covered foam rubber pad. Pat and relax his/her shoulder; slowly massage the arm starting from the shoulder down to the hands. When baby has opened his her/her hand, help the infant stroke his/her body and face as well as yours.

LEG STRETCH TO RELAX AND STRENGTHEN LEGS

Action: Place baby flat on back on the carpet or on a covered pad on a table. Relax baby first by supporting baby's legs under the knee joint. Gently toss legs up and down. Then with one hand on the knees, carefully straighten legs. The hips should be in contact with the surface.

EXERCISES AND ACTIVITIES FOR SIX TO TWELVE MONTHS

SIDE TO SIDE

Action: Adult and child sit astride a large roll. Support on the hips. Lean the roll to the right and then to the left, so that the child transfers the weight to one foot for support as s/he learns to stand. Stop between each movement.

ROLLING

Action: Place child on all fours over a roll or on an adult's thighs. Roll child slightly, transferring the weight from hands to feet, feet to hands. Continue rolling until the arms have been released and the child's weight is on the feet. Gradually the child will push off the roll to a standing position. Support child's hips.

SIT AND REACH

Action: Encourage the child to sit on a low stool or wide-based wooden box with feet flat on the floor. Sit behind the infant, holding one thigh. Do not support his/her back. Hold a toy on one side, then the other. As the child reaches, s/he may lose balance. Teach the child how to support him/herself with the feet.

EXERCISES AND ACTIVITIES FOR SIX MONTHS TO TWELVE MONTHS *con't*

CRAWL WITH ME

Action: As the child learns to crawl, lead the way around different objects such as a chair, a stool, a box. Crawl through a hoop, cardboard box tunnel, tire structures. Arrange favorite objects to encourage child to crawl under tables, benches, or a person's body forming a bridge. Challenge the child to crawl zigzag, straight, in the circles, slowly, quickly, forward, backward.

SWING AND SWAY

Action: Sit on carpeted or padded surface facing the child, feet crossed in front of you. Grasp the child's hands and gently push and pull, swing and sway. Repeat the same action as both of you tug on opposite ends of a hand towel, rope or hoop.

STAND UP

Action: Standing directly behind your child, support his/her arms. As the child gains balance and confidence, reduce your support progressively by holding one hand raised above shoulder level. The child will use his/her other hand for balance as s/he learns to stand alone.

PULL UP

Action: Place child close to safe, stable surfaces which provide adequate support. Encourage the child to pull him/herself to standing position. Praise the child's attempts to stand alone.

WALK TO ME

Action: To encourage the child to walk, stand one foot in front of the child and encourage him/her to step toward you. Gradually increase the distance between you and the child as his/her balance improves and confidence heightens. Two adults may be involved encouraging the child to walk back and forth between them.

EXERCISES ACTIVITIES FOR THE SECOND YEAR (12-18 MONTHS)

JACK IN THE BOX

Action: Show the child how to curl up into a tiny ball in an imaginary box and then to spring up when the lid is lifted. This can be accompanied by singing.

FOLLOW THE LEADER

Action: Have the child follow you. This is an excellent game for children in this age group, since they love to imitate an adult. Be imaginative as you lead your child over, under, through, off, on, into, up, down, and a variety of other actions. Change the rhythm of moving by crawling, walking, or jumping.

IN AND OUT

Action: Provide the child with a variety of household items to crawl into, out of, and through such as a box, a laundry basket, a cupboard, a chair, hoop or a playhouse.

DROP AND PICK UP

Action: Encourage the child to drop and pick up different objects such as a ball, feather, bib, or can. Also encourage the child to pick up an object such as a small toy using another object like a large spoon. Demonstrate several times. Praise any action attempted and generously acknowledge accomplishment.

EXERCISES AND ACTIVITIES FOR THE ALMOST TWO (18-24 MONTHS)

MY BODY

Action: To increase body awareness, have the child lie on back. Ask the child to lift different parts of his/her body.

- Have him/her lift two parts at one time; for example, two arms, two legs
- Have him/her lift two different parts; for example, foot and arm, elbow and knee
- Have child hide parts of the body; for example, hands behind back, feet under buttocks
- Have child move body parts in different ways; waving, shaking, tapping, rubbing, patting, pointing, wiggling, clapping, grasping
- Finally, have the child place a toy "between" his/her feet, then your feet

EXERCISES AND ACTIVITIES FOR THE ALMOST TWO (18-24 MONTHS) *con't*

LET'S PRETEND

Action: Imitate animals through movement, while at the same time making up stories involving animals moving body parts, such as a bear stomping through the forest, snake moving on its stomach through the grass, bird flying through the air, a dog digging, and a turtle hiding in its shell. Imitate the actions of animals by bending, stretching, twisting, turning, swinging and swaying body parts and by moving in different directions.

LOG ROLL

Action: Have child roll like a log with his/her body stretched, legs together, and hands together, above head.

UP AND DOWN

Action: Encourage the child to learn about various "levels" by squatting down, standing up; lying down, sitting up; crouching down, standing up; climbing up, climbing down; wiggling or shaking body parts, holding them up and down. Also practice rising and falling by raising arms and letting them fall, standing and letting your body slowly fall to the floor, and playing and singing "Ring-Around-the-Rosy."

OVER AND UNDER

Action: Explore "over" and "under" by providing equipment -ropes, poles, hoops, climbing apparatus - that the child can walk, run, climb and jump "over" and "under".

ROPE

Action: To refine loco-motor skills and enhance spatial awareness, stretch two ropes along the the floor and encourage the child to walk or run "between" ropes, "over" ropes, and "along" ropes. Gradually introduce walking along a balance board or balance beam, placed one foot above ground, first with support and then without support. Look for natural balance beams such as fallen logs, sidewalk curbs, picnic benches.

WHERE AM I?

Action: Find objects the child can sit, crawl, or walk "in front of" and "behind." Crawl, walk, or jump "into", "out of" and "through" a variety of small boxes, tunnels, hoops, or tents made from blankets.

EXERCISES AND ACTIVITIES FOR TWO TO FIVE YEAR OLDS

CHASE GAMES

Action: Invite toddlers to run, especially at impromptu times-let them chase you, and you chase them. Toddlers also like to chase moving objects, such as balls, rings, and floating scarves.

MOUNTAIN CLIMBERS

Action: Set up soft play equipment and ladders so toddlers can climb and develop upper-body strength. Climbing builds strength in arms, chest, and back. A nearby adult is a must for assistance and safe play.

TARGET TIME

Action: Around the playground hang various size targets, laminated or on bed sheets, with bells sewn on them (to give children, especially those with visual impairments, instant feedback when they hit the target). Targets may be hung on the side of a building or on a fence. Toddlers stand close to or far away from the targets to aim and throw objects of different sizes, shapes, and weights (tennis balls, bean bags, lightweight floating balls, foam cubes with dots similar to dice, balls with numbers, and so on).

CHASE BUBBLES

SILLY WALKS AND RUNS

Action: Invent walks and runs like a monkey, hopping like a bunny, and flapping like a bird.

ENCOURAGE RIDING

Action: Encourage the use of scooters and tricycles, and play with push toys such as trucks, doll broom hockey and toy lawn mowers.

LEG ROCKS

Action: Have child stand with feet shoulder distance apart. Ask child to point the right (left) toe forward lifting the foot off the floor. Squeeze as hard as they can. Make the calf muscles feel like a rock. Ask the child to touch it - to make it harder. Ask him/her to make it bigger. The ask them to let it go mushy. Do the same with the other leg. Then have them jump with both feet. Ask them to jump higher if the toes point down to the floor. Then have theme shake the right (left) leg out so it's loose like spaghetti.

Encourage them to get moving at least 60 minutes a day for active free play. Let them have fun, climb, march, pedal, throw, roll, skip, dig, and jump in a safe space until they are tired. Offer riding toys, balls, bean bags, climbers, balance beams and obstacle courses.

PLAYGROUND SAFETY SELF ASSESSMENT CHECKLIST

This form is intended as a guide to ensure that the playground is a safe and fun environment for children to play. Use this checklist to observe the entire playground at least once a month. Train all personnel to be alert for hazards and report them promptly. Do not use hazardous equipment until it is repaired!

Date _____

SUPERVISION	YES	NO	DATE REPAIR COMPLETED
Has supervision training been provided for all staff?			
Is adequate supervision and care provided at all times only by individuals who are designated by the operator to provide supervision and care?			
Are activities provided for children that are age appropriate and meet the child's age, needs and capabilities?			
Do staff/child ratios meet the OCC Child Care Center regulations?			
Are children wearing appropriate clothing and appropriate footwear on climbing and moving equipment? Capes, flip-flops, etc. are not recommended.			
FACILITIES			
Are sufficient indoor and outdoor facilities provided to accommodate the number of children?			
Are there 9-12 inch deep resilient ground covers under all swings designed for older children, merry go rounds, slides and climbing or moving equipment?			
Is the resilient surface in place and not compacted?			
If concrete or asphalt is under the equipment, is there an CPSC or ASTM approved manufactured installed playground surfacing product on the surface?			
Is the outdoor play area free of standing water and does it have appropriate drainage?			
Is the space for physical activity large enough to accommodate all children and allow all of them to move safely at the same time?			
Are indoor and outdoor facilities free of hazards so children may participate safely? For example animal feces, broken glass, etc			
Is the outdoor play area free from electrical hazards such as accessible air conditioners, switch boxes, or accessible power lines?			
Are grass, trees and shrubs properly trimmed and maintained?			
Is the outdoor play area free from obstructions (such as tree stumps, roots and rocks) that may interfere with normal play activity?			
Are facilities inspected before activity begins to ensure safety of space and equipment?			
Is play equipment free of openings that could trap a child's head? (Openings should be less than 3.5" in width or more than 9" in width)			
Are there concrete supports below the ground, and are they secure?			
Do the climbing areas prevent children from falling more than their reaching height when standing erect?			
Are the wood timbers not rotting, splitting, splintering, or excessively worn?			

SUPERVISION	YES	NO	DATE REPAIR COMPLETED
Are there ample equipment and supplies provided so each child can participate fully in physical activity?			
Is all equipment maintained and in good repair and is all equipment regularly inspected and repaired or replaced?			
Is an emergency first aid kit readily accessible on the playground at all times?			
Is the equipment free from protrusions that can catch clothing?			
Are portable toys such as tricycles and wagons in good repair?			
Is the equipment free of crush points or shearing actions such as hinges of seesaws and under carriage of revolving equipment?			
Is the fence at least 4 feet high and in good repair. Can gates be secured?			
Is the equipment free from frayed cables, worn ropes, open hooks, or chains that can pinch?			
Is the equipment free from sharp edges, broken parts, pinching actions, loose bolts, or wobbly equipment not properly anchored?			
Are swing seats light weight with no protruding parts?			
Are Preschool children prevented from playing on elementary school playground equipment unless it is designated for preschool age children ages 2-5?			

Comments:_____

_____

_____

_____

_____

_____

Modified from form developed by Dr. Joe L. Frost, Professor of Curriculum and Instruction, University of Texas at Austin

SWIMMING SAFETY SELF-ASSESSMENT for

CHILD CARE CENTERS, FAMILY DAY CARE HOMES and BEFORE AND AFTER SCHOOL PROGRAMS

FACILITY NAME:

Swimming is a fun and healthy. But take precaution at swimming activities to prevent recreational water illnesses, injuries and drowning. The following guidelines help you prepare and provide a safe activity.

- Complete sections A, B, C and D of the water safety self-assessment: **for each** swim activity.
- Sign and date the water safety self-assessment form and maintain the signed document in the facility records.
- Before participating in a swim activity, train facility staff and volunteers so that a person understands the safety risks and rules.
- Questions? Please contact MSDE Office of Child Care at:
  http://marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch

A. SWIM SAFETY PLAN

1. Swimming Activity Date	2. Swimming Activity Time

3. Public Pool Information ☐ Not Applicable

Public Pool Name	Phone

Pool Permit Number

☐ Yes ▸ Enter Permit #: ▸ Enter Permit Expiration Date:

☐ No **Do not swim at a pool that is not permitted by the Local Health Department**

4. Natural Bathing Place Information ☐ Not Applicable

Natural Bathing Place Name	Phone
Natural Bathing Place Swim Site Location	

Swimming water sampled or permitted by the Local Health Dept.

☐ Yes ▸ Enter Permit #: ▸ Enter Permit Expiration Date:

☐ No **Do not swim at a natural bathing place that is not approved by the Local Health Department**

Beach hazards	☐ No	☐ Yes or Do Not Know **Do not swim until hazards are identified and eliminated.**
5. Written swimming safety procedures prepared	☐ Yes	☐ No **Do not swim. Prepare plan.**
6. Program personnel trained in swim safety procedures. Training documented.	☐ Yes	☐ No **Do not swim. Train staff.**
7. Parent authorization form obtained for each child	☐ Yes	☐ No **Do not swim. Obtain authorization.**
8. Child behavior rules established	☐ Yes	☐ No **Do not swim. Establish activity rules.**

B. SWIM SITE SUPERVISION AND DESIGNATED SWIM AREAS

1. The facility director or the director's designee is present at the swim site supervising the overall activity.	Name	Phone During Activity
	☐ No	**Do not swim. Provide management supervision at the swim site.**
2. One lifeguard is positioned and on duty for each 50 swimmers or less.	☐ Yes	☐ No **Do not swim until adequate lifeguard supervision is provided.**
3. More than one lifeguard is required at this site and is positioned and on duty.	☐ Yes	Number of lifeguards required:
	☐ Unknown/Not Provided	**Do not swim until adequate lifeguard supervision is known and provided.**

4. Appropriate swim areas are established by the facility **and** aquatic staff.	Group	Non-Swimmers	Designated Swim Area
The areas must be based on the children's swimming ability, age and height with direct and active supervision provided AT ALL TIMES by lifeguards and facility staff		☐	
		☐	
		☐	

to prohibit a non-swimmer from entering water chest deep or deeper.		Swimmers	
		☐	
5. In addition to lifeguards, the facility staff are positioned at each designated swim area and are supervising children in the water as required by State regulations.		☐ Yes	☐ No **Do not swim until adequate supervision is provided.**
6. In addition to lifeguards, the facility staff directly supervises a non-swimmer child who is allowed in water chest deep or deeper at the ratio of one adult to 1 non-swimmer child.		☐ Yes	☐ No **Do not swim until adequate supervision is provided.**
7. Children who are not swimming and are at the swim site are supervised by facility staff according to State regulation.		☐ Yes	☐ No **Do not allow child to swim until safeguards are in place.**
8. A special needs child is supervised and accommodated according to the established care plan.		☐ Yes	☐ No **Do not swim until supervision is provided.**
9. Two persons certified in CPR (age-appropriate) and First Aid; *The individuals may be facility personnel or aquatic staff.*		☐ Yes	☐ No **Do not swim until first aid personnel are provided.**
C. SWIM PROCEDURES			
1. First visit: The lifeguard or aquatic manager discusses the swim site rules with children and facility staff before children enter the water.	☐ Yes	☐ No **Do not swim until the rules are discussed.**	
2. Before allowing a child in water chest deep or deeper, swimmers are tested for swimming skills by the ***lifeguard on site.*** ☐ Not Applicable, Children restricted to shallow water.	☐ Yes	☐ No **Children who are not tested by the lifeguard on site must be classified a non-swimmer and is not allowed in water chest deep or deeper.**	
3. First visit: The facility's safety procedures are practiced at the swim site.	☐ Yes	☐ No **Do not swim until safety procedures are practiced.**	
4. The provider can quickly account for all children during a swim activity.	☐ Yes	☐ No **Do not swim; Establish procedure.**	
5. Swimmer rest periods and bathroom breaks are scheduled.	☐ Yes	☐ No **Do not swim until scheduled.**	
6. Facility personnel remove children who are not following rules from the water.	☐ Yes	☐ No **Do not allow child to swim until distraction is eliminated.**	
D. BARRIER			
1. A barrier prevents a child from getting over, under or through the fence gaining access to water. Public Pool: Barrier includes wading pool separation from main pool with fence and self-closing gate. Natural Bathing Place: Instead of barrier enhanced safety procedures and supervision must be provided by on-site facility staff restricting activity to safest area.		☐ Yes	☐ No **Do not swim until the hazard is eliminated.**
E. COMMENTS			
Facility Director or Designee's Signature		Date	

4/2008

FIRST AID SUPPLY LIST

REQUIRED ITEM	USE TO
Band Aids (assorted sizes)	To cover and protect cuts or open wounds.
Flashlight (operable, may be small	To check eyes, inside nose, throat and ears.
Gauze pads (2"x2" or 4"x4")	To clean, cover and protect cuts or open wounds.
Gauze pad (large, thick size) or sanitary napkin	To control bleeding or cover large wounds.
Gauze, flexible rolls (2 rolls)	To hold gauze bandages in place.
Gloves (disposable vinyl-latex gloves are acceptable, but they may cause a skin reaction for the wearer)	To protect person administering aid.
Ice Bag or Chemical Ice Pack	To control swelling when filled or activated.
Paper Towels	To clean up spills (then discard).
Pocket mask/Face shield for CPR	To perform rescue breathing during CPR.
Safety Pins	To secure sling in place.
Scissors (blunt tip)	To cut gauze and bandages to size.
Soap (liquid, fragrance-free)	To clean injured area.
Tape (hypo-allergenic)	To hold gauze bandages to size.
Thermometer (non-glass, non-mercury) or fever strip	To take body temperature. Do not take rectally.
Triangular bandage (pre-made or 40"x40"x64" piece of clean cotton cloth	To immobilize body parts as a sling or a tie for a splint; To hold dressing on large wounds.
Tweezers	To remove splinters.
Wash cloths (disposable)	To clean injured area.
If you suspect that a child has been poisoned, call Poison Control immediately! Follow all instructions given by Poison Control. Do not induce vomiting unless instructed to do so by Poison Control. **POISON CONTROL: 410 529-7701 (Metropolitan Baltimore) or 1-800-222-1222 (Maryland only, toll-free)**	

Note: First aid supplies are to be kept in a location which is convenient and easily accessible. All first aid items are to be maintained in a sufficient quantity for the size of the child care program. First aid supplies are to be available at the child care facility and on all field trips.

Recommended Additional Items:

- Coins for emergency phone calls or cell phone
- Pen/pencil and note pad for recording emergency events for use on field trips
- Splints (metal or plastic)
- Emergency medication for children with special needs (as approved and provided by parents)
- Purchased bottled water (replace once opened)

AGENCY REGULATIONS

OFFICE OF CHILD CARE CENTER REGULATIONS
Maryland State Department of Education Family Law Article 5-560, 5-64, and 5-570-5-585; State Government Article, 10-617; Article 88A. Effective January 1, 2006, the chapter was re-codified as COMAR 13A.14.02. These regulations govern non-parental care of children for part of a 24-hour day, not in the child's own home, in a group setting such as a child care center, preschool, child development center, nursery school, before-school and after-school program, school aged child care or early learning center, by whatever name known, under private nonprofit, proprietary, public, and religious auspices.

OFFICE OF CHILD CARE FAMILY DAY CARE HOME REGULATIONS
Maryland State Department of Education Family Law Article 5-550-5-557.1 and 5-560; State Government Article, 10-617; Article 88A; Annotated Code of Maryland (COMAR) is re-codified as COMAR 13A.14.01. The purpose of registration of family day care homes is to protect the health, safety, and welfare of children while they are in family day care, and to identify family day care homes.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE PUBLIC POOLS AND SPA REGULATIONS
Health-General Article Sections 2-102, 2-104, 18-102 and 20-303 - Code of Maryland Regulations (COMAR) 10.17.01 Public Swimming Pools and Spas is administered by Maryland's Department of Health and Mental Hygiene (DHMH). The purpose of this chapter is to enact regulations that protect and promote the public health and safety of individuals at public spas and pools in Maryland. Public pools include limited public-use pools, recreational pools, and semipublic pools. This chapter adopts construction standards, updates disinfection standards, recognizes certain new technologies and design concepts, and establishes minimum criteria for public pools and spas.

MARYLAND DEPARTMENT OF THE ENVIRONMENT BEACH REGULATIONS
26.08.09.00 Title 26 DEPARTMENT OF THE ENVIRONMENT Subtitle 08 WATER POLLUTION Chapter 09 Public Bathing Beaches Authority: Environment Article, §9-252, 9-313?9-315, and 9-319, Annotated Code of Maryland 26.08.09.01 26.08.09.01. 01 Definitions. A. In this chapter, the following terms have the meanings indicated. B. Terms Defined. 1) "Approving authority" means the Secretary of the Department of the Environment or the Secretary's designee. 2) Beaches. a) "Beaches" means natural waters, including points of access, used by the public for swimming, bathing, surfing, or other similar water contact activities. b) Beaches are places where people engage in or are likely to engage in activities that could result in immersion or ingestion of water.

LOCAL GOVERNMENT PROGRAMS, i.e. Local Recreation and Parks Units and Local School Boards
COMAR 10.16.06 allows local government programs to self-regulate its recreation and park programs (camp-intramural-swimming), providing that it has its own health and safety standards. DHMH annually advises the local unit of any violation of State regulation, but does not certify the program.

ADMINISTRATION for CHILDREN AND FAMILIES HEAD START
Federal safety requirements at 45 CFR §§ 1304.53 (a)(7) and 1304.53 (a)(10) (x) for public school or public playgrounds used by grantees and delegate agencies are to "provide for the maintenance, repair, safety, and security of all Early Head Start and Head Start facilities. The regulations requirements include the "selection, layout, and maintenance of playground equipment and surfaces to minimize the risk of injury to children. These programs must, as prescribed by local laws and comply with the minimum specifications described in the Consumer Product Safety Commission (CPSC) Handbook for Public Playground Safety (Chapter 4.5) of various surfacing materials.

RESOURCES

*Caring for Our Children: National Health and Safety Standards*_American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care (2002).

Child & Family Canada, Moving and Growing: Exercises and Activities for Five and Six-Year Olds, www.cfc-efc.ca/docs/cich/0003-en.htm

"Concurrent and longitudinal relations between children's playground behavior and social preference, victimization and bullying." Child Development 70 (4), 944-954

Consumer Product Safety Handbook for Playground Safety, Consumer Product Safety Commission (1997)

Safety Barriers Guidelines for Home Pools, Consumer Product Safety Commission, Pub 362 http://www.cpsc.gov/CPSCPUB/PUBS/Pool.pdf

"Elements of Negligence", in Law for Recreation and Sports Managers, (3rd Edition), O. Cotton and J.T. Wolsham (eds), (pp. 56-65) Dubuque, IA. Kendall Hunt

High Expectations: Playgrounds for Children of All Abilities, 1st Edition, pp. 54, National Center for Boundless Playgrounds

Illinois Early Learning Project, Resources on Early Learning Tip Sheets, Physical Fitness for Preschool-Age Children, http://www.illinoisearlylearning.org/tipsheets/fitness-preschool.htm

National Program for Playground Safety website: http://www.playgroundsafety.org/ ,
S.A.F.E. Play Areas: Creation, Maintenance, Renovation, Thompson, Hudson, Olsen (2007)

National Child Care Information Center, http://www.nccic.acf.hhs.gov/poptopics/playgrounds.pdf

Raising Children Network, Activities for Younger Children,
http://raisingchildren.net.au/articles/activities_for_younger_kids.html

S.A.F.E. Playground Supervision Manual, Cedar Falls IA: National Program for Playground Safety. Bruya, Hudson, S. Olsen, H. Thompson, D, and Bruya (2002)

Suite101.com, Broom Hockey Daycare Activity: Physical Gross Motor Lesson Plan for Preschool,
http://day-care activities.suite101.com/article.cfm/broom_hockey_daycare_activity

"Supervision on elementary school playground." Unpublished master's thesis, Gonzaga University, Spokane WA

Webster's II New Riverside University Dictionary (1984)

Work Sampling System (WSS™), Dichtemiller, et al (1999)

WEBSITES:

American Standards for Testing Materials (ASTM)
www.astm.org

National Resource Center for Health and Safety in Child Care and Early Education
http://nrc.uchsc.edu

CPSC Handbook
http://www.cpsc.gov/cpscpub/pubs/325.pdf

Safety Checklist for Active Play (PA ECELS program) - I really like this checklist - you may want to compare with the one you have for any additional information
http://www.ecelshealthychildcarepa.org/content/Safety%20Checklist%20for%20Active%20Play%20Areas.pdf

Sun Safety Alliance Resource List
http://www.sunsafetyalliance.org/resources.html

Moving and Growing: Exercises and Activities for the First Two Years
http://www.cfc-efc.ca/docs/cich/00001_en.htm

IEL Tip Sheets: Physical Fitness for Preschool-Aged Children
http://www.illinoisearlylearning.org/tipsheets/fitness-preschool.htm

Public Health Seattle and King County Child Care Health Program , The Power of Physical Activity
http://wwwmetrokc.gov/health/childcare/physical.htm

SunGuardMan Online
www.sunguardman.org/core.html

FIRST AID KIT SUPPLIERS:

Channing Bete Company 1-800-611-6083 www.channing-bete.com

Laerdal Medical Corporation 1-888-562-4242 www.laerdal.com

WorldPoint ECC, Inc. 1-888-322-8350 www.worldpoint-ecc.com

First -Aid Product .com www.first-aid-product.com/industrial/cprl.htm

www.cpr-savers.com

www.cprkits.com.

Playground and Water Safety Guidelines

Division of Early Childhood Development
200 West Baltimore Street
Baltimore, MD 21201

www.MarylandPublicSchools.org