

**Caring for Children Who are Ill
Training Module
version 3
(Last updated 4/23/13)**

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NOTE TO TRAINER

This Module presents information about options for caring for children who are ill and are temporarily unable to fully participate in their usual child care program. The Toolkit contains a Trainer's Guide to leading training sessions, PowerPoint slides, and materials for participants' packets. Please note that the title of the Module has been changed from *Caring for Children Who Are Ill or Temporarily Disabled*; the general content remains the same.

For more information about using the NTI materials, please read "Guidelines for Using the NTI Curriculum Materials," available in the "Curriculum" section of the NTI Resources Website (accessed by entering your NTI username and password at <http://sakai.unc.edu>).

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LEARNING OBJECTIVES

After reading this Module, Trainers will be able to:

- Cite *CFOC* standards related to caring for children who are ill
- Describe the general and specific guidelines for exclusion
- Describe types of care arrangements available to parents/guardians of children who are ill
- Compare advantages and disadvantages of each type of care
- Discuss what topics should be included in policies related to the exclusion of children who are ill
- Describe the difficulties faced by parents/guardians, child care staff and health care providers with respect to children who are ill
- Describe some specific ways to improve communication among parents/guardians, child care staff, and health care providers in order to reduce friction over conflicting needs

INTRODUCTION: THE ROLE OF THE CCHC

The child care health consultant (CCHC) is in a position to assist child care staff, parents/guardians, health care practitioners, and public health officials in determining best practices for caring for children who are ill. Three main responsibilities of the CCHC in this area include:

- Educating caregivers/teachers and parents/guardians about when to exclude a child from the child care setting
- Providing information about options for the care of a child who is ill
- Assisting with the development and implementation of policies

The CCHC should understand the national standards and state regulations for when a child should be excluded from a child care facility in the event of an illness or temporary disability. The CCHC also must be aware of varying needs and perspectives of those involved in caring for children who are ill—parents/guardians, employers, child care staff, and health care providers—and they should facilitate communication among these various parties. The CCHC should collaborate with the child care facility to write policies and procedures that are consistent with current evidence-based standards and applicable state regulations regarding care for children who are ill. She/he should also assist the child care facility in communicating the rationale for their exclusion criteria to parents/guardians.

The CCHC may also take advantage of opportunities to work as an advocate on behalf of children who are ill and may be enrolled in child care; for example, by advocating for expanded paid sick leave for parents/guardians as well as for expanded options within the community for the care of children who are unable to attend their regular child care programs.

The above considerations are covered in the sections that follow. In addition to the topics discussed in this Module, the CCHC should be familiar with the NTI Training Module *Infectious Disease in Child Care Settings* which presents more specific details about the incidence, spread, prevention, management and reporting of specific infectious diseases in child care.

CARING FOR OUR CHILDREN NATIONAL STANDARDS (3rd ed., 2011)

Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Third Edition (*CFOC*) is a set of 686 attainable standards that are intended for use by health care professionals, trainers, regulators, caregivers/teachers, academics and researchers, parents/guardians, and others “who work toward the goal of ensuring that all children from day one have the opportunity to grow and develop appropriately, to thrive in healthy and safe environments, and to develop healthy and safe behaviors that will last a lifetime” (*CFOC*, 3rd ed., 2011, p. xxi). These standards, supported by the Maternal and Child Health Bureau, were developed by the American Academy of Pediatrics, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care and Early Education.

The following is a list of the standards relating to caring for children who are ill in the child care environment, along with a short description and the page number in *CFOC* on which the standard can be found. All listed standards are referenced throughout this Module.

[3.1.1.1](#) – Conduct of Daily Health Check, p.89

States that a health check should be conducted as soon as possible after the child enters the child care facility and whenever a change in the child’s behavior or appearance is noted while that child is in care. Standard lists five areas to be covered in daily health check.

[3.1.1.2](#) – Documentation of the Daily Health Check, p.89

States that the caregiver/teacher should conduct and document a daily health check of each child upon arrival.

[3.6.1.1](#) – Inclusion/Exclusion/Dismissal of Children, p.131

Lists over five steps that facilities should take to prepare for managing illness and over twenty conditions/symptoms that do not require exclusion. Also lists over twenty conditions that require temporary exclusion and procedures for a child who requires exclusion.

[3.6.2.1](#)-- Exclusion and Alternative Care for Children Who Are Ill, p. 137

States that exclusion conditions for facilities should be followed as outlined in Standard [3.6.1.1](#) and lists minimum requirements for alternative care for children who are ill.

[3.6.2.2](#) – Space Requirements for Care of Children Who Are Ill, p. 137

Lists six requirements for environmental space used for the care of children who are ill.

[3.6.2.3](#) – Qualifications of Directors of Facilities that Care for Children Who Are Ill, p. 138

Lists three minimum qualifications for the director of a facility in addition to the general qualifications described in Director’s Qualifications, Standards [1.3.1.1](#) and [1.3.1.2](#).

[3.6.2.4](#) – Program Requirements for Facilities That Care for Children Who Are Ill, p. 138

Describes the minimum requirements a facility that cares for children who are ill should have.

[3.6.2.5](#) – Caregiver/Teacher Qualifications for Facilities that Care for Children Who Are Ill, p.138

Lists required topics, grouped into five categories, to be included in twenty hours of pre-service training for staff that care for children who are ill.

[3.6.2.6](#) – Child-Staff Ratios for Facilities that Care for Children Who Are Ill, p. 139

Provides required child-staff ratios for facilities that care for children who are ill, related to the age of the children.

[3.6.2.7](#) – Child Care Health Consultants for Facilities that Care for Children Who Are Ill, p.139

Lists seven topic areas in which child care health consultants can support by reviewing written policies and procedures.

[3.6.2.8](#) – Licensing of Facilities that Care for Children Who Are Ill, p.140

States that a facility may care for children with symptoms requiring exclusion provided that the licensing authority has given approval of the facility, written plans describing symptoms and conditions that are admissible, and procedures for daily care.

[3.6.2.9](#) – Information Required for Children Who Are Ill, p.140

Lists six pieces of information that a child care facility should have for a child who is ill.

[3.6.2.10](#) – Inclusion and Exclusion of Children From Facilities that Serve Children Who Are Ill, p.141

States that facilities that care for children who are ill who have conditions that require additional attention from the caregiver/teacher, should arrange for or ask the child care health consultant to arrange for a clinical health evaluation, by a licensed primary care provider, for each child who is admitted to the facility.

[3.6.3.1](#) – Medication Administration, p. 141

States that the administration of medicines at the facility should be limited to: (1) Prescription or non-prescription medication (over-the-counter [OTC]) ordered by the prescribing health professional for a specific child with written permission of the parent/guardian. Written orders from the prescribing health professional should specify medical need, medication, dosage, and length of time to give medication; (2) Labeled medications brought to the child care facility by the parent/guardian in the original container (with a label that includes the child's name, date filled, prescribing clinician's name, pharmacy name and phone number, dosage/instructions, and relevant warnings).

[3.6.3.2](#) – Labeling, Storage, and Disposal of Medications, p.143

Lists procedures and policies for labeling, storing and disposing of medications.

[3.6.3.3](#) – Training of Caregivers/Teachers to Administer Medication, p.143

Lists seven topics that should be covered in medication administration training for caregivers/teachers.

[3.6.4.2](#) – Infectious Diseases that Require Parent/Guardian Notification, p.145

Lists eleven diseases or conditions about which the child care facility should, in cooperation with the child care regulatory authority and health department, inform parents/guardians if a child has been exposed.

[3.6.4.4](#) – List of Excludable and Reportable Conditions for Parents/Guardians, p.145

Lists five situations and symptoms in which the advice of the primary care provider should be documented.

[5.4.6.1](#) – Space for Children Who Are Ill, p.255

States that each facility should have a separate room or designated area within a room for the temporary or ongoing care of a child who needs to be separated from the group because of injury or illness. This room or area should be located so the child may be supervised and may be within the child's usual child care room.

[7.3.3.2](#) – Influenza Control, p. 303

States that facilities should encourage parents/ guardians to keep children with symptoms of acute respiratory tract illness with fever at home for a specified amount of time.

[7.3.4.1](#) – Mumps, p. 304

Provides exclusion criteria for children and caregivers/teachers with suspected or proven mumps infection.

[7.3.6.1](#) – Attendance of Children with Erythema Infectiosum (EI) (Parvovirus B19), p. 306

States that children who develop Erythema Infectiosum (EI), also known as fifth disease, following infection with parvovirus B19, should be allowed to attend child care because they are no longer contagious when signs and symptoms appear.

[7.3.7.3](#) – Exclusion for Pertussis, p. 307

Lists three criteria for the permission of return to the facility for a symptomatic child or staff member with pertussis.

[7.3.8.1](#) – Attendance of Children with Respiratory Syncytial Virus (RSV) Respiratory Tract Infection, p. 307

Provides exclusion/inclusion criteria for children with known RSV infection.

[7.3.10.2](#) – Attendance of Children with Latent Tuberculosis Infection or Active Tuberculosis Disease, p. 310

States that children with active tuberculosis disease may attend group child care once effective therapy has been instituted, adherence to therapy has been documented, and clinical symptoms are absent.

[7.3.11.1](#) – Attendance of Children with Unspecified Respiratory Tract Infection, p. 311

Outlines three specific criteria for the possible exclusion of children from the facility due to an unspecified respiratory tract infection.

[7.4.0.1](#) – Control of Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections, p. 311

Provides specific procedures that facilities should follow to prevent and control infections of the gastrointestinal tract (including diarrhea) or hepatitis A,

[7.5.1.1](#) – Conjunctivitis, p. 315

Provides exclusion and inclusion criteria for children and staff with conjunctivitis.

[7.5.2.1](#) – Enterovirus Infections, p. 316

Provides exclusion and inclusion criteria for children and staff with enterovirus infections.

[7.5.3.1](#) – Human Papillomaviruses (HPV) (Warts), p. 316

States that children and staff with warts should not be excluded from child care.

[7.5.4.1](#) – Impetigo, p. 317

Specifies five steps that should be instituted when children or staff with lesions suspicious for impetigo are identified and under what circumstances exclusion should occur.

[7.5.5.1](#) – Lymphadenitis, p. 317

Provides exclusion criteria for children or staff with lymphadenitis are identified.

[7.5.7.1](#) – Molluscum Contagiosum, p. 318

Provides information about molluscum contagiosum and states that children and staff with the skin disease should not be excluded from child care.

[7.5.8.1](#) – Attendance of Children with Head Lice, p. 319

States that children should not be excluded immediately or sent home early from child care due to the presence of head lice. Parents/guardians of affected children should be notified and informed that their child must be treated before returning to the child care facility.

[7.5.9.1](#) – Attendance of Children with Ringworm, p. 319

States that children with ringworm of the scalp (tinea capitis) or body (tinea corporis) should receive appropriate treatment. Children receiving treatment should not be excluded from child care.

[7.5.10.1](#) – *Staphylococcus Aureus* Skin Infections Including MRSA, p. 320

Specifies two steps that should be implemented when children or staff with lesions suspicious for *Staphylococcus aureus* infections are identified and under what circumstances exclusion should occur.

[7.5.11.1](#) – Attendance of Children with Scabies, p. 321

States that children with scabies should be removed from the child care facility until appropriate treatment has been administered. Children should be allowed to return to child care after treatment has been completed.

[7.5.12.1](#) – Thrush (Candidiasis), p. 321

States that children with thrush do not need to be excluded from group settings. Provides information about the best way to prevent the spread of thrush.

[7.6.1.1](#) – Disease Recognition and Control of Hepatitis B Virus (HBV) Carrier, p. 321

Highlights the importance of facilities having written policies for the inclusion and exclusion of children known to be infected with hepatitis B virus (HBV) and for the immunization of all children with hepatitis B vaccine per the “Recommended Immunization Schedules” for children and adolescents. Also states that children who carry HBV chronically and who have no behavioral or medical risk factors may be admitted to the facility without restrictions.

[7.6.1.2](#) – Observation and Follow-Up of a Child Who Is an Hepatitis B Virus (HBV) Carrier, p. 322

States that staff should observe a child who is a known hepatitis B virus (HBV) carrier and the other children in the group for development of aggressive behavior, then, if this type of behavior occurs, the child’s primary care provider or the health department should evaluate the need for immediate disease prevention measures.

[7.6.3.1](#) – Attendance of Children with HIV, p. 324

States that children who enter child care should not be required to be tested for HIV or to disclose their HIV status.

[7.7.1.2](#) – Testing of Children with Cytomegalovirus (CMV), p. 327

States that testing children to detect cytomegalovirus (CMV) excretion or excluding children known to be CMV-infected is not recommended since all infants and toddlers should be assumed to excrete CMV in their urine and saliva.

[7.7.3.1](#) – Roseola, p. 327

States that children with roseola or clinical evidence of infection with human herpes virus 6 or 7 need not be excluded from child care as long as certain conditions exist.

[7.7.4.2](#) – Exclusion of Children with Varicella-Zoster (Chickenpox) Virus, p. 328

States that children who develop chickenpox should be excluded until all sores have dried and crusted (usually six days).

[9.2.1.1](#) – Content of Policies, p. 348

Details what content should be covered by policies at child care facilities, including the care of children and staff who are ill.

[9.2.3.2](#) – Content and Development of the Plan for Care of Children and Staff Who Are Ill, p. 354

Details what a plan for the management and care of children who are ill should include.

[9.2.3.3](#) – Written Policy for Reporting Notifiable Diseases to the Health Department, p.355

States that a written communication policy should be in place to describe needed communication between parents/guardians and caregivers/teachers during transitions that occur at times when children are being dropped off or picked up and other interactions with parents/guardians.

[9.2.3.4](#) – Written Policy for Obtaining Preventive Health Service Information, p. 355

States that each facility should develop and follow a written policy for obtaining necessary medical information including immunizations and periodic preventive health assessments as recommended by the American Academy of Pediatrics (AAP) in Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents.

[9.2.3.5](#) – Documentation of Exemptions and Exclusion of Children Who Lack Immunizations, p. 356

States that for children who have been exempted from required, up-to-date immunizations, these exemptions should be documented in the child's health record as a cross reference, (acceptable documentation includes a statement from the child's primary provider, a legal exemption with notarization, waiver, or other state-specific required documentation signed by the parent/guardian).

[9.2.3.6](#) – Identification of Child's Medical Home and Parent/Guardian Consent for Information Exchange, p. 356

Lists five categories of health providers that the facility should exchange information with upon the enrollment of the child.

[9.2.3.9](#) – Written Policy on Use of Medications, p. 358

Lists nine general categories that should be included in a facility's policy and five components of a medication administration record.

[9.2.4.1](#) – Written Plan and Training for Handling Urgent Medical Care or Threatening Incidents, p. 364

Lists nine types of incidents about which the management, documentation, and reporting should be included in a written plan for emergency incidents. Also lists more than ten procedures that should be addressed in a plan for urgent care.

[9.2.4.2](#) – Review of Written Plan for Urgent Care, p. 365

States the facility's written plan for urgent medical care and threatening incidents should be reviewed and updated annually or as needed. It should be reviewed with each employee upon employment and yearly thereafter in the facility to ensure that policies and procedures are understood and followed in the event of such an occurrence.

[9.2.4.4](#) – Written Plan for Seasonal and Pandemic Influenza, p. 368

States that the facility should have a written plan for seasonal and pandemic influenza (flu) and provides detailed information on what the plan should include.

[9.4.1.2](#) – Maintenance of Records, p. 378

Details what types of records should be maintained in the facility, including child health records and a list of reportable diseases.

[9.4.1.10](#) – Documentation of Parent/Guardian Notification of Injury, Illness or Death in Program, p. 383

Lists four situations that the facility should document in accordance with state regulations.

[9.4.2.4](#) – Contents of Child’s Primary Care Provider’s Assessment, p. 389

Lists thirteen items to be included in a child’s primary care provider’s initial health assessment.

[9.4.2.5](#) – Health History, p. 390

Lists fourteen items that should be included in a child’s history, completed by the parent/guardian at admission to the facility.

[9.4.2.6](#) – Contents of Medication Record, p. 391

Lists seven items to be included in the child’s medication record.

[9.4.2.7](#) – Contents of Facility Health Log for Each Child, p. 391

Lists seven items to be included in the facility health log for each child, which should be regularly maintained on an ongoing basis by designated staff.

[Appendix F](#) – Enrollment/Attendance/Symptom Chart, p. 430

Template for recording enrollment, attendance and symptoms of children attending child care.

WHAT THE CCHC SHOULD KNOW: EXCLUSION CRITERIA

Mild illnesses such as respiratory infections (colds, coughs, and runny noses), and gastrointestinal problems (nausea, vomiting, and diarrhea) are part of childhood. Children in out-of-home child care settings experience a higher incidence of infections than children who are cared for in their own homes. Because of their propensity to share toys and put objects in their mouths, young children cared for in groups of more than six have higher rates of infections as well as longer and more severe illnesses and more doctor visits than children in smaller groups (Aronson and Shope, 2005)¹. Although most of these illnesses are mild respiratory or gastrointestinal infections and common complications, such as ear infections, they can have a significant impact on the field of child care.

Exclusion occurs when a child is sent home or prevented from attending his/her regular child care program due to illness. Often this is because the child is too sick to take part in the daily activities or because the child's illness requires more care than the facility staff can reasonably provide. It is common practice for child care facilities to require parents/guardians to pick up their children if they become ill during the day. Usually children are not expected to return until they are asymptomatic (Richardson, Elliman, et al. 2001; Dailey 2003). Exclusion can cause difficulties for parents/guardians who may not be able to leave work or have access to alternative caregivers. The additional fact that children may need child care as they recover from temporary disabilities (burns, fractures, or surgery) places further stress on the child care system and families.

Although the *CFOC* standards support exclusion when an illness prevents a child from participating comfortably or when the illness requires greater care from staff than they can provide without compromising the health and safety of the other children^{3.6.1.1}, often justifications for exclusion are not clear. Child care staff, parents/guardians, and health care providers do not agree and do not know about nationally-recommended criteria for exclusion and inclusion of children who have symptoms of minor illness. Richardson et al. note that the decision to exclude is often based on the perceived seriousness of the child's illness rather than evidence of serious illness (Richardson, Elliman et al. 2001).

For example, common perceptions among non-medically trained professionals about the meaning of fever and the ease of measuring body temperature probably explains its widespread use as the major indicator for sending mildly ill children home from child care facilities. Whether or not a child has a fever is often used as the primary criterion for exclusion. A study of child care centers in Virginia found that 69% of centers surveyed considered temperatures greater than 100°F to represent fever. Forty-three percent of child care centers responding to this study immediately excluded children with fever, 31% allowed the child to remain within their group, and 10% allowed the child to remain at the center, but kept them isolated from the other children (Pappas, Schwartz, et al., 2000). In a survey conducted in Baltimore, Maryland in 2000, on average, neither child care caregivers/teachers nor parents, nor pediatricians had an understanding of how the national guidelines recommend managing common conditions. Child care caregivers/teachers were more likely than pediatricians to believe that exclusion was warranted to control infection or for the child's personal needs (Copeland, Duggan and Shope, 2005).

¹ see also NTI's *Infectious Disease in Child Care Settings?*

Fever is not a reliable indicator of severity of illness in young children (Dailey, 2003; Jensen, 2003; Mayo Foundation for Medical Education and Research, 2003). Therefore, the evidence does not support automatic exclusion of children (who are older than six months of age) with fevers above 101°F orally, 102°F rectally, or 100°F axillary, especially when there are no additional symptoms (Dailey, 2003; Jensen, 2003; Mayo Foundation for Medical Education and Research, 2003; *CFOC*, 3rd ed., 20011). Most illnesses do not require exclusion and a child with a can remain in care as long as he is able to participate comfortably in the program's activities. [3.6.1.1](#)

Child care staff, as compared to parents/guardians and pediatricians, are more likely to exclude a child from care (Copeland, Duggan and Shope, 2005; Friedman, Lee, et al. 2003). Copeland, Duggan and Shope suggest several reasons for this result:

- The child care caregiver/teacher may want to reduce the spread of an infectious disease
- The child may require extra attention and increase the provider's work
- The child care caregiver/teacher may not feel qualified to care for the child
- The child care caregiver/teacher may not have sufficient knowledge about mild illnesses and temporary disabilities
- The caregiver/teacher may think the child will feel best at home with a caregiver

It is important for child care staff, parents/guardians, and health care providers to agree on what conditions will exclude a child from care. In general, a child should only be excluded when any of the following are true about his/her illness:

- 1) inhibits him/her from participating comfortable in normal activities
- 2) requires greater care than the staff can provide with compromising the health and safety of other children
- 3) poses a risk of spread of harmful diseases to others [3.6.1.1](#)

These conditions should include indicators that an illness may be serious and require medical attention (Pappas, Schwartz, et al. 2000).

Specific Guidelines for Exclusion Criteria

In addition to the above three criteria for exclusion, *CFOC* standards [3.6.1.1](#) and [3.6.4.4](#) and the AAP's *Managing Infectious Diseases in Child Care and Schools* (Aronson and Shope, 2009) offer the following guidelines for exclusion based on specific indicators. These should be considered as part of determining whether the above three criteria are met, and not used as a basis for exclusion on their own. For example, a single incidence of vomiting may not warrant exclusion, whereas a child who is vomiting repeatedly and cannot participate in activities and requires special care may be appropriately excluded.

In the case of respiratory illness: A child may be excluded if she/he manifests a fever along with behavior or secondary signs and symptoms such as:

- Lethargy
- Uncontrolled coughing

- Inexplicable irritability or persistent crying
- Difficulty breathing
- Wheezing
- Other signs or behaviors that are unusual for that child.

Children who are excluded from care for these reasons can return once symptoms have abated and/or they have a health care provider certify that they are safe to return to care. There are a number of diseases, including influenza, measles, rubella, and varicella that are infectious for 1-2 days before symptoms begin. Thus, exclusion of ill children may not prevent an outbreak and hygiene should be a top priority at all times².

For gastroenteritis: The following exclusion criteria are suggested:

- Inexplicable bloody stools
- Abdominal pain for more than two hours
- Intermittent abdominal pain accompanied by fever or other signs or symptoms
- Two or more incidences of vomiting
- Diarrhea that can't be contained in a diaper or that is causing older children who usually use the toilet to have accidents [3.6.1.1](#), [7.4.0.1](#)

Children with Hepatitis A should also be kept out of child care until a health care provider confirms it is safe for them to return. [3.6.1.1](#), [7.4.0.1](#)

For diseases that are spread through skin-to-skin contact or through other body fluids:

Children exhibiting the following signs or symptoms may be excluded:

- Mouth sores with drooling (unless determined to be noninfectious)
- Rash with fever or behavior change (until determined by a health care provider not to have a communicable disease)
- Impetigo (until 24 hours after treatment has started) [7.5.4.1](#)
- Draining boils or skin lesions that are accompanied by fever, pain, or behavior change
- Purulent conjunctivitis (until treatment has started) [7.5.1.1](#)
- Scabies (until after treatment has been completed) [7.5.11.1](#)

Children with head lice do not have to be excluded in the middle of the day, but the lice should be treated overnight before the children may be admitted the following day. [7.5.8.1](#) (For additional disease-specific exclusion/inclusion criteria not previously listed in this Module, please reference the following *CFOC* standards: [7.3.4.1](#), [7.3.6.1](#), [7.3.7.3](#), [7.3.8.1](#), [7.3.10.2](#), [7.3.11.1](#), [7.5.1.1](#), [7.5.2.1](#), [7.5.3.1](#), [7.5.4.1](#), [7.5.5.1](#), [7.5.7.1](#), [7.5.8.1](#), [7.5.9.1](#), [7.5.10.1](#), [7.5.12.1](#), [7.7.3.1](#).)

Actions Items for the CCHC

The CCHC should:

- Assist child care caregivers/teachers and parents/guardians in understanding exclusion criteria
- Communicate to all parties that the purpose of their exclusion criteria is to:
 - Decrease the spread of infectious diseases to other children and staff

² see also NTI's *Infectious Disease in Child Care Settings*

- Provide for the child's comfort and well-being

WHAT THE CCHC SHOULD KNOW: TYPES OF CARE FOR CHILDREN WHO ARE ILL

Models of care for children who are mildly ill may differ among communities depending on their unique child care needs. For this reason, the CCHC must know and understand the full range of alternative types of care arrangements and the associated advantages and disadvantages.

Several different types of care are available for children who are ill. These include:

- Care in the child's usual facility in a special area for care of children who are ill^{3.6.2.2, 3.6.2.3, 3.6.2.4, 3.6.2.5, 3.6.2.6, 3.6.2.8, 3.6.2.9, 5.4.6.1} Care in a separate small family child care home or center that serves only children with illness or temporary disabilities^{3.6.2.3, 3.6.2.4, 3.6.2.5, 3.6.2.6, 3.6.2.8, 3.6.2.9, 5.4.6.1}
- Care by a child care caregiver/teacher in the child's own home^{3.6.2.5}

Several researchers (Capizzano & Adams, 2003; Camilli et al., 2010; Griffin, 1993) have broken down these care options into even finer categories. For example, care in the child's own home is differentiated by whether it is provided by the parent/guardian, relative, friend, or a trained health worker. The "infirmary model" is differentiated by whether the child's own facility has a "Get Well Room" or whether the child is included in his/her regular classroom. Separate facilities may include a family child care home, a satellite to a child care facility or to the parents/guardians' workplace, or a centrally located special facility serving the community.

Advantages and Disadvantages of Different Types of Care

The following are some of the prominent advantages and disadvantages of various types of care available for children who are ill. These assessments have been developed based on suggestions offered by Capizzano & Adams, 2003; Camilli et al., 2010; Griffin, 1993)

The Child's Own Home

If the child is cared for in his/her own home by a parent/guardian, advantages include being in a familiar environment with a familiar caretaker. The child does not have to leave home and can receive restful, individual care. The same advantages hold true if the child is cared for by a friend or relative in his/her own home. Disadvantages include the possibility of missed work/wages for the caregiver/teacher. A babysitter or trained health worker allows for the benefits of individual home care but may be expensive, not available when needed, and may not be familiar to the child. These individuals also may not be able to pick up a child from the child care facility.

Child's Own Program: "The Infirmary Model"

A special "get well" room in the child's own child care facility allows the child to remain in a familiar environment. Care is immediately available, and the child care staff may be familiar with the child's health care provider. Such an arrangement, however, may be expensive for the child care staff, may incur an additional charge for the parents/guardians, and requires the child care facility to have available space and staff. If a child is kept in the regular classroom, benefits include familiarity and less expense, but parents/guardians of non-ill children may

object, child care caregivers/teachers will need extra training in caring for children who are ill, additional staff may be required, and there is the possibility for infections to spread.

Separate Setting for Children Who Are Ill

Having a child cared for in a separate, family child care home eliminates the need for parents/guardians to miss work, but the environment may be unfamiliar to the child and may be expensive. A special facility for children who are ill at the parent's/guardian's workplace would allow for the parent/guardian to visit the child without missing work. Such an arrangement may be a good employee benefit but may be expensive to both the employee and the workplace, and it may be an unfamiliar and uncomfortable environment for the child. A separate, specialized facility could be staffed by medically trained personnel who could provide health education. Consultation and assessment from a health provider would be readily available, and these professionals may be able to provide training to regular child care staff about follow-up care needed by the child and health promotion activities for all children. Children in these specialized facilities can have a personalized daily care plan approved by a parent/guardian and health professional. Disadvantages to this type of care may be that the provider and environment are unfamiliar to the child. This type of care would likely be very expensive as well.

Action Items for the CCHC

The CCHC should:

- Facilitate an exchange of information between child care programs and families about the full range of alternative types of care arrangements for children who are ill available in their community
- Be aware of the associated advantages and disadvantages of the alternatives for care
- Provide health information, parent/guardian education resources, and access to health consultation to the selected care provider of the child who is ill

WHAT THE CCHC SHOULD KNOW: DEVELOPING POLICIES AND PROCEDURES RELATED TO THE CARE OF CHILDREN WHO ARE ILL

The CCHC can be instrumental in assisting child care staff and parents/guardians with the development of site-specific policies relating to caring for children who are ill [3.6.2.7](#), [9.2.1.1](#), [9.2.3.2](#), [9.2.4.4](#), [9.4.1.10](#). The CCHC can assist in identifying the need for a written policy, writing the policy, and reviewing and revising the policy, as needed. For more information about writing policies, please refer to NTI's *Building Consultation Skills* Training Module. The CCHC can also play a role in establishing communication between the child care staff and parents/guardians about the policies.

The table of *CFOC* standards found at the beginning of this document provides a list of the key issues that should be addressed in policies related to the exclusion of children who are ill. The CCHC should also be familiar with the content of the AAP's 2nd edition of *Managing Infections in Child Care and Schools* (2008) which is consistent with the current recommendations of infectious disease experts who set the standards for the American Academy of Pediatrics.

Dilemmas and Difficulties For Child Care Staff of Children Who Are Ill

In addition to the recommendations from state and national sources, there are additional concerns that should be addressed in the development of exclusion policies. These include the key concerns caregivers/teachers and families have about caring for children who are mildly ill. Not only does the child who is ill have specific needs, but his/her parents/guardians, child care staff, and health care providers do also.

Parents/Guardians

The parents/guardians of children who are ill face stresses and conflicts as parents/guardians and expectations that derive from their other roles (Mayo Foundation for Medical Education and Research, 2003). On the one hand, they are concerned about child-focused issues, such as determining an accurate diagnosis of the child's illness, knowing the severity of the illness, obtaining medical care if needed, weighing the advantages and disadvantages of the different care options, and wanting to be available to nurture their child. On the other hand, parents/guardians are concerned about job-related issues, such as how much flexibility their employer will allow, the availability of paid leave, meeting work deadlines, and fear of losing their jobs. They may have others in their family and community to whom they are responsible as well. Parents/guardians may also feel time and financial pressure to schedule additional visits to their health care provider in order to receive permission to return their child to the child care setting.

Child Care Caregivers/Teachers

Child care staff face several dilemmas when they provide care for the child who is ill. They are concerned about providing the best care to the individual child but are also concerned about preventing the spread of infectious diseases to other children in care. Child care caregivers/teachers are torn between giving the child who is ill extra attention while attending to the other children's needs. Many times child care caregivers/teachers are in position to make an initial assessment of children who are ill but worry about making correct decisions regarding exclusion and care of the child while that child remains their

responsibility and awaits parent/guardian arrival to leave the program. They also face a dilemma when they are willing to take care of a child who is mildly ill but feel the child would recover more rapidly and be more comfortable at home in a less stimulating environment. Child care staff may feel that they are not qualified to assess whether a child should be allowed back into the program.

Health Care Providers

Health care providers also must consider several issues when providing care for children who are ill. First of all, consideration must be given to what is best for the health and well-being of the child. However, the needs of the parents/guardians, the child care program and the health of the other children in the program must also be considered when they make any recommendation about the child's care. These needs are not always the same. Health care professionals may know little about the actual circumstances of the child care setting and the skills of the child care staff to make informed recommendations. Parents/guardians may ask the health care provider to have the child return to child care as soon as possible so they may resume their work responsibilities. Providing appropriate written instructions about what to do for parents/guardians to convey recommendations to caregivers/teachers whom the health care provider does not know is challenging. Unfortunately, communicating effectively with child care staff about an ill child brought to the office by a parent/guardian is constrained by the need to care for other patients in the practice. Health care providers may also feel burdened by additional, and possibly unnecessary, visits to determine whether a child is healthy enough to return to the child care setting.

Action Items for the CCHC: How to Facilitate Communication about Exclusion and Care

By understanding the varying concerns of parents/guardians, child care staff, and health care providers, CCHCs can help improve communication among all involved. In order to facilitate communication, the CCHC should:

- Help child care programs develop related policies and procedures, and ensure that parents/guardians are involved in the development and review of these policies.
- Work with the child care caregivers/teachers to help parents/guardians develop an “alternative child care plan” before the child is sick, so they will already have some options in place in the event of illness or temporary disability.
- Encourage the staff to establish protocol for referencing policies and resources whenever a child is excluded from the setting for illness or temporary disabilities.
- Encourage the child care caregiver/teacher to utilize a daily health check [3.1.1.1](#), [3.1.1.2](#) as children arrive at the facility with their parent/guardian. For more information, see suggested instruction for a daily health check in Appendix G of Model Child Health Care Policies (Aronson 2002).
- Help the child care facility develop a “Symptom Record” [Appendix F](#) for parents/guardians and child care caregivers/teachers to share information about the child who is ill. This record also serves as a way to transmit information to a health care provider if medical

care is sought. For more information, see sample form in Appendix J of Model Child Care Health Policies (Aronson 2002).

- Encourage the child care staff to use peer-reviewed, evidence-based references to make decisions about how to prepare for illness, to make decisions about exclusion and inclusion of ill children, and to inform staff and parents/guardians about management of illness. For more information, see *Managing Infectious Diseases in Child Care and Schools* (Aronson and Shope, 2009).
- Encourage the child care caregivers/teachers to develop a lending library with books, magazines, and brochures for parents/guardians. Information on topics such as handwashing, providing care for children who are ill, infectious and non-infectious diseases, first aid, and psychological and developmental needs of children who are ill could be covered.
- Help the child care facility develop a form letter to send to families about any exposures children may have to communicable diseases. For more information, see sample form in Appendix K of Model Child Care Health Policies (Aronson, 2002) and in *Managing Infectious Diseases in Child Care and Schools* (Aronson and Shope, 2009).
- Assist the child care facility in developing a form for medication consent and log.³ For more information, see sample form in Appendix M of Model Child Care Health Policies (Aronson, 2002).
- Ensure that staff who give medications in child care settings receive necessary training to carry out this procedure competently. [3.6.3.3](#).
- Encourage physicians and other health care providers to prescribe medications that can be taken at times when the child is not in a child care setting.

³ In some states, only nurses may develop a medication log. CCHCs should check their state regulations before working with child care facilities in this capacity.

WHERE TO FIND MORE INFORMATION

American Academy of Pediatrics, Red Book:

<http://aapredbook.aappublications.org/>

Aronson SS, Shope TR. Improving the health and safety of children in non-parental early education and child care. *Pediatrics in Review*. 2005;26:86-95.

<http://pedsinreview.aappublications.org/cgi/content/full/26/3/86>

Aronson SS, Shope TR (Eds.). 2nd Edition *Managing infectious disease in child care and schools: a quick reference guide*. Elk Grove Village, IL: American Academy of Pediatrics. 2009.

Aronson SS, Stubbs-Wynn P, Krajicek MJ. When a child is sick: Child care exclusion criteria from the new national child care health and safety standards. *Proceedings from the 130th Annual Meeting of the American Public Health Association*; 2002 Nov 9-13; Philadelphia, PA.

Centers for Disease Control and Prevention, *Infectious Disease Information: Childhood Diseases*

<http://www.cdc.gov/ncidod/diseases/children/>

Healthy Child Care America, *Inclusion and Exclusion Guidelines for Child Care*

<http://www.healthychildcare.org/inclusionexclusion.html>

National Association for Sick Child Daycare

<http://sbdcnrn.blogspot.com/2009/11/national-association-for-sick-child.html>

National Network for Child Care

<http://www.nncc.org/>

Pennsylvania Chapter of American Academy of Pediatrics

ECELS: Early Childhood Education Linkage System

<http://www.ecels-healthychildcarepa.org/>

Supporting Families Together Association

Providing Child Care for Mildly Ill Children

<https://supportingfamielsttogether.org/uploads/midlyill.pdf>

Resources

https://supportingfamielsttogether.org/Resources_for_Child_Care.html

REFERENCES

American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care. (2011). *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs*. 3rd Edition. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association.

Available at: <http://nrckids.org/>. Accessed April 23, 2013.

Aronson SS. (2002). *Model Child Care Health Policies*. (4th Ed.) Rosemont (PA): American Academy of Pediatrics; Pennsylvania Chapter; Healthy Child Care Pennsylvania; The Early Childhood Education Linkage System.

Aronson SS, Shope TR (Eds.) (2009). *Managing infectious disease in child care and schools: a quick reference guide* (2nd Ed.) Elk Grove Village, IL: American Academy of Pediatrics.

Camilli G, Vargas S, Ryan S, Barnett W.S, (2010). *Teach. Coll. Rec.* 112, 579.

Capizzano, J., & Adams, G. (2003). Children in low-income families are less likely to be in center-based child care (Snapshot of America's Families III No. 16). Washington, DC: Urban Institute.

Centers for Disease Control, National Immunization Program. (2011). Coverage estimates for school entry vaccinations 2008-2009 school year. Available at:

<http://www2.cdc.gov/nip/schoolsurv/nationalAvg.asp>. Accessed April 23, 2013

Copeland K, Duggan A, Shope T. (2005). Knowledge and Beliefs About Guidelines for Exclusion of Ill Children From Child Care. *Ambulatory Pediatrics*.

Dailey L, California Childcare Health Program. (2003). Excluding children due to illness. Available at: http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/exclen081803_adr.pdf. Accessed April 23, 2013.

Friedman JF, Lee GM, Kleinman KP, et al. (2003). Acute care and antibiotic seeking for upper respiratory tract infections for children in day care: parental knowledge and day care center policies. *Arch Pediatr Adolesc Med*;157:369-74.

Griffin A. (1993). Caring for mildly ill infants and toddlers in the context of child care: Emotional, medical, and practical perspectives. *Zero to Three*;13(4):15-23.

Jensen S, California Childcare Health Program. (2003). Fever: What you need to know. Available at: http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/feveren081803_adr.pdf . Accessed April 23, 2013.

Mayo Foundation for Medical Education and Research. Parental dilemma: What to do when your child is sick. Available at: <http://www.hatzalah.ch/?p=100> Accessed October 7, 2011.

Pappas DE, Schwartz RH, Sheridan MJ, et al. (2000). Medical exclusion is sick children from child care centers: a plea for reconciliation. *South Med J*;93(6):575-78.

Richardson M, Elliman D, Maguire H, et al. (2001). Evidence base of incubation periods, periods of infectiousness and exclusion policies for the control of communicable diseases in schools and preschools. *Pediatr Infect Dis J*;20(4):380-91.