

**Injury Prevention in Child Care Part B: Common Injury Risks
Training Module
version 4
(revised 6/6/13)**

Copyright Information

NTI has obtained permission from the copyright holders to reproduce certain quoted material in this document. All such material is clearly designated with the expression, “Reproduced with permission.” Trainers may not reproduce such material for any purpose without themselves obtaining permission directly from copyright holders. All other material contained in this document may be used and reprinted by NTI Trainers for training purposes without special permission. Use of the following citation, however, is requested and greatly appreciated.

Suggested Citation

The National Training Institute for Child Care Health Consultants. Injury prevention in child care part B: common injury risks training module version 4. Chapel Hill (NC): The National Training Institute for Child Care Health Consultants, Department of Maternal and Child Health, The University of North Carolina at Chapel Hill; 2013.

Supported by grant U46MC00003 from the Maternal and Child Health Bureau, Health Resources and Services Administration, US DHHS.

NOTE TO TRAINERS

This Module addresses the following six common injury risks in child care facilities:

- Airway Obstruction
- Poisoning
- Sudden Infant Death Syndrome (SIDS)
- Human Biting
- Emergencies
- Vehicle-Related Injuries

The Toolkit contains a Trainer’s Guide to leading training sessions, PowerPoint slides, and materials for participants’ packets.

In *Injury Prevention in Child Care Part A: Playground Safety and Outdoor Learning*, we discuss the outdoor environment with a section on play areas/playground safety and a section on outdoor learning environments.

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>).

TABLE OF CONTENTS

LEARNING OBJECTIVES.....	2
INTRODUCTION: THE ROLE OF THE CCHC	3
CARING FOR OUR CHILDREN NATIONAL STANDARDS	4
AIRWAY OBSTRUCTION	12
What the CCHC Should Know: Types of Airway Obstruction.....	12
What the CCHC Should Know: How to Assess Risks of Airway Obstruction.....	13
What the CCHC Should Know: How to Prevent Airway Obstruction.....	14
What the CCHC Should Know: How to Respond to an Airway Obstruction Injury	14
Action Items for the CCHC	15
POISONING.....	16
What the CCHC Should Know: How Poisoning Occurs.....	16
What the CCHC Should Know: How to Assess Risks of Poisoning.....	17
What the CCHC Should Know: How to Prevent Poisoning in the Child Care Facility	19
What the CCHC Should Know: How to Respond to Poisoning.....	19
Action Items for the CCHC	20
SUDDEN INFANT DEATH SYNDROME (SIDS)	21
What the CCHC Should Know: SIDS in Child Care Settings.....	21
What the CCHC Should Know: How to Assess Risks for SIDS.....	21
What the CCHC Should Know: How to Prevent SIDS in the Child Care Environment.....	22
What the CCHC Should Know: How to Respond to a SIDS Death in the Child Care Setting	24
Action Items for the CCHC	24
HUMAN BITING.....	25
What the CCHC Should Know: Reasons for Biting Behavior	25
What the CCHC Should Know: How to Prevent Biting Behavior	25
What the CCHC Should Know: How to Respond When Biting Occurs	26
Action Items for the CCHC	26
EMERGENCIES.....	27
What the CCHC Should Know: Emergencies That Can Occur in a Child Care Facility	27
What the CCHC Should Know: How to Prepare for and Respond to Emergencies.....	27
Action Items for the CCHC	35
VEHICLE-RELATED INJURIES.....	36
What the CCHC Should Know: Types of Vehicle-Related Injuries that May Occur in Child Care Settings	36
What the CCHC Should Know: How to Prevent Vehicle-Related Injuries.....	36
What the CCHC Should Know: How to Respond to Vehicle-Related Injuries.....	39
Action Items for the CCHC	39
WHERE TO FIND MORE INFORMATION	40
REFERENCES	46
APPENDIXES	51

LEARNING OBJECTIVES

After reading this Module, Trainers will be able to:

Airway Obstruction

- Define airway obstruction and describe the differences among choking, strangulation, suffocation, and entrapment
- Describe four reasons why children under age 4 are at higher risk of an airway obstruction
- List at least eight foods, toys, and objects that can obstruct a child's airway
- Describe at least five ways to prevent airway obstruction
- Describe signs of airway obstruction and how to respond to an airway obstruction emergency

Poisoning

- Define poisoning and list the five ways poisoning can occur
- Describe five reasons why children under age six are at higher risk of poisoning
- List at least eight poisons commonly found in child care facilities
- List four ways child care staff can prevent poisoning in the child care environment
- Describe how to respond to a poisoning emergency

Sudden Infant Death Syndrome (SIDS)

- Define SIDS
- List five factors that increase the risk for SIDS
- Describe how to create a safe sleep environment in the child care facility
- Describe how to respond to a SIDS death in a child care setting
- List resources that can assist parents/guardians and child care caregivers/teachers in the event of a SIDS death in the child care setting

Human Biting

- List five reasons for biting behavior in the child care environment
- Describe how human biting may be prevented in the child care environment
- Describe how to respond when biting occurs in the child care environment
- Explain the risk of disease transmission from human bites

Emergencies

- List five emergencies that could occur in a child care facility
- Describe how to prepare for emergencies
- Describe how to respond to emergencies
- Describe three different evacuation techniques
- Describe how to respond to signs of stress in children and staff after an emergency

Vehicle-Related Injuries

- Describe types of vehicle-related injuries that may occur in child care settings
- List at least 5 ways to prevent injuries from vehicles while children are in child care
- List five tips for child pedestrian safety
- Describe how to respond to vehicle-related injuries

INTRODUCTION: THE ROLE OF THE CCHC

This Module covers six common risks for injuries and death in child care environments: airway obstruction, poisoning, sudden infant death syndrome, biting, emergencies, and vehicle-related injuries. For each of these risks, the role of the CCHC is defined by four main tasks:

- Educating child care staff about the kind of injuries possible in the child care environment
- Helping child care caregivers/teachers assess the child care environment for risks associated with these injuries—these risk factors may be normal age-related developmental factors or environmental factors
- Helping child care staff develop policies and practices to prevent these injuries
- Helping child care caregivers/teachers prepare to respond in the event that an injury does occur

Each section in this module will address these four tasks by providing a definition of the injury, tips for assessing the environment for risk factors that may contribute to the injury, tips for preventing the injury, and tips for responding when an injury does occur. Please note that the recommendations for responding to an injury are provided to assist in developing policies and plans of action—they are not intended to replace professional training in infant and child rescue breathing, choking response, and first aid. The CCHC should provide child care staff with local resources for attaining such training and should encourage all child care staff to attain up-to-date, comprehensive training..

The CCHC's role also extends to educating parents/guardians, children, and the community about injury risks in child care. Many child care injury risks can be ameliorated with action outside the child care environment, such as limiting smoking in the home environment as a way of reducing SIDS risks, creating community-wide emergency response plans, or improving traffic laws and pedestrian awareness. The CCHC should be aware of and, as much as possible, involved in community action to promote injury prevention for children.

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 (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 injury prevention 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.

[1.1.1.4](#) - Ratios and Supervision During Transportation, p. 6

States that all child: staff ratios be maintained during transportation for out-of-home child care. The driver is not included in the ratio.

[1.4.1.1](#) – Pre-service Training, p.19

Details what topics should be covered in pre-service training for directors, and caregivers/teachers.

[1.4.2.1](#) - Initial Orientation of All Staff, p. 21

Details the orientation and knowledge new full-time, part-time staff, and substitutes should receive.

[1.4.3.1](#) - First Aid and CPR Training for Staff, p. 24

States that the director must ensure that all staff members involved in providing direct care should have documentation of satisfactory completion of training in pediatric first aid and pediatric CPR skills.

[1.4.3.2](#) - Topics Covered in First Aid Training, p. 25

Lists what should be covered in first aid training.

[1.4.4.1](#) - Continuing Education for Directors and Caregivers/Teachers in Centers and Large Family Child Care Homes, p. 26

Details the continuing education requirements for directors and caregivers/teachers.

[1.4.4.2](#) - Continuing Education for Small Family Child Care Home Caregivers/Teachers, p. 28

States that small child care home caregivers/teachers should have at least 30 clock hours per year of continuing education.

[1.5.0.2](#) - Orientation of Substitutes, p. 32

Lists the requirements of substitute caregivers/teachers.

[1.6.0.1](#) - Child Care Health Consultants, p. 33

Lists the training and knowledge requirements of a child care health consultant.

[2.2.0.7](#) – Handling Physical Aggression, Biting, and Hitting, p. 72

States that the caregiver/teacher should intervene when a child’s safety is in jeopardy, but that, when appropriate, interventions should be age-appropriate. Also states that the CCHC can help to develop a plan for a child with consistent aggressive behavior.

[2.4.1.1](#) - Health and Safety Education Topics for Children, p. 81

Details health education topics should be integrated into the facility’s program of activities.

[2.4.2.1](#) – Health and Safety Education Topics for Staff, p. 83

Includes over 25 topics which should be included in health and safety education topics for child care staff.

[2.4.3.2](#) – Parent/Guardian Education Plan, p. 84

Includes over 15 topics which should be included in a parent/guardian education plan.

[3.1.4.1](#) – Safe Sleep Practices and SIDS/Suffocation Risk Reduction, p. 96

Details required safe sleep practices for staff, parents/guardians, volunteers and other who care for infants in the child care setting.

[3.1.4.2](#) – Swaddling, p. 99

States that in child care settings, swaddling is not necessary or recommended.

[3.1.4.3](#) – Pacifier Use, p. 99

States that facilities should follow AAP guidelines around pacifier use. Outlines ten topic areas to be included in facility written policy for pacifiers.

[3.1.4.4](#) - Scheduled Rest Periods and Sleep Arrangements, p. 100

States that a facility must provide an opportunity for, but should not require, sleep and rest.

[3.4.2.1](#) - Animals That Might Have Contact with Children and Adults, p. 119

States that any animal present at the facility, indoors or outdoors, should be trained/adapted to be with young children, in good health, be fully immunized, and be maintained on an intestinal parasite control programs.

[3.4.3.1](#) - Emergency Procedures, p. 122

Details the emergency procedures when an immediate emergency medical response is required.

[3.4.3.2](#) - Use of Fire Extinguishers, pp. 123

States that staff should demonstrate the ability to locate and operate the fire extinguisher.

[3.4.3.3](#) – Response to Fire and Burns, p. 123

States that children who are developmentally able to understand should be instructed to STOP, DROP, and ROLL when garments catch fire.

[3.4.6.1](#) - Strangulation Hazards, p. 129

Details the storage and features of cords and strings necessary to be maintained in a facility, to prevent strangulation.

[3.5.0.1](#) -- Care Plan for Children with Special Health Care Needs, p.129

Lists over 20 items to include in a care plan for children with special health care needs, when it needs to be updated and who will be involved in its development.

[3.6.4.5](#) - Death, p. 146

Details protocol for responding to the death of a child enrolled in a facility.

[4.2.0.8](#) - Feeding Plans and Dietary Modifications, p. 158

Describes necessary dietary information a facility should obtain before a child begins care at the facility.

[4.2.0.10](#) - Care for Children with Food Allergies, p. 160

Details what should be included in a care plan for a child with food allergies.

[4.5.0.3](#) - Activities that are Incompatible with Eating, p. 178

States that children should not eat while standing, walking, running, playing, lying down, watching TV, playing on the computer, or riding in vehicles.

[4.5.0.10](#) -Foods that are Choking Hazards, p. 181

Details foods that are inappropriate for children younger than four years old.

[5.1.3.3](#) - Screens for Ventilation Openings, p. 205

States that all openings used for ventilation should be screened against insect entry.

[5.1.4.1](#) - Alternate Exits and Emergency Shelter, p. 206

States that each building or structure, new or old, should be provided with a minimum of two exits, on different sides of the building, that lead to open space at ground level.

[5.1.4.2](#) - Evacuation of Children with Special Health Care Needs and Children with Disabilities, p. 206

States that facilities that include children who have physical disabilities or other developmental disabilities should have exits with approved ramps.

[5.2.1.4](#) - Ventilation When Using Art Materials, p. 213

States that areas where arts and crafts activities are conducted should be well-ventilated.

[5.2.1.10](#) - Gas, Oil or Kerosene Heaters, Generators, Portable Gas Stoves and Charcoal and Gas Grills, p. 214

Prohibits the use of gas or oil heaters, portable open-flame kerosene space heaters, and gas cooking appliances for heating purposes.

[5.2.8.1](#) - Integrated Pest Management, p. 226

States that facilities should adopt an integrated pest management program.

[5.2.8.2](#) - Insect Breeding Hazard, p. 228

Prohibits a receptacle or pool, whether natural or artificial, containing water in such a condition that insects breeding therein may become a public health issue.

[5.2.9.1](#) - Use and Storage of Toxic Substances, p. 228

Lists all chemicals and cleaning supplies that should be stored in their original labeled containers, in a locked room or cabinet, and kept away from children, stored medications and food.

[5.2.9.2](#) - Use of a Poison Center, p. 229

Describes the procedure to be followed in case of any exposure to a toxic substance, or any poisoning emergency.

[5.2.9.3](#) - Informing Staff Regarding Presence of Toxic Substances, p. 229

States that employers should provide staff with hazard information about the presence of toxic substances in use in the facility.

[5.2.9.7](#) - Proper Use of Art and Craft Materials, p. 231

States that only art and craft materials that are approved by the Art and Creative Materials Institute (ACMI) should be used in the child care facility.

[5.2.9.8](#) – Use of Play Dough and Other Manipulative Art or Sensory Materials, p.232

Lists eight procedures which facilities should have in place on the use and life span of manipulative art or sensory materials.

[5.2.9.10](#) - Prohibition of Poisonous Plants, p. 234

States that poisonous or potentially harmful plants are prohibited in any part of a child care facility that is accessible to children.

[5.3.1.1](#) - Safety of Equipment, Materials and Furnishings, p. 237

States that all equipment, materials, furnishings, and play areas should be safe, sturdy, and in good repair, meeting the recommendations of the U.S. Consumer Safety Commission with regard to specific safety hazards.

[5.3.1.12](#) – Availability and Use of a Telephone or Wireless Communication Device, p. 243

Outlines locations and usage for telephone or wireless communication device within and in additional premises beyond child care facility.

[5.4.5.2](#) - Cribs, p. 253

Details the safety features necessary in child care facility cribs.

[5.4.5.3](#) – Stackable Cribs, p. 254

States that the use of stackable cribs in child care facility is not advised and any that are used should conform to CPSC regulations.

[5.5.0.7](#) - Storage of Plastic Bags, p. 257

States that all plastic bags should be stored out of reach of all children.

[5.6.0.1](#) - First Aid and Emergency Supplies, p. 257

Details what should be included in a first aid and emergency supplies kit, and how it should be maintained.

[5.7.0.2](#) - Removal of Hazards from Outdoor Areas, p. 259

Lists items and conditions that should not be in or around outdoor activity areas.

[6.2.1.9](#) - Entrapment Hazards of Play Equipment, p. 272

Details strategies and steps that need to be maintained in order to prevent entrapment.

[6.2.4.3](#) – Sensory Table Materials, p. 275

States that all materials used in a sensory table should be nontoxic and should not be of a size or material that could cause choking.

[6.3.1.7](#) - Pool Safety Rules, p. 280

States that legible safety rules for the use of swimming and built-in wading pools should be posted in a conspicuous location, and that an emergency plan be developed and reviewed by staff.

[6.4.1.2](#) - Inaccessibility of Toys or Objects to Children Under Three Years of Age, p. 284

States that small objects, toys, and toy parts available to children under the age of three years should meet the federal small parts standards for toys.

[6.4.1.3](#) - Crib Toys, p. 285

States that crib gyms, crib toys, mobiles, mirrors, and all objects/toys are prohibited in or attached to an infant's crib.

[6.4.1.5](#) - Balloons, p. 285

Details the restrictions of balloon accessibility in a child care facility.

[6.4.2.1](#) - Riding Toys with Wheels and Wheeled Equipment, p. 286

Lists safety requirements of riding toys and wheeled equipment.

[6.4.2.2](#) - Helmets, p. 286

States all children one year of age and over should wear properly fitted and approved helmets when using riding toys with wheels or using any wheeled equipment.

[6.4.2.3](#) - Bike Routes, p. 287

States that all bike routes be reviewed and approved by the local police.

[6.5.1.1](#) - Competence and Training of Transportation Staff, p. 287

States that at least one adult who accompanies or drives children for field trips and out-of-facility activities should receive training by a professional knowledgeable about child development and procedures, to ensure safety of all children.

[6.5.1.2](#) - Qualifications for Drivers, p. 288

Lists the qualifications for a driver transporting children.

[6.5.2.1](#) - Drop-off and Pick-up, p. 289

States that a facility must have a plan for safe, supervised pick-up and drop-off points and pedestrian crosswalks in the vicinity of the facility, all of which must be communicated to staff and parents/guardians.

[6.5.2.2](#) - Child Passenger Safety, p. 289

Details the safety standards that should apply when children are driven in a motor vehicle other than a bus, school bus, or bus operated by a common carrier.

[6.5.2.4](#) - Interior Temperature of Vehicles, p. 291

States that the temperature must be comfortable for children inside of a vehicle. Cooling is necessary when the interior temperature is above 82 degrees F and heating is necessary when below 65 degrees F.

[6.5.2.6](#) - Route to Emergency Medical Services, p. 292

States any driver who transports children in a child care program should keep instructions in the vehicle for the quickest route to the nearest emergency medical facility from any point in route.

[6.5.3.1](#) – Passenger Vans, p. 293

States that conventional twelve- to fifteen-passenger vans cannot be certified as school buses by the National Highway Traffic Safety Administration (NHTSA).

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

States that facilities should have written policies for 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.

[7.6.2.1](#) - Infection Control Measures with Hepatitis C Virus (HCV), p. 324

Addresses inclusion and protocol of children with hepatitis C virus (HCV) infection.

[7.6.3.3](#) - Staff Education About Preventing Transmission of HIV Infection, p. 325

States that caregivers/teachers should be knowledgeable about prevention and transmission of bloodborne pathogens, including HIV, and practice preventative measures.

[9.2.1.3](#) - Enrollment Information to Parents/Guardians and Caregivers/Teachers, p. 349

Lists information the facility should provide to parents/guardians and caregivers/teachers at enrollment.

[9.2.3.2](#) - Content and Development of the Plan for Care of Children and Staff Who are Ill, p. 354
States that all child care facilities should have written policies for the management and care of children and staff who are ill.

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

States that the caregiver/teacher should request the parent/guardian to identify and provide consent to communicate with the child's primary care provider, his or her medical home, and other specialty health care professionals.

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

Lists ten topics in which the management, documentation and reporting should be addressed in a written plan. Ten additional topics, at a minimum, should also be addressed in the plan for urgent care.

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

States that the facility's written plan for urgent care should be reviewed annually and by each employee and a child care health consultant.

[9.2.4.3](#) - Disaster Planning, Training and Communication, p. 366

States that facilities should consider how to prepare for and respond to emergency or natural disaster situations and develop written plans accordingly.

[9.2.4.5](#) - Emergency and Evacuation Drills/Exercises Policy, p. 370

Lists what emergency drills/exercises should be practiced and how often, when applicable.

[9.2.4.8](#) – Authorized Persons to Pick Up Child, p. 371

Details protocol for pick up and drop off of a child.

[9.2.4.9](#) – Policy on Actions to Be Followed when No Authorized Person Arrives to Pick Up a Child, p. 372

States that child care facilities should have a written policy identifying actions to be taken when no authorized person arrives to pick up a child.

[9.2.4.10](#) – Documentation of Drop-Off, Pick-Up, Daily Attendance of Child, and Parent/Guardian/Provider Communication, p. 372

Details what should be included in a child care programs' policies on the documentation of drop-off, pick-up, daily attendance of child, and parent/guardian/provider communication.

[9.2.5.1](#) - Transportation Policy for Centers and Large Family Homes, p. 373

Details what should be included in a written transportation policy for centers and large family child care homes.

[9.2.5.2](#) - Transportation Policy for Small Family Child Care Homes, p. 373

Details what should be included in a written transportation policy for a small family child care home.

[9.4.1.6](#) - Availability of Documents to Parents/Guardians, p. 380

Lists what items should be posted in an easily available place at a facility.

[9.4.1.15](#) - Availability of Reports on Inspections of Fire Protection Devices, p. 385

States that a report of the inspection and maintenance of fire prevention mechanisms need to be available for review.

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

Details what should be included in each child's initial health assessment.

[9.4.2.5](#) - Health History, p. 390

Lists what should be included in each child's health history.

[Appendix P](#) – Situations that Require Medical Attention Right Away, p. 458

Lists situations that require immediate medical attention.

[Appendix Y](#) – Even Plants Can Be Poisonous, p. 470

Lists both the common and botanical name of non-poisonous and poisonous plants.

[Appendix BB](#) - Emergency Information Form for Children with Special Needs, p. 479

Offers a two-sided template on which to record the necessary emergency medical information of a child with special needs.

[Appendix II](#) – Bike Helmets: Quick-Fit Check, p. 499

Highlights “Eyes, Ears, Mouth Test” for bike helmets developed by the Bicycle Coalition of Maine.

[Appendix KK](#) – Authorization for Emergency Medical/Dental Care, p. 501

Provides sample form for authorization for emergency medical/dental care

AIRWAY OBSTRUCTION

Airway obstruction occurs when some type of blockage prevents air from getting in and out of the lungs. This obstruction may occur when something gets caught in the throat, something constricts the neck, or something blocks the nose and mouth. Airway obstruction leads to asphyxiation, which occurs when air cannot get in and out of the lungs for several minutes. Asphyxiation is lack of oxygen to the brain and other tissues. During asphyxiation, a child gradually becomes blue, limp, and unconscious. According to the National Center for Health Statistics (2005), airway obstruction is the leading cause of unintentional injury-related death among infants under age 1 and a particular risk for children up to age 4.

What the CCHC Should Know: Types of Airway Obstruction

Four principal causes of asphyxiation in children—choking, entrapment, strangulation, and suffocation—are presented below. These terms are sometimes used interchangeably; they all imply compromised airflow.

Choking

Choking occurs when a child's internal airway (trachea) gets blocked. This can happen when a child ingests a piece of food or an object and is unable to immediately swallow or expel it. Choking can be caused by something caught in the airway or by something stuck in the esophagus, since a bulging in the esophagus can block the trachea.

Entrapment

Entrapment occurs when a child's body slips through a space that is too small for his/her head, and the weight of the child's body bends the neck leaving the head trapped, resulting in a constriction of the neck and airway. This can happen when cribs, play equipment, strollers, or other furniture have openings that a child's body can fit through but not his/her head.

Strangulation

Strangulation occurs when a child's neck becomes constricted, usually by a ligature such as a drawstring that becomes tightly wrapped around his/her neck. Common items that can strangle a child include clothing drawstrings, ribbons, necklaces, pacifier strings, and window blind and drapery cords.

Suffocation

Suffocation occurs when the child's external air passage is obstructed either by pressure on the throat or chest, covering of the nose and mouth. With infants, suffocation may occur if the baby is placed on furniture that does not have a firm surface, such as a bean bag chair, and ends up with his/her mouth and nose trapped against the soft material. An infant can also suffocate when sleeping on his/her stomach, if soft bedding blocks the airways, or when his/her head is caught between the mattress and the side of the crib. Although not strictly an example of airway obstruction, children can also suffocate by becoming enclosed or confined in an airtight space. Examples of spaces in which a child might become enclosed include refrigerators, freezers, coolers, plastic storage boxes, and plastic bags.

What the CCHC Should Know: How to Assess Risks of Airway Obstruction

Special Age-Related Risks of Airway Obstruction

In 2002, more than 80% of children treated in hospital emergency rooms for airway obstruction injuries were under age 4 (Safe Kids USA, 2004). Children in this age group have certain developmental characteristics that make them particularly vulnerable to airway obstruction injury and death. Children of that age have small upper airways, relative inexperience with chewing, and a natural tendency to explore the world by putting objects in their mouths. Additionally, infants' inability to lift their heads or move themselves out of dangerous positions puts them at greater risk (Safe Kids USA, 2004).

Foods and Objects That May Cause Choking

Food and objects [6.4.1.2](#) that pose the greatest risk are usually pliable and of a size and shape that can become lodged in and obstruct the airway. Unless they are cut up into small pieces, foods that are firm and round in shape are the most common choking hazards (AAP, 2006). [4.5.0.10](#) Eating circumstances are also risk factors. For example, children should not eat when standing, walking, running, playing, lying down, watching TV, playing on the computer, or riding in vehicles. [4.5.0.3](#)

Any item that fits in the mouth, including food, toys or objects [6.2.4.3](#) that can be compressed to fit in the mouth, can cause choking. The following foods and household items are potentially harmful for children under age four:

Common Foods the Cause Choking	Common Items that Cause Choking
Hot dogs	Balloons (inflated or deflated)
Spoonfuls of peanut butter	Coins
Chunks of meat or cheese	Marbles
Popcorn	Toys or games with small parts
Whole grapes	Buttons
Chewing gum	Pen and marker caps
Raisins	Small button-type batteries
Raw vegetables	Medicine syringes
Hard or sticky candy	Small balls
Nuts and seeds	Safety pins

Adapted from American Academy of Pediatrics (2006)

According to the Child Safety Protection Act (CPSC, 1995), items with a diameter of 1.75 inches (44.4 mm) or less are banned for children under age 3. If they are intended for children age 3 or older, the item must be labeled as follows:



What the CCHC Should Know: How to Prevent Airway Obstruction in the Child Care Environment

Some actions the child care caregiver/teacher should take to help reduce the risk of airway obstruction are:

- Always supervise mealtime and snack time
 - Offer food only when children are seated at a table
 - Avoid serving foods that are known to cause airway obstruction
 - Prepare and cut foods into pieces no larger than ½ inch
 - Teach children how to chew their food well
 - Serve small amounts of food at a time
 - Decrease distractions during meal/snack time (including television)
 - Use a choke tube (a toilet paper roll works!) to determine the safety of an object
 - Choose toys with the youngest user in mind, and supervise older children who might bring toys that present choke hazards into the child care setting
 - Conduct regular inspections of toys for broken parts
 - Have a place for staff and visitors to store personal belongings out of reach of children
 - Use only one-piece pacifiers and rattles
 - Ensure that all toys (including pull toys and toy telephones) have cords of less than 12 inches; crib toys should not have cords longer than 7 inches
 - Remove drawstrings from children's clothing
 - Always supervise children during outdoor play
 - Cut or tie up cords from drapery and blinds
 - Read and post Consumer Product Safety Commission Recall Alerts
 - Keep cribs free of soft toys, pillows, and excess bedding (see the section in this Module on SIDS for more about ensuring a safe sleeping environment)
 - Crib slats should be no more than 2 3/8 inches (60 mm) apart. Crib corner posts should be no higher than 1/16 inch to prevent entanglement of babies' clothing.
 - Safely dispose of all plastic bags
 - Check under furniture and between cushions for small items
 - Ensure that fridges, freezers, and toy chests are securely closed
- (Adapted from Healthy Child Care, 2008, and AAP, 2006)

What the CCHC Should Know: How to Respond to an Airway Obstruction Injury

Even with supervision and safety precautions, airway obstruction may occur in the child care environment. Child care staff should be trained in cardio-pulmonary resuscitation (CPR) and the Heimlich maneuver for infants and children. A chart showing the steps to respond to choking and how to conduct CPR may be displayed in the child care setting, but this does not replace professional training in these measures. Staff should also be informed of the signs of airway obstruction.

Signs of Compromised Airflow in Children

It is critical to recognize the signs of airway obstruction quickly and immediately take steps to help the child. Brain damage can occur within four minutes of oxygen deprivation, and death can occur within six minutes. The most common signs include:

- Difficulty speaking or breathing (making “wheezing sounds”)
- Unable to cough
- Clutching throat or gesturing to throat
- Bluish facial tinge
- Appearance of discomfort, strain, or agitation
- Unexplained loss of consciousness (Consider airway obstruction as a possible cause, and check the mouth for a visible object.)

How to Respond to Airway Obstruction

- If the child is coughing, allow him/her to clear the obstruction without assistance. Do not pat a child on the back or use fingers to clear the airway. This can push the object further into the throat.
- Use the Heimlich maneuver and/or CPR as indicated.
- If a child is unconscious, call 911.
- After a choking incident, the child’s parents/guardians should be contacted with instructions to contact their child’s medical care provider since food or other objects may still remain in the airway.

(Adapted from Healthy Child Care, 2008)

Action Items for the CCHC

The CCHC should:

- Ensure that the child care staff receive training in the prevention of choking, suffocation, strangulation, and entrapment and how to reduce the risks
- Assist the staff in educating parents/guardians about airway obstruction hazards and how to reduce the risks at home
- Assess and identify potential airway obstruction hazards in the child care facility and offer detailed recommendations for reduction/elimination of the risks
- Provide educational materials for the caregiver/teacher and parents/guardians about emergency procedures to follow in cases of compromised airflow

POISONING

In 2006, over 50% of the 2.5 million unintentional poisoning reports involved children under the age of 6 (National Safety Council, 2008). Most often, poisoning occurs in the home environment and involves common household substances, such as cleaning supplies, pesticides, and medicines. In addition to the information listed below, please see the NTI Modules *Environmental Health in the Child Care Setting* and *Environmental Health in the Child Care Setting: Lead* for more information about poisoning risks in the child care environment from air pollution, art materials, pesticides, plastics, and lead.

What the CCHC Should Know: How Poisoning Occurs

Poisoning results from exposure to a harmful chemical substance. The exposure may be brief, such as a bee sting, or long-term, such as exposure to lead paint. It may be caused by injection, ingestion, inhalation or skin contact.

Bites and Stings

The toxic substance emitted in insect stings can cause an allergic reaction in many children, which may lead to death. Animal bites (dogs, snakes, etc.) puncture the skin and may inject toxic substances directly into the blood stream.

Ingestion

Toxic substances that are swallowed are absorbed into the blood stream through the gastrointestinal tract in the same way that food is absorbed.

Inhalation

Inhaling poisons into the lungs allows them to be absorbed into the blood stream. Commonly-inhaled poisons include carbon monoxide, chlorine and other gases, ammonia, and aerosol can fumes. Particles of poisonous materials, such as lead dust, can also be inhaled from the air.

Skin/Eye Contact

Poisons can be absorbed into the bloodstream through contact with the skin or eye. Caustic materials, such as undiluted bleach, can chemically destroy the skin tissue.

Puncture/Injection

A puncture of the skin can bring a toxic substance into direct contact with the bloodstream. Punctures also raise the possibility of tetanus, which is caused by a toxin or poison produced by bacteria.

What the CCHC Should Know: How to Assess Risks of Poisoning

Special Age-Related Risks of Poisoning

Small children are more at risk for poisoning than adults because of their general curiosity and the tendency to explore by putting things in their mouths. They are also more likely to be playing and exploring at ground-level, where many poisonous substances may be found. Their smaller bodies also increase the risk because they absorb toxins faster and in relatively greater quantities, and they excrete toxins more slowly, than adults. Children also learn by imitation and may copy adults in using medicines, cosmetics, or other poisonous substances.

Common Poisons

Household Items: The most dangerous poisons include items that are commonly found in many households and child care facilities:

- Medicines, including iron pills (Many pills look like candy to children.)
 - Furniture polish
 - Lighter fluid
 - Antifreeze
 - Windshield washer fluid
 - Drain opening fluid
 - Toilet bowl cleaner
 - Oven cleaner
 - Rust remover
 - Carbon monoxide (such as that released from common appliances)
 - Pesticides (including rat poison, weed killer, and insecticides)
 - Wild mushrooms
 - Paint thinner
 - Turpentine
 - Toiletries (such as nail polish remover and hairspray)
 - Alcohol (all kinds)
- (American Association of Poison Control Centers, 2004)

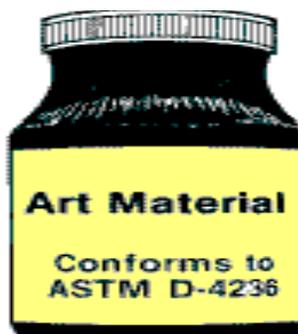
Even products that are not particularly harmful, such as mouthwash, soaps, and toothpaste, can be poisonous to young children if consumed in sufficient quantities.

Art Materials: Many common art materials are poisonous. [5.2.1.4](#), [5.2.9.7](#), [5.2.9.8](#) These include:

- Powdered clay
- Ceramic glazes or copper enamels
- Solvents (turpentine, toluene, rubber cement)
- Aerosol sprays
- Commercial dyes
- Permanent felt tip markers
- Epoxy or powdered glues
- Powdered tempera paints

- Pastels, chalks, or dry markers that create dust
 - Instant paper mache
- (Canadian Child Care Federation, 2001)

Since 1988, all art materials must be reviewed for the presence of hazardous substances and warning labels must be placed on those materials that may pose a chronic health threat (CPSC, 1996). Child care caregivers/teachers and parents/guardians should only purchase art materials that clearly have the “Conforms to ASTM D-4236” label, as recommended by the U.S. Consumer Product Safety Commission (CPSC, 1996). Additionally, an Approved Product label by the Art and Creative Materials Institute (ACMI) appears on appropriate materials (ACMI, 2004). Examples of the two labels are presented below.



CPSC, 1996



Conforms to
ASTM D 4236
ACMI, 2004

c) Poisonous Houseplants

Poisonous Houseplants: Many plants are poisonous, and houseplants are commonly ingested by small children. All plants, seeds, and fruits from outside trees should be considered poisonous unless known to be otherwise. [5.2.9.10](#), [5.7.0.2](#), [Appendix Y](#) See below for a list of common plants that are poisonous and symptoms of ingestion:

Plant	Poisonous Parts	Complications
Castor Bean (Castor oil plant)	Seeds are beanlike pod	Stomach irritation, diarrhea, abdominal pain, increased heart rate, sweating, collapse, death
Dumbcane (Dieffenbachia)	Roots, leaves, stems	Mouth and throat irritation, maybe stomach irritation and diarrhea
English Ivy (Hedera helix)	Leaves and berries	Oral and stomach irritation, diarrhea, breathing problems, coma, death
Jerusalem Cherry	Fruit and leaves	Abdominal pains, gastroenteritis, Vomiting
Mistletoe	Berries	Diarrhea, irregular pulse
Oleander (Nerium oleander)	All parts	Gastrointestinal irritation, cardiac abnormalities, sudden death
Philodendron	All parts, especially leaves	Stomach irritation, abdominal pain abnormal heart rate and rhythm, seizures, coma, death

Poinsettia	Leaves	Very irritating to mouth, throat and stomach, death
Rhododendron	All parts	Vomiting, seizures, paralysis

(Zamani AR, California Childcare Health Program, 2003)

What the CCHC Should Know: How to Prevent Poisoning in the Child Care Facility

Child care caregivers/teachers should take the following actions to reduce the risk of poisoning:

- Whenever possible, replace all toxic (poisonous) substances with non-toxic alternatives—effective non-toxic alternatives are available for cleaning supplies, plants, art materials, pesticides, and toiletries/cosmetics
- Lock all toxic substances in a cabinet that is inaccessible to children [5.2.9.1](#)
- Make sure all toxic substances in the original labeled containers [5.2.9.1](#)
- When toxic substances must be stored in the same room as food items, store them in a separate and clearly labeled and locked cabinet away from food items [5.2.9.1](#)
- If the manufacturer’s “Material Data Safety Sheet” for any product used in the child care facility shows the presence of toxic effects, replace the product with a non-toxic substitute. Otherwise, eliminate the product altogether [5.2.9.3](#)
- Use only chemicals approved by the EPA as “non-restricted.” Store chemicals as any other toxic material – in their original containers, clearly labeled, and under lock and key [5.2.9.1](#)
- Use non-toxic alternative art materials, such as:
 - Talc-free, pre-mixed clay
 - Water-based paints, solvents, glues or paste, and markers
 - Liquid tempera paints
 - Dustless alternatives to chalk or dry markers
 - Paper Mache made from newspaper and paste

What the CCHC Should Know: How to Respond to Poisoning

Signs of Poisoning

The following conditions suggest the possibility of poisoning:

- Unusual stains or odors on skin and clothes
- Unusual breath odor
- Nausea, drooling, vomiting, or sudden stomach pain
- Skin or eye irritation
- Coughing or shortness of breath
- Cold, clammy skin
- Burns around the mouth
- Disoriented, slurred speech
- Dizziness or drowsiness

Signs of moderate or serious poisoning include:

- Fever
- Muscle twitches or weak, uncoordinated muscles
- Intense thirst

- Fast breathing or difficulty breathing
 - Unexplained convulsions
 - Unconsciousness
- (National Agriculture Safety Database, 2006)

How to Respond to a Poisoning Incident

In the past, the American Academy of Pediatrics (AAP) advised that 1-ounce bottles of ipecac syrup be used to induce vomiting if it was believed that a child had swallowed a poisonous substance. The AAP changed their previous recommendation in 2003 citing a lack of evidence to demonstrate that ipecac syrup actually helps a child who ingests something poisonous. Instead, if a child care caregiver/teacher observes a child with symptoms of a poisoning incident, she/he should call the **National Poison Control Center (1-800-222-1222)** immediately, describe the situation, and follow the instructions of the Poison Control operator. [5.2.9.2](#)

Action Items for the CCHC

The CCHC should:

- Educate both staff and parents/guardians about the five ways poisoning may occur
- Educate staff about the developmental and environmental risks associated with poisoning
- Provide educational materials and instructions for caregivers/teachers to share with parents/guardians on what to do in a poisoning emergency
- Assess poison hazards in the child care setting and instruct the staff in ways to reduce/eliminate the risks
- Assist caregivers/teachers in planning an emergency procedure for contacting poison control

SUDDEN INFANT DEATH SYNDROME (SIDS)

The National Institute of Child Health and Human Development (NICHD) defines SIDS as “the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history” (Beckwith, 2003, p. 288). SIDS, also known as “crib death,” is the major cause of death in infants from 1 month to 1 year of age in the United States, with most deaths occurring between ages 2 and 3 months (AAP, 2005). SIDS is a recognized medical disorder listed in the International Classification of Diseases, 9th Revision, but there is still much controversy over the definition and diagnosis of SIDS. Unlike other diseases, SIDS does not have a single unique cause. Instead it is a complex combination of predisposing factors, external stresses, and underlying vulnerabilities (Byard and Krous, 2003).

What the CCHC Should Know: SIDS in Child Care Settings

Since 1992, when the American Academy of Pediatrics (AAP) recommended placing infants on their backs to sleep, the rate of SIDS has decreased over 50% (AAP, 2005). Approximately 20% of all SIDS deaths occur with nonparental/guardian caregivers, and despite the overall decrease in SIDS since the 1990s, this rate has not changed over the years (AAP, 2005). This indicates a need for greater education for nonparental/guardian caregivers about safe sleep. Many child care deaths have been associated with infants sleeping on their tummies, especially when the infants are unaccustomed to such a sleeping position. Being placed to sleep on the tummy when an infant is used to sleeping on the back results in an 18-fold increased risk of SIDS (AAP, 2005). Child care caregivers/teachers are often the ones who place infants to sleep in an unaccustomed tummy position.

What the CCHC Should Know: How to Assess Risks for SIDS

The following are the most consistent risk factors for SIDS:

- Sleeping on the tummy (this includes infants who are put to sleep on their side but roll onto their tummy)
 - Sleeping on soft bedding or other soft surfaces
 - Maternal smoking during pregnancy and exposure to secondhand smoke
 - Overheating
 - Late or no prenatal care
 - Young maternal age
 - Preterm birth and/or low birth weight
 - Male gender
 - Black and American Indian or Alaska Native ethnicity
- (AAP, 2005)

In the child care environment, the greatest risks for SIDS are from placing infants to sleep on their tummies or sides, from placing infants to sleep in cribs with soft bedding, pillows, or stuffed animals, or from placing infants to sleep on other soft surfaces (such as a sofa or bean bag chair).

Bed-sharing has been suspected as a risk factor for SIDS. On the other hand, it has been shown to facilitate breastfeeding and maternal-infant bonding. Although some sources consider bed-

sharing to be hazardous under certain circumstances (AAP, 2005), research from Europe suggests that bed-sharing is only a risk if the adult sharing the child's bed is a smoker (Blair et al., 1999).

What the CCHC Should Know: How to Prevent SIDS in the Child Care Environment^{[3.1.4.1](#)}

The most important message to emphasize to child care staff is the importance of always putting infants up to twelve months of age to sleep in the supine position (wholly on their back). Side sleeping is not a safe alternative to back sleeping, since infants can easily roll on to their tummies. A back sleep position is especially important if the infant is accustomed to a back sleep position at home. Parents/guardians should provide a signed waiver from a primary care provider if there is a medical reason to place an infant in an alternate sleeping position. Child care staff should be sure to discuss the sleep position with parents/guardians to ensure that it is kept consistent. Child care caregivers/teachers should make sure to give infants plenty of opportunities for "tummy time" and upright "cuddle time" during awake periods to ensure proper development of musculature and motor skills.

Creating a Safe Sleep Environment

In addition to the back sleep position, the following steps toward creating a safe sleep environment have been shown to decrease the risk of SIDS:

- Infants should be placed in cribs that conform to the safety recommendations of the Consumer Product Safety Commission (CPSC) and ASTM International (ASTM)^{[5.4.5.2](#)}, not sofas, car seats, adult beds, or water beds, for sleep
- Provide a firm crib mattress covered by a tight-fitting sheet
- Infants should not nap or sleep in a car safety seat, bean bag chair, bouncy seat, infant seat, swing, jumping chair, play pen or play yard, highchair, chair, futon, or any other type of furniture/equipment that not a safety approved crib
- If the infant arrives at the facility asleep in a car safety seat or if the infant falls asleep in any place that is not a safe sleep environment, s/he should immediately remove the sleeping infant from this seat and place them in the supine position in a safe sleep environment (i.e., the infant's assigned crib)
- Keep the crib free of bumper pads, sleep positioning devices, blankets, flat sheets, cloth diapers, bibs, comforters, quilts, sheepskins, pillows, stuffed animals, or cushions
- Never cover an infant's face
- Swaddling infants when they are in a crib is not necessary or recommended, but rather one-piece sleepers should be used^{[3.1.4.2](#)}
- Toys, including mobiles and other types of play equipment that are designed to be attached to any part of the crib should be kept away from sleeping infants and out of safe sleep environments^{[6.4.1.3](#)}
- Only one baby per crib (stackable cribs are not recommended)^{[5.4.5.3](#)}
- Ensure that the temperature in the room is comfortable for a lightly clothed adult, check the infants to ensure that they are comfortably clothed (not overheated or sweaty), and that bibs, necklaces, and garments with ties or hoods are removed
- Infants should be directly observed by sight and sound at all times
- Bedding should be changed between children

Room sharing (having the infant sleep in the parent's/guardian's bedroom) and the use of a pacifier during sleep are also associated with a reduced risk of SIDS (AAP, 2005). Pacifiers introduced after the first month of life have not been shown to have a negative impact on breastfeeding or dental development (AAP, 2005). Pacifiers should never be coated in anything sweet to encourage use. If an infant does not want a pacifier, he or she should not be forced to take it. [3.1.4.1](#), [3.1.4.3](#)

What the CCHC Should Know: How to Respond to a SIDS Death in the Child Care Setting

The following are emergency procedures a child care caregiver/teacher should follow for an unresponsive infant:

- Start CPR and continue until relieved by another adult certified in CPR
- Dial 911
- Calm the other children and remove them from the area
- Call the child's parents/guardians first, then call the parents/guardians of the other children
- Call their licensing agency
- As much as possible, leave the area where the baby was found undisturbed. Do not clean or tidy anything in the room until the investigators say that it is okay to do so
- Contact his/her local SIDS organization
(National SIDS/Infant Death Support Center, 2007)

A fact sheet with details about conducting a sample drill on these procedures is available online here:

http://www.vahealth.org/childadolescenthealth/EarlyChildhoodHealth/HealthyChildCareVA/documents/2009/pdf/SIDSresourceemergency_drill.pdf

Action Items for the CCHC

The CCHC should:

- Routinely assess sleep areas to ensure a safe sleep environment
- Recommend bedding and sleep structures that comply with the *CFOC* (3rd ed., 2011) standards
- Provide educational materials to caregivers/teachers and parents/guardians on SIDS and creating a safe sleep environment
- Encourage communication between parents/guardians and caregivers/teachers on the safe sleep position of infants
- Advise the staff on developing an action plan in the case of a SIDS death in the facility
- Advise the staff regarding emergency procedures for an unresponsive child

HUMAN BITING

Biting is a common behavior for infants and toddlers, up to age 3 (Minnesota Department of Health, 2001). In fact, it's estimated that 1 out of every 10 toddlers (2 year olds) engages in biting behaviors (Ramming et al., 2006). However, repeated biting creates concern for everyone involved in this behavior—the biter, the victim, the child care staff, and the parents/guardians of both the biter and the victim.

What the CCHC Should Know: Reasons for Biting Behavior

Children may bite for a variety of reasons. It is important to understand what is motivating the child's behavior so an appropriate intervention can be selected.

The most common reasons for biting in children up to age 3 include the following:

- **Experimenting:** Infants and toddlers explore the world by putting things in their mouths. This is normal developmental behavior. Toddlers may also bite as a way of experimenting with social interaction.
- **Teething:** Infants and toddlers experience discomfort when teething and often try to relieve their pain by biting down on objects or sometimes while breastfeeding or on a shoulder or arm.
- **Feeling frustrated or overwhelmed:** Biting may be a response to frustration, especially for children who lack language or social skills to express themselves in other ways. This may also be a result of feeling stress at home or in child care, including overstimulation by loud noise or light.
- **Responding to feeling threatened:** Biting may be a self-defense mechanism.
- **Seeking attention:** Toddlers may use biting as a means of getting attention from adults.
- **Imitating other biters:** Young children often learn behavior through watching and imitating others.
- **Attempting to exert control over others:** Biting may be means for toddlers to attempt to exert independence and control.

(Oklahoma State Dept. of Health, 2006; Zero to Three, n.d.)

What the CCHC Should Know: How to Prevent Biting Behavior

Biting is a common behavior for infants and toddlers. It is explained by normal developmental behavior and is best stopped through prevention. It is important to keep in mind that biting may be the result of multiple causes and may need multiple solutions. The most important tool in biting prevention is close observation of children and reaction before the biting occurs.

Ways to prevent biting may include:

- Help children understand the difference between positive and negative social interaction.
- Use dolls or stories to demonstrate cause and effect when one child hurts another.
- Model and praise positive social interactions.
- Cold (not frozen) teething rings, bagels, and washcloths can be given to relieve teething discomfort.

- Notice when a child is feeling frustrated and help the child respond with words or help the child leave the situation.
- Ensure that toddlers feel safe around other children.
- Provide praise for positive behavior.
- Give toddlers plenty of opportunities to make the right choice throughout the day.
- Do not label children who have bitten others as “biters,” since labeling can lead to children taking on the identity assigned to them (Zero to Three, n.d.).

What the CCHC Should Know: How to Respond When Biting Occurs

- Cleanse the wound with mild soap and water. Use an ice pack to relieve any swelling.
- Provide comfort and attention to both the child who has been bitten and the child who did the biting.
- Use the experience as an opportunity to discuss positive and negative social interaction.
- Reinforce the feelings of the child who did the biting, but make it clear that hurting others is not acceptable—e.g., “I know you are angry that Joe took your truck, but I can’t let you bite other people.”
- When the environment is calm again, help the children practice assertiveness and communication skills, such as using language (“That’s mine” or “Move away”). Those who aren’t talking can be taught to growl or shake their head.
- Never use biting or other physical violence to show how it feels to be bitten.
- Try to determine how and why the biting occurred and consider prevention techniques for similar situations in the future.

(Oklahoma State Dept. of Health, 2006)

Disease Transmission from Human Bites

There is a low incidence of the hepatitis B virus (HBV) carriage by preschool age children, and the likelihood of disease transmission by a bite exposure is low.^{7.6.1.1} Transmission of the hepatitis C virus (HCV) via contamination of mucous membranes or broken skin probably has an intermediate risk between that for blood infected with HIV and HBV.^{7.6.2.1} The risk of a child with HIV transmitting the disease to others through biting is theoretically possible but believed to be rare. If the bite results in blood exposure to either person involved, caregivers/teachers should practice measures recommended by the U.S. Public Health Service for prevention of transmission of infections.^{7.6.3.3}

Action Items for the CCHC

The CCHC should:

- Assist staff in developing policies regarding biting, other acts of aggression and related behavior policies
- Educate staff and parents/guardians about biting (causes, prevention, first aid, appropriate interventions, etc.) as needed^{2.2.0.7}
- Be prepared to recommend community mental health or child development resources if biting behaviors extend past age 3 ½ or if a child continues to bite others despite intervention

EMERGENCIES

Crises and emergencies can occur at any time in a child care facility. It is important that child care program staff know how to identify emergency situations and be equipped to handle them quickly and appropriately. Emergency preparedness before, during, and after emergencies is essential to ensuring the safety and well-being of children and staff.

Emergency situations are usually unexpected, often life-threatening, and require immediate action. They are defined as:

- Illnesses or injuries that may threaten a child's life
 - Situations that can cause permanent harm if action is not taken right away
- (Kendrick et al., 2009)

What the CCHC Should Know: Emergencies That Can Occur in a Child Care Facility

There is a wide range of emergency situations that can occur, but child care program should develop an emergency plan framework that is adaptable to specific events. The geographic location of a child care program may determine the types of natural disasters that require special preparation. For example, a child care program located in a coastal town should have an emergency plan for hurricanes, floods, etc. The Federal Emergency Management Agency (FEMA, 2004) recommends contacting the local Red Cross chapter in order to find out what types of disasters are most likely to affect your local area. The American Red Cross website is available online at: <http://www.redcross.org/>

All child care facilities should have plans in place to respond to all of the following:

- General emergencies
- Missing children
- Disgruntled or impaired parents/guardians or their authorized representatives
- Medical emergencies
- Natural disasters, including hurricanes, tornados, and severe storms
- Fire/smoke emergencies
- Bioterrorism/war emergencies (including bomb threats)
- Nuclear or radiation emergencies
- Utility disruption
- Hazardous materials
- Chemical leaks

What the CCHC Should Know: How to Prepare for and Respond to Emergencies

The table on the following pages offers prevention and response procedures for these emergencies.

Emergencies in Child Care Settings: Preparation and Response

(Adapted from Bright Horizons Family Solutions, 2003, and AAP, APHA, and NRC, 2011)

Type of Emergency	CFOC Standards (3 rd ed., 2011)	Preparation	Response
General Emergency	1.4.3.1 (p. 24) 1.4.3.2 (p. 25) 1.4.4.2 (p. 28) 1.5.0.2 (p. 32) 3.4.3.1 (p. 122) 6.5.2.6 (p. 292) 5.1.4.1 (p. 206) 5.1.4.2 (p. 206) 5.6.0.1 (p. 257) 6.3.1.7 (p. 280) 9.2.1.3 (p. 349) 9.2.4.2 (p. 365) 9.2.4.3 (p. 366) 9.2.4.5 (p. 370) Appendix KK (p. 502)	<ul style="list-style-type: none"> • Check facility for structural or environmental hazards • Maintain emergency contact information • Prepare emergency plan, including evacuation plans • Notify parents/guardians of evacuation routes and shelter information • Prepare first aid and emergency supplies kit • Provide parents/guardians and teachers/caregivers on policies for handling urgent medical care, disasters, emergency plan and drills, evacuation plans, and alternative shelter arrangements Train all staff on first aids and CPR, and emergency/disaster planning and response	<ul style="list-style-type: none"> • Employ first aid and emergency supplies kit • Implement emergency plan, including emergency transportation plan • Follow evacuation route to shelter room, building, or area
Missing Child	9.2.4.1 (p. 364) 9.2.4.8 (p. 371) 9.2.4.9 (p. 372) 9.2.4.10 (p. 372)	<ul style="list-style-type: none"> • Keep daily rosters of children’s attendance • Collect photos of children with matching descriptions • Maintain a record (include names, addresses, and telephone numbers) of authorized persons for child pick-up and drop-off 	<ul style="list-style-type: none"> • Perform a search of the facility and immediate surrounding area including vehicles • Notify police • Notify parents/guardians

<p>Parent/Guardian/Caregiver/Teacher Intoxication Unauthorized pick-up (non-custodial parent/guardian) No pick-up</p>	<p>9.2.4.1 (p. 364) 9.2.4.8 (p. 371) 9.2.4.9 (p. 372) 9.2.4.10 (p. 372) 9.4.1.6 (p. 380)</p>	<ul style="list-style-type: none"> • Maintain a record of authorized persons for child pick-up and drop-off • Have documentation of persons other than the custodial parent/guardian(s) who are authorized to pick-up child(ren) • If a non-custodial parent/guardian is not authorized to pick-up the child, have documentation (i.e., court orders, restraining orders, divorce agreements) on hand 	<ul style="list-style-type: none"> • Do not attempt to handle an intoxicated parent/non-custodial parent/guardian alone • If the intoxicated person is authorized to pick up the child and does so, ask them where they are going and take note of the car they are driving for the police • Notify police
--	--	--	---

Type of Emergency	CFOC Standards (3 rd ed., 2011)	Preparation	Response
Medical Severe asthma attacks Allergic reactions Loss of consciousness Poisoning Airway obstruction	3.5.0.1 (p. 129) 4.2.0.8 (p. 158) 4.2.0.10 (p. 160) 9.2.3.2 (p. 354) 9.2.3.6 (p. 356) 9.4.2.4 (p. 389) 9.4.2.5 (p. 390) Appendix P (p. 458) Appendix BB (p. 479) Appendix KK (p. 502)	<ul style="list-style-type: none"> • Train staff in first aid and CPR • Make sure there is always a staff person working who is trained in first aid and CPR • Keep medical profiles on each child with special conditions • Compile list of primary care providers and emergency contact information for each child 	<ul style="list-style-type: none"> • Determine that the situation is a medical emergency • Call 911 or your local emergency number • Staff persons trained in first aid should perform appropriate first aid procedures until help arrives
Natural Disasters Fires Earthquakes Storms Flood	9.2.4.3 (p. 366) 9.2.4.5 (p. 370)	<ul style="list-style-type: none"> • Practice fire drills monthly and evacuation/sheltering drills on a regular schedule and record all drills/exercises • Check facility for hazards (i.e., broken windows, unstable foundations, etc.) • Keep a first aid and emergency supplies kit ready. Be sure to include a list of children’s names and emergency contact numbers as well as first aid materials 	<ul style="list-style-type: none"> • Listen for reports on disaster activity and whether evacuation is needed • Determine what type of evacuation to perform (on-site/off-site evacuation, shelter-in-place) • In a fire, tell children to cover their mouths and noses • Do not attempt to put out an electrical fire (has gray smoke with brown wisps) or a fire with toxic gases (yellow smoke)

Type of Emergency	CFOC Standards (3 rd ed., 2011)	Preparation	Response
Bioterrorism/War Disasters Chemical emergencies Bomb threats	9.2.4.3 (p. 366)	<ul style="list-style-type: none"> • Be aware of potential threats: call Red Cross or local emergency management department to determine levels of potential danger • Have protocol in place for dealing with bomb threats and emergency plans to handle war-related emergencies 	<ul style="list-style-type: none"> • For bomb threats, notify security/911 and evacuate building • Take all threats seriously • Take notes about the caller (type of voice, background noises) and press *69 after the call to get the caller's phone number if there is no caller ID • During a bomb threat turn off all cell phones, pagers and radios; designate a staff person to call 911 from a landline • For chemical or other war-related emergencies, listen to news and reports for sheltering in place instructions or mass ordered evacuations
Nuclear or Radiation Emergency		<ul style="list-style-type: none"> • If located near a nuclear reactor: seek expert training about potassium iodide (KI) and what size doses to administer to children in case of emergency; educate parents/guardians and obtain signed releases for KI administration • Develop a protocol and obtain necessary supplies (KI tablets, duct tape, radio, etc.) 	<ul style="list-style-type: none"> • Evacuate if instructed by authorities • If not evacuating, seal doors and windows with duct tape, administer KI in appropriate doses (generally 65 mg for children and 130 mg for adults), await further instruction from authorities
Man-made Disasters Gas leaks Fires Chemical spills Power-outages	3.4.3.2 (p. 123) 3.4.3.3 (p. 123) 9.2.4.3 (p. 366) 9.2.4.5 (p. 370) 9.4.1.15 (p. 385)	<ul style="list-style-type: none"> • Have building inspectors and fire department check building for potential hazards (i.e., heating, ventilation, fire alarms) • Check smoke detectors, fire extinguishers, carbon monoxide detectors, and sprinkler systems regularly for proper functioning, and maintain inspection and maintenance reports • Train all staff that the first priority is to 	<ul style="list-style-type: none"> • Call 9-1-1 and determine evacuation type • In event of a gas leak, do not light a match, turn on OR off any electrical switches, or use a cell phone near the leak • Close facility if power or water will be out for more than one hour or if temperature falls below 64 or rises above 85 degrees

		<p>remove the children from the facility safely and quickly</p> <ul style="list-style-type: none">• Instruct children to STOP, DROP , and ROLL when garments catch fire	
--	--	---	--

Different Types of Evacuation

Evacuation responses will depend on the type and circumstances of the emergency. Child care staff should be aware of all types of responses and should have regular drills to practice each type. Drills should include not only evacuation techniques but also practice with which technique is appropriate for which emergencies. In all cases, when evacuating the facility, parents/guardians should be notified using a phone tree and posted signs at the child care location.

Type of Evacuation	When to Evacuate	Implementing Evacuation
On-site	Immediate area threat (i.e., bomb threat, fire, flood, other major building problem)	Leave the building and gather in a predetermined location, within walking distance
Off-site/local	More widespread threat (i.e., chemical spill, widespread fire, etc.) Mass-ordered evacuation (i.e., declared state of emergency)	Pick a safe accessible area/building and transport children and staff Transport children/staff to nearest evacuation shelter designated by Red Cross/local authorities
Shelter-in-place	Natural emergency (i.e., tornado, severe storm, etc.) Emergency where air quality is threatened (i.e., release of toxic chemicals)	Make a shelter area <i>within</i> the facility: <ul style="list-style-type: none"> - At the lowest level, with as few windows as possible for natural emergencies - For chemical events, the shelter should be as high as possible in the facility to avoid vapors that sink

(Adapted from Centers for Disease Control and Prevention, 2003; Aronson SS, 2002; and Bright Horizons Family Solutions, 2003)

First Aid and Emergency Supplies Kit

A first aid and emergency supplies kit should be assembled and stored in a closed container, cabinet, or drawer that is labeled and stored in a location known to all staff, accessible to staff at all times, but locked and otherwise inaccessible to children. The facility should also have a transportable first aid kit to be used when children and staff leave the facility for a walk or to be transported.

The following supplies should be included:

- List of emergency phone numbers, including parent/guardian contact information
- Cell phone (charged), calling card, change for pay phones, “walkie talkies”
- Water—backup supply of what is typically used in a day
- Non-perishable food, manual can opener
- First aid kit [5.6.0.1](#)

- Blankets
- Radio, flashlights, extra batteries
- Hand washing solution that does not require running water
- Extra clothing/shoes
- Diapers, baby food/formula, other special items for infants and toddlers
- Prescription medicines for children and staff (check storage recommendations— items that must be refrigerated may need to be stored separately)
- Other items for safety and comfort
- If evacuating/relocating, remember child records, attendance sheets
(NC Division of Child Development, 2005)

What the CCHC Should Know: How to Respond to Children’s Emotional Needs After an Emergency

Experiencing a traumatic event, whether it is a human-caused emergency or a severe natural disaster, can cause anxiety and psychological stress among children, parents/guardians, and staff of a child care center.

Recognizing Child Stress Symptoms

A child’s reaction to a stressful emergency will vary with age, but some of the common reactions are listed below.

- Irritability, crying
- Anxious attachment and clinging
- Separation anxiety
- Acting out of traumatic events
- Sadness
- Generalized fear
- Loss of verbal skills
- Sleep disturbance
- Loss of toileting skills
- Uncharacteristic hostility/acting out
(Project Cope, 2001; FEMA, 2006)

How to Respond to Child Stress Symptoms

After a traumatic event, it is important to 1) limit further exposure to trauma; 2) address concerns about safety; 3) find out what children are thinking and feeling; and 4) find activities to help children and staff cope with the trauma (AAP, 2000).

Returning to normal daily routines can also help young children cope with the aftermath of an emergency. Child care providers should contact local medical and mental health resources, including those provided by disaster relief organizations such as the American Red Cross, to help with children who are experiencing stress as a result of events. Acute Stress Disorder should be considered when stress symptoms appear within 1 month of a traumatic event. Post-traumatic Stress Disorder should be considered if stress symptoms persist for more than a few weeks. Acute and Post-traumatic Stress Disorders should be diagnosed and treated by a professional.

How to Help Child Care Staff Cope with Emergencies

Child care staff should also receive physical and mental health support after the experience of a traumatic event. A child care program can be prepared by:

- Documenting the local/state resources for crisis support
- Having emergency plans in place that provide a sense of safety and confidence (Joshi, Lewin, and O'Donnell, 2002)

Action Items for the CCHC

The CCHC should:

- Assist the program in developing an emergency preparedness policy
- Review the program's emergency and evacuation plans^{1.6.0.1}
- Assess the availability of emergency equipment and safety supplies in the child care program and advise the provider on how to maintain supplies
- Review the facility's drill/evacuation policies and documented records of previous emergencies and make recommendations for improvement, if necessary
- Be knowledgeable about local emergency preparedness resources
- Assist in training staff to recognize child and adult trauma symptoms
- Be knowledgeable about local mental health services

VEHICLE-RELATED INJURIES

What the CCHC Should Know: Types of Vehicle-Related Injuries that May Occur in Child Care Settings

Children often need to be transported by child care staff, including while on field trips, while providing a pick-up or drop-off service to parents/guardians, or in emergency situations. Often, child care caregivers/teachers have no special training in vehicle safety and are not using appropriate restraints for children. Vehicle-related injuries are the leading cause of death for children over six months of age and can occur when child care staff are transporting children in cars, vans, or buses (CDC, 2008). Injuries can also involve children on foot in the drop-off/pick-up area of the child care facility, or children who are near vehicles while taking walks or enjoying other outdoor activities. Children may also be injured while riding on non-motorized vehicles, such as bicycles, tricycles, scooters, and skateboards.

What the CCHC Should Know: How to Prevent Vehicle-Related Injuries in the Child Care Setting

Guidelines for Safe Transportation of Children

Child care programs should have written guidelines for when and how children will be transported in motor vehicles. These guidelines should include the following:

- All drivers must have an excellent driving record and a valid driver's license, and the license must be valid for the type of vehicle being used. [6.5.1.2](#), [9.2.5.1](#), [9.2.5.2](#)
(For example, some states require special licenses for driving busses.)
- Vehicles should be well-maintained and inspected according to the manufacturer's recommendations or at least every three months. [9.2.5.1](#), [9.2.5.2](#)
- Staff-to-child ratios for transport should meet or exceed those required for the classroom. The driver is not included in the ratio. [1.1.1.4](#)
- All children should be supervised during transport, either by staff or a parent/guardian volunteer, so the driver can focus on driving.
- Children should only be transported in a developmentally appropriate car safety seat or booster seat. [6.5.2.2](#)
- Staff and drivers should know what to do in an emergency, know how to properly use car safety seats and seat belts, and be aware of other safety requirements. [6.5.1.1](#) Drivers should know the quickest route to the nearest emergency medical facility from all points on their trip. [6.5.2.6](#)
- A first aid kit [5.6.0.1](#) and charged cell phone should be accessible in the vehicle. [5.3.1.12](#)
- Children should never be left alone in vehicles, even those that are not moving
- Adults driving or riding with children must always wear their own seat belts
- Children should not ride in the front seat of vehicles, and a rear-facing safety seat must never be placed in the front seat of a car with a passenger air bag
- Child care staff should have a plan for how to transport children safely in the event of an emergency

- The temperature inside the vehicle should be comfortable (between 65 and 82 degrees).^{6.5.2.4} The vehicle should always be checked for passengers left behind, and children should never be left in a vehicle regardless of the outside temperature. Remember: a vehicle can heat up to dangerous temperatures in a matter of minutes on hot days.
 - When transporting many children at once, vehicles that meet standards for school busses are recommended—SUVs and 15-passenger vans are not recommended as they are more prone to rollover.^{6.5.3.1}
- (Adapted from AAP, 2008; Aird, 2007; and *CFOC*, 3rd ed., 20011)

Loading Zone Safety

The pick-up and drop-off area at a child care facility should be carefully assessed for safety, which includes attention to proximity to local traffic, parking lots, and pedestrian areas.^{6.5.2.1} Safety tips include:

- Children should be well-supervised as they are getting into and out of vehicles, especially when they are in the area immediately around the vehicle where a driver cannot see small children easily (this is called the “danger zone”).
 - Have someone observe what happens during pick-up and drop-off times. This may lead to important observations to help improve safety.
 - If children have to walk through a parking lot to get to outside play areas, a special path should be roped or marked where vehicles are not allowed.
 - Parents/guardians should be informed of parking lot protocol and danger zones.
 - Local traffic officers may be available to help develop loading zone safety policies and procedures.
- (Aird, 2007)

Choosing and Using Car Safety Seats

At least 90% of car seats inspected at safety seat checkups are incorrectly used, significantly reducing the protection offered to children (SafetyBeltSafe USA, 2007). Properly used child safety seats reduce the risk of death in passenger cars by 71% for infants and by 54% for toddlers ages 1 to 4 years (CDC, 2008). For children 4 to 7 years, booster seats reduce injury risk by 59% compared to seat belts alone. Child care caregivers/teachers should be aware of how to select and use developmentally appropriate safety seats.^{6.5.2.2} The table on the following page shows how to select the proper seat.

Selecting the Appropriate Child Safety Seat

Age	Type of Seat	General Guideline
Infant	Infant only and rear-facing convertible	All infants should always ride rear-facing until they are 2 years of age and weigh at least 20 pounds.
Toddlers	Convertible, combination, and forward-facing	Children 1 year of age and at least 20 pounds can ride forward-facing. It is best to ride rear-facing as long as possible.
School Age	Booster	Booster seats are for older children who have outgrown their forward-facing car safety seats. Children should stay in a booster seat until the adult seat belts fit correctly (usually when a child reaches about 4' 9" in height and is between 8 and 12 years of age).
Older Children	Seat belt	Children who have outgrown their booster seats should ride in a lap and shoulder belt; they should ride in the back seat until 13 years of age.

(Table adapted from AAP, 2008)

Child care caregivers/teachers should be aware of the following resources for assistance with car seat installation:

- A list of child safety seat inspection stations is available by state or ZIP code on the NHTSA Web site at <http://www.nhtsa.dot.gov/cps/cpsfitting/index.cfm>
- A list of inspection stations is available in English and Spanish at <http://www.seatcheck.org> or toll-free at (866) SEATCHECK or NHTSA Auto Safety Hotline at (888) DASH-2-DOT
- For children with special health care needs, special car safety seats may be required. The National Easter Seal Society at (800) 221-6827 or the child's health care provider may be able to provide information about how to get low cost special seats for children with special needs.

Child Pedestrian Safety Tips

The following are tips for keeping children safe while walking near traffic:

- Children should always walk and cross the street with an adult
 - Bright-colored clothing in the daytime and reflective clothing at dusk or nighttime can help drivers see children
 - Cross the street at designated crosswalks only
 - Walk, do not run, near traffic and in parking lots
 - Walk on the sidewalk if there is one, and on the side of the street facing traffic if there is no sidewalk
 - Children should not be allowed to play with balls or toys near traffic
 - Take time during indoor activities to teach about pedestrian safety, including how to recognize street signs and traffic lights
- (Seattle and King County Public Health, 2007)

Bicycle Safety Tips

Whether riding on a bicycle with or without training wheels, tricycle, scooter, or skateboard, all children should follow the following safety standards:

- Always wear a properly fitted [Appendix II](#) and approved helmet [6.4.2.2](#)
- Ride only on something that is the right size for them [6.4.2.1](#)
- Ride on the same side of the road as the cars traveling in the same direction
- Use hand signals to let others know when stopping or turning
- Stop before crossing any street to look left-right-left, scanning for cars
- Bike routes should be reviewed and approved by local police and taught to the children in the facility [6.4.2.3](#)

What the CCHC Should Know: How to Respond to Vehicle-Related Injuries in the Child Care Setting

Child care staff should follow emergency procedures for any injuries related to vehicles, including alerting medical response teams and parents/guardians. All uninjured children should be carefully supervised while they are near roads or parking lots after a crash. All car seats and helmets should be carefully inspected after a crash and should be replaced if any damage is visible or if the crash resulted in an injury or damage to the vehicle.

Action Items for the CCHC

The CCHC should:

- Assist child care staff in developing policies for safely transporting children in vehicles, including children with special needs [5.6.0.1](#), [9.2.5.1](#), [9.2.5.2](#)
- Provide resources and assistance with selecting and installing child safety seats
- Provide education to caregivers/teachers, parents/guardians, and children about loading zone, pedestrian, and bicycle safety [2.4.1.1](#), [2.4.2.1](#), [2.4.3.2](#).

WHERE TO FIND MORE INFORMATION

Arizona Department of Health Services
Safety Information Flip Chart: Emergency and Prevention Guidelines for Schools,
Early Childhood Programs and Parents
<http://www.azdhs.gov/phs/owch/pdf/safety.pdf>

The Injury Prevention Program of the AAP
<http://www.aap.org/family/tippmain.htm>

Airway Obstruction

American Society for Testing and Materials International
<http://www.astm.org/index.html>

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
<http://www.cdc.gov/injury/index.html>

CSN National Injury & Violence Prevention Resource Center
<http://www.childrenssafetynetwork.org/>

Healthy Child Care
Airway Obstruction Injuries
http://www.healthychild.net/SafetyFirst.php?article_id=129

Safe Kids, USA
Injury Facts, Airway Obstruction
<http://www.safekids.org/our-work/research/fact-sheets/choking-and-suffocation-prevention-fact-sheet.html>

U.S. Consumer Product Safety Commission
Requirements for rattles
<http://www.cpsc.gov/businfo/regsumrattle.pdf>.

U.S. Consumer Product Safety Commission
Recalls and product safety news
<http://www.cpsc.gov/cpscpub/prerel/prerel.html>

U.S. Consumer Product Safety Commission
The safe nursery: A booklet to help avoid injuries from nursery furniture and equipment
<http://www.cpsc.gov/cpscpub/pubs/202.pdf>

Poisoning

American Association of Poison Control Centers

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

Cornell University

Poisonous plants informational database

<http://www.ansci.cornell.edu/plants/>

CSN National Injury & Violence Prevention Resource Center

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

Eco-Healthy Child Care

http://www.oeonline.org/our-work/kidshealth/ehcc/index_html

National Capitol Poison Center

Even Plants Can Be Poisonous

<http://www.poison.org/prevent/plants.asp>

The Art & Creative Materials Institute, Inc.

<http://www.acminet.org/index.htm>

The Children's Hospital at Westmead

Poisonous Plants

http://www.chw.edu.au/parents/factsheets/poisonous_plants.htm

U.S. Consumer Product Safety Commission

<http://www.cpsc.gov>

SIDS

A Child Care Providers Guide to Safe Sleep

<http://www.healthychildcare.org/pdf/SIDSchildcaresafesleep.pdf>

American Academy of Pediatrics, Healthy Child Care America

Healthy Child Care America Back to Sleep Campaign

http://www.healthychildcare.org/section_SIDS.cfm

American SIDS Institute

<http://www.sids.org>

Association of SIDS and Infant Mortality Programs

<http://www.asip1.org/>

Back to Sleep Campaign

National Institute of Child Health and Human Development

<http://www.nichd.nih.gov/sids/sids.cfm>

CJ Foundation for SIDS

<http://www.cjsids.com/>

California Childcare Health Program

Model Safe Sleep Policy for Infants in Child Care

http://www.ucsfchildcarehealth.org/pdfs/forms/SafeSleep_policy.pdf

First Candle/SIDS Alliance

<http://www.sidsalliance.org>

Healthy Child Care America

American Academy of Pediatrics

<http://www.healthychildcare.org>

Horne RSC, Parslow PM, Ferens D, Watts AM, Adamson TM. Comparison of evoked arousability in breast and formula fed infants. Arch Dis Child. 2004;89:22-25.

Medical Cribs

<http://www.fda.gov/medicaldevices/deviceregulationandguidance/ucm142656.htm>

Moon RY, Patel KM, Shaefer SJ. Sudden infant death syndrome in child care settings. Pediatrics. 2000;106(2):295-300.

National Sudden and Unexpected Infant/Child and Pregnancy Loss Resource Center
SIDS in Child Care

<http://www.sidscenter.org/Childcare/index.html>

National Resource Center for Health and Safety in Child Care and Early Education

<http://nrckids.org/>

At homepage, type: SIDS into Search window

Safe Sleep Videos

<http://www.sidscenter.org/SafeSleep/videos.html>

The Juvenile Products Manufacturers Association

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

U.S. Consumer Product Safety Commission

<http://www.cpsc.gov>

Biting

Banks R, Yi S. University of Illinois, Early Childhood and Parenting Collaborative.
Dealing with biting behaviors in young children.

<http://ceep.crc.uiuc.edu/poptopics/biting.html>

Child Care Aware

When children bite

<http://childcareaware.org/parents-and-guardians/newsletters/are-you-aware/when-children-bite>

Child Care Information Exchange

Reality Bites: Biting at the Center (Fee-based Training Kit for Child Care Providers)

http://www.childcareexchange.com/catalog/product_info.php?products_id=4400910&search=&category=

ZERO TO THREE

National Center for Infants, Toddlers and Families

<http://www.zerotothree.org>

Emergency Preparedness

American Academy of Pediatrics Children's health topics: Terrorism and disasters

<http://www.healthychildren.org/English/safety-prevention/at-home/Pages/Terrorism-Disaster-Fact-Sheet.aspx>

American Academy of Pediatrics, Committee on Pediatric Emergency Medicine.

Emergency preparedness for children with special health care needs. *Pediatrics* 1999;104(4):e53.

American Red Cross Disaster services

<http://www.redcross.org/www-files/Documents/GovernmentRelations/GuideToServices.pdf>

Bioterrorism Preparedness and Response Planning Centers for Disease Control and Prevention

<http://www.bt.cdc.gov>

The Child Trauma Academy

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

Federal Emergency Management Agency

<http://www.fema.gov/pdf/library/children.pdf>

Institute for Business and Home Safety

<http://www.ibhs.org>

National Association of Child Care Resource and Referral Agencies
Children and Disasters

<http://www.naccrra.org/public-policy/policy-issues/disaster-planning-recovery-basics>

National Child Care Information and Technical Assistance Program
Emergency Preparedness in Child Care Programs

<http://www.acf.hhs.gov/programs/ccb/initiatives/emergency/index.htm>

United States Department of Veterans Affairs
PTSD in Children and Adolescents

<http://www.ptsd.va.gov/public/pages/ptsd-children-adolescents.asp>

Bereavement Resources

What Every Childcare Provider Should Know About Coping with Grief after the Death of a Baby from SIDS

http://www.sidsresources.org/?page_id=922

SIDS Resources Bereavement Program

http://www.sidsresources.org/?page_id=597

A Response to Parents After the Loss of a Baby

http://www.sidsresources.org/?page_id=878

National SIDS/Infant Death Resource Center Bereavement Support

<http://www.sidscenter.org/Bereavement/index.html>

State-by-state list of grief resources

<http://www.sidscenter.org/links.html>

Transportation Safety

American Academy of Pediatrics

Car Safety Seats: A guide for families

[Car Safety Seat Guide](#)

Policy Statement: School Transportation Safety

<http://aappolicy.aappublications.org/cgi/content/full/pediatrics;120/1/213>

Policy Statement: Transporting Children with Special Health Care Needs

<http://aappolicy.aappublications.org/cgi/content/full/pediatrics;104/4/988>

North Carolina Child Passenger Safety Resource Center

Requirements and Recommendations for the Transportation of Children by Schools,
Child Care Centers and other Organizations in North Carolina

http://www.buckleupnc.org/downloads/nc_cps_bus-van-transportation.pdf

Safe Kids, USA

Transportation in Child Care Settings

<http://www.safekids.org/assets/docs/ourwork/research/research-report-cps-2003.pdf>

REFERENCES

- Aird, L. Moving Kids Safely in Child Care: A Refresher Course. Exchange 2007; January/February: 25-28. Available at: <http://www.childcareexchange.com/library/5017325.pdf>. Accessed September 23, 2011.
- American Academy of Pediatrics. Choking prevention. 2006. Available at: <http://www.healthychildren.org/English/health-issues/injuries-emergencies/Pages/Choking-Prevention.aspx>. Accessed September 23, 2011.
- American Academy of Pediatrics. AAP revises recommendations on reducing the risk of SIDS. 2005. Available at: <http://aapnews.aappublications.org/content/26/10/1.2.full>. Accessed September 23, 2011.
- American Academy of Pediatrics. Q and A: Poison treatment in the home. No date. Available at: <http://www.aap.org/advocacy/archives/novpoisonqanda.htm>. Accessed October 2, 2008.
- American Academy of Pediatrics. 2003. Position statement. *Pediatrics*; 112(5): 1182-85.
- American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. 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. Also available at <http://nrckids.org>.
- American Academy of Pediatrics, Healthy Child Care America Back to Sleep Campaign. Reducing the risk of SIDS in child care: Training for child care providers. Elk Grove Village (IL): 2004.
- American Academy of Pediatrics. Car safety seats: A guide for families 2008. <http://www.aap.org/FAMILY/carseatguide.htm>. Accessed October 1, 2008. No longer available.
- American Academy of Pediatrics. Responding to children's emotional needs during times of crisis: Information for parents. 2000. <http://www.aap.org/disasters/pdf/Responding-to-Childrens-Emotional-Needs.pdf>. Accessed September 23, 2011.
- American Academy of Pediatrics; Task Force on Infant Sleep Position and Sudden Infant Death Syndrome. The changing concept of sudden infant death syndrome: diagnostic coding shifts, controversies regarding the sleeping environment, and new variables to consider in reducing risk. *Pediatrics*. 2005;116: 1245-1255. Available at: <http://pediatrics.aappublications.org/content/116/5/1245.full.pdf+html?sid=d7fa8432-6823-423a-9342-a291c89d81a1>. Accessed February 6, 2013.

American Association of Poison Control Centers. Poison proof your home. 2004. Available at: <http://www.aapcc.org/dnn/PoisoningPrevention/PoisonProofYourHome/tabid/118/Default.aspx>. Accessed September 23, 2011.

American Red Cross. Available at: <http://www.redcross.org/>. Accessed September 23, 2011.

Aronson SS. American Academy of Pediatrics, Pennsylvania Chapter, Healthy Child Care Pennsylvania, The Early Childhood Education Linkage System. Model child care health policies. 4th ed. Rosemont, (PA); 2002.

Art and Creative Materials Institute, Inc. Safety-what you need to know. 2004. Available at: <http://www.acminet.org/Safety.htm#one>. Accessed September 23, 2011.

Blair PS, Fleming PJ, Smith IJ, et al, and the CESDI SUDI Research Group. Babies sleeping with parents: Case-control study of factors influencing the risk of sudden infant death syndrome. *BMJ* 1999;319:1457–62

Bright Horizons Family Solutions. Ready to respond emergency preparedness plan for early care and education centers. 2003. Available at: <http://www.wvdhhr.org/bcf/ece/earlycare/documents/TierIIFacilityHSN.pdf>. Accessed September 23, 2011.

Beckwith JB. Defining the sudden infant death syndrome. *Arch Pediatr Adolesc Med*. 2003;157:286-290.

Byard RW, Krous HF. Sudden infant death syndrome: Overview and update. *Pediatr Dev Pathol*. 2003; 6(2): 112-27.

California Childcare Health Program. Poisoning. 2003. Available at: <http://www.ucsfchildcarehealth.org/pdfs/factsheets/poisoningsen011804.pdf>. Accessed September 23, 2011.

Canadian Child Care Federation. Safety in the arts. Resource Sheet #21. 2001. Available at: http://www.cccf-fcsge.ca/wp-content/uploads/RS_21-e.pdf. Accessed February 6, 2013.

Centers for Disease Control and Prevention. Chemical agents: Facts about sheltering in place. 2003. Available at: <http://www.bt.cdc.gov/planning/Shelteringfacts.pdf>. Accessed September 23, 2011.

Centers for Disease Control and Prevention. Nonfatal choking-related episodes among children – United States, 2001. *MMWR* 2002;51:945-48.

Centers for Disease Control and Prevention. Child passenger safety: Fact sheet. 2008. Available at: http://www.cdc.gov/MotorVehicleSafety/Child_Passenger_Safety/CPS-Factsheet.html. Accessed September 23, 2011.

Federal Emergency Management Agency. State offices and agencies of emergency management. 2005. Available at: <http://www.fema.gov/regional-operations/state-offices-and-agencies-emergency-management>. Accessed February 6, 2013.

Federal Emergency Management Agency. Helping children cope with disaster. 2006. Available at: <http://www.fema.gov/news-release/fema-helps-children-cope-disaster>. Accessed February 6, 2013.

Fowlkes S, Poplin N, Bennett E, Isbell P, Kotch JB. Emergency preparedness and response for child care. Chapel Hill: The University of North Carolina at Chapel Hill, School of Public Health, Department of Maternal and Child Health, 2005.

Healthy Child Care. Airway obstruction injuries. 2008. Available at: http://www.healthychild.net/SafetyFirst.php?article_id=129. Accessed September 23, 2011.

Joshi PT, Lewin SM, O'Donnell, DA. The handbook of frequently asked questions following traumatic events: Violence, disasters, or terrorism. 2002. Available at: http://www.childrensnational.org/files/PDF/DepartmentsandPrograms/ichoc/handbook_english.pdf. Accessed September 23, 2011.

Kendrick D, Barlow J, Hampshire A, Polnay L, Stewart-Brown S. Parenting interventions for the prevention of unintentional injuries in childhood. (2009). Cochrane Library. Available at: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006020.pub2/pdf/standard> Accessed June 4, 2013.

Moon RY, Biliter WM, Croskell SE. Examination of state regulations regarding infants and sleep in licensed child care centers and family child care settings. *Pediatrics*. 2001; 107(5): 1029-1036.

Moon RY, Oden RP. Back to sleep: Can we influence child care providers? *Pediatrics*. 2003;112(4):878-882.

National Agriculture Safety Database. Symptoms and First Aid for Poisonings. 2006. Available at: <http://nasdonline.org/document/977/d000817/symptoms-and-first-aid-for-poisonings.html> Accessed September 23, 2011.

Ramming P, Kyger CS, Thompson SD. (2006). A new bit on toddler biting: The influence of food, oral motor development, and sensory activities. *Young Children*, 61(2): 17-18.

National Safety Council. Children and poisons. 2008. Available at: http://www.nsc.org/SAFETY_HOME/RESOURCES/Pages/Poisoning.aspx. Accessed September 23, 2011.

National SIDS/Infant Death Support Center. Sudden Infant Death Syndrome and the Child Care Provider Sample Drill: Emergency Procedures for an Unresponsive Infant. 2007. Available at: <http://www.firstcandle.org/publications/Emergency-Procedures-for-an-Unresponsive-Infant.pdf>. Accessed September 23, 2011.

North Carolina Division of Child Development. Emergency preparedness tips for child care providers. 2005. Available at: http://ncchildcare.dhhs.state.nc.us/pdf_forms/emrtips.pdf. Accessed September 23, 2011.

North Carolina Child Care Health and Safety Resource Center. Biting: A familiar challenging behavior! 2002. Available at: <http://www.healthychildcarenc.org/PDFs/CCNEW1202.pdf>. Accessed September 23, 2011.

North Carolina Department of Health and Human Services; Division of Child Development. Disaster plan. 2004. Available at: http://ncchildcare.dhhs.state.nc.us/pdf_forms/dccdis.pdf. Accessed September 23, 2011.

Oklahoma State Department of Health. Biting in the toddler years. 2006. Available at: <http://www.ok.gov/health2/documents/cgs.pub.BitingTodYears.pdf>. Accessed February 6, 2013.

Safe Kids Worldwide. Injury facts: Airway obstruction. 2004. Available at: <http://www.safekidsnebraska.org/fact-sheets/AOI%20facts.pdf>. Accessed February 6, 2013.

Safe Kids Worldwide. Editorial calendar: More than one million children poisoned each year. 2004. [Poison Prevention Fact Sheet](#) Accessed September 23, 2011.

SafetyBeltSafe USA. Parents warned of risk to kids in day care: New program offers child care providers free child passenger safety training. 2007. Available at: http://www.carseat.org/Events_Media/PressRel.02-07-07.pdf. Accessed September 23, 2011.

Seattle and King County Public Health. Child care health program: Pedestrian safety. 2006. Available at: <http://www.kingcounty.gov/healthservices/health/child/childcare/education/pedestrian.aspx>. Accessed September 23, 2011.

U.S. Consumer Product Safety Commission (CPSC). Child safety protection act fact sheet. CPSC document #282. 1995. Available at: <http://www.cpsc.gov/cpscpub/pubs/282.pdf>. Accessed October 1, 2008.

U.S. Consumer Product Safety Commission (CPSC). Law requires review and labeling of art materials. Safety alert. CPSC document #5016. 1996. Available at: <http://www.cpsc.gov/cpsc/pub/pubs/art.html>. Accessed September 23, 2011.

U.S. Consumer Product Safety Commission (CPSC). Locked up poisons. Prevent tragedy. CPSC document #382. 2001. Available at: <http://www.cpsc.gov/cpsc/pub/pubs/382.pdf>. Accessed September 23, 2011.

U.S. Consumer Product Safety Commission (CPSC). Poison lookout checklist. CPSC document #383. 2001. Available at: http://www.nchh.org/Portals/0/Contents/CPSC_Poison_Lookout_Checklist.htm. Accessed September 23, 2011.

U.S. Consumer Product Safety Commission (CPSC). The safe nursery: A booklet to help avoid injuries from nursery furniture and equipment. 1997. Available at: <http://www.cpsc.gov/Safety-Education/Safety-Guides/Topics/The-Safe-Nursery/>. Accessed February 6, 2013.

Zamani AR, California Childcare Health Program. Beware of poisonous houseplants. 2002. Available at: <http://www.ucsfchildcarehealth.org/pdfs/factsheets/poisonplanten011804.pdf>. Accessed September 23, 2011.

Zero to Three. Chew on this: Responding to toddlers who bite. No date. Available at: http://www.zerotothree.org/site/PageServer?pagename=ter_key_social_biting. Accessed September 23, 2011.

APPENDIXES

Appendix A: Additional Materials

Protecting Young Children
Airway Obstruction Checklist
Poisonous Substances Checklist

NOTE: These documents for Appendix A are available on the NTI Training and Resources Website, under the Injury Prevention in Child Care, Part B link in the Curriculum Section.