ADDITIONAL RESOURCES
In 2008, the American Academy of Pediatrics (AAP) completed a needs assessment of 1,500 licensed child care centers. Results show that more can be done to prepare the early education and child care community for a pandemic influenza. The survey results also indicated that while knowledge of and preparation for a pandemic influenza was poor, child care center directors were willing to take steps to improve preparedness. The top choices for improving preparedness were use of print materials, participation in training sessions, and access to downloadable or interactive web-based tools. The purpose of this handout is to recommend topics, strategies, and resources that can be used to improve preparedness for pandemic influenza within child care settings.

Face-to-face training sessions are an effective way to help early education and child care program staff learn how to improve day-to-day preparedness and determine plans to respond when there is an active infectious disease outbreak or pandemic influenza. Asking a local pediatrician, health department representative or qualified child care health consultant to present a professional development session is a great way to engage these partners in child care health and safety activities. Also, such teaching activities help develop relationships that keep staff informed of current community preparedness efforts. A strong connection between child care and public health leaders is critical. During a pandemic, recommendations and communication strategies evolve rapidly. Early education and child care programs need to be aware of existing mechanisms for information dissemination and decision-making.
Instruction of early education and child care providers about infection control and pandemic influenza preparedness should include the following topics for discussion:

**Infection Control During an Infectious Disease Outbreak:**
- What constitutes an infectious disease outbreak, epidemic, pandemic, and public health emergency
- Role of hand washing, cough/sneeze etiquette, and personal hygiene/sanitation practices
- Protocols for effective cleaning, sanitizing, and disinfecting of toys and other objects/surfaces
- Use of symptom, illness, and absence records as well as daily health checks
- Importance of written infectious disease control, hygiene and sanitation, and immunization policies
- Importance of and options for collecting immunization record data for children and staff in child care and using the data to identify children and staff who need to be referred to their health care providers to fill gaps in the vaccines they have received to meet recommended schedules.
- Benefits of partnerships with child care health consultants and local health care professionals

**Pandemic Influenza Topics:**
- What constitutes a pandemic and when it becomes a public health emergency
- Difference between seasonal and pandemic influenza viruses (transmission, spread, and severity)
- Why young children are at increased risk during a pandemic
- Which children may be at highest risk during a pandemic
- Importance of annual seasonal influenza immunization for children and child care providers as well as approaches to supplemental vaccine when recommended by public health authorities (e.g. as in the H1N1 pandemic influenza)
- Importance of family preparedness, employer contingency planning, and business continuity strategies for early education and child care programs
- Lessons learned during the H1N1 pandemic influenza
  - Challenges of this pandemic; why the US was not prepared
  - How to respond to anti-immunization misinformation and vaccine refusals
  - Use of laboratory testing, hospitalization, and other data
  - Review of clinical trials for H1N1 vaccines; why children initially need 2 shots, etc.
  - Role of the media in providing updates (discussion of “the worried well”)
  - Why certain public health departments, primary care physicians, emergency hotline personnel, and hospital emergency departments were overwhelmed; how child care programs can help
Appendix: Preparing for Infectious Disease Outbreaks or Pandemic Influenza

Steps for Improving Preparedness

- Develop a written emergency/disaster plan that includes a process and timeline for updating this document
- Identify “trusted sources” of health information (CDC, health department, community pediatrician, and child care health consultant)
- Establish protocols/assignments for communication systems that can be used in an emergency. This would include a process to share key information as well as an immediate alert plan. Compile and maintain a list of community contacts and key phone numbers in advance to be ready to communicate during an emergency
- Determine who will monitor information and health alerts and report back on key findings
- Develop a process for sharing key information with staff, parents, and children during an emergency
- Prepare template handouts for staff and parents in advance
- Discuss the process for ordering supplies (and maintaining inventory) during times of staff absences or when there is an increased need for certain hygiene or cleaning supplies
- Use seasonal influenza as an opportunity to practice preparedness and response efforts
- Collaborate with community partners on preparedness activities or contingency planning
- Review criteria for and steps involved in facility closure
- Implement steps to support families and employees to develop personal preparedness plans

Strategies

In addition to the steps described above, encourage child care programs to implement one or more new strategies to enhance preparedness, such as:

- Provide seasonal influenza immunizations on site at the child care facility
- Collaborate with nearby centers on the use of substitutes, mass supply ordering, or training
- Create a Web site or answering service message to provide daily updates to clients
- Form a team that includes a child care health consultant and/or local public health representative to make decisions during an outbreak or pandemic
Resources
American Academy of Pediatrics
• AAP Children and Disasters Web site http://www.aap.org/disasters/index.cfm
• AAP Preparing Child Care Programs for Pandemic Influenza Web site http://www.aap.org/disasters/pandemic-flu-cc.cfm
• AAP Healthy Child Care America Web site www.healthychildcare.org
• Hand Hygiene http://aapredbook.aappublications.org/news/MIDCCS2hygiene.pdf
• Outbreaks, Epidemics, and Other Infectious Disease Emergencies http://aapredbook.aappublications.org/news/MIDCCSOutbreaks.pdf

US Department of Health and Human Services
• H1N1 Flu: Resources for Child Care and Early Childhood Programs www.cdc.gov/h1n1flu/childcare
• FLU.gov http://www.flu.gov/index.html

Other
North Carolina Child Care Health and Safety Resource Center Pandemic Flu in Child Care Trainer’s Manual: The Pandemic Flu and Child Care trainer’s manual is designed to increase a trainer’s knowledge of pandemic influenza and provides the trainer with the content, handouts, and a PowerPoint presentation that instructors can use to teach early care educators about pandemic flu. The curriculum covers an introduction to the flu, preventing the spread of flu in child care settings, preparing for pandemic flu in child care and responding to pandemic flu. For more information or to order a copy, contact the NC Child Care Health and Safety Resource Center at jackie_quirk@unc.edu.

California Child Care Health Program Preparing for Pandemic Flu in Child Care Programs http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/PandemicFlu_EN_020210.pdf

Healthy Child Care Pennsylvania
WellCareTrackerTM: an immunization tracking and child care health record quality improvement tool http://www.wellcaretracker.org/index1.php

Workshop on Pandemic Flu
http://www.ecels-healthychildcarepa.org/section.cfm?subID=15&scope=all

Additional resources
http://www.ecels-healthychildcarepa.org/


Washington Coalition for Safety and Health in Early Learning Informational materials for child care providers and parents; available in multiple languages. www.del.wa.gov/publications/development/#flu
Parent/Guardian Alert Letter

Notice of Exposure to Communicable Disease

Name of Facility/School ____________________________________________________________

Address of Facility/School _________________________________________________________

Telephone Number of Facility/School ________________________________________________

Dear Parent or Legal Guardian:

A child in our facility/school has or is suspected of having _______________________________________________.

Without violating the confidentiality of this child, the facts you need to know about your child’s exposure in this situation are:

We want to inform you about this condition and the related exclusion and return-to-care practices at our facility/school. Please read the attached information sheet closely and call us with any questions.

Facility/School Staff Person’s Name ____________________________________________

Telephone Number ________________________________________________________
Information About This Disease

Note: To be used if there is no applicable Quick Reference Sheet in Chapter 7. You may copy those pages for communications with families/health professionals.

The disease is spread by ________________________________________________________________

The symptoms are ________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

The disease can be prevented by ________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

What the facility/school is doing to reduce the spread: ________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

What you can do at home: ________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Is exclusion necessary? ________________________________________________________________

When can an excluded child return? ________________________________________________________________

Comments ________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________
Symptoms or Suspected Illness—Sample A
(See alternate type of form on page 178.)

Name of Child __________________________________________________________________________________________

Facility/School _________________________________________________________ Date __________________________

Dear Parent/Guardian:

Today at our facility/school, your child was observed to have one or more of the following signs or symptoms:

**General**
- □ Fever (101°F [38.3°C] or above orally or axillary)
- □ Complained of headache
- □ Swelling of or pus from ___________

**Eye**
- □ Pinkeye
- □ Tears, redness of eyelid lining

**Gastrointestinal**
- □ Diarrhea _____ times in the last 24 hours (had an abnormally loose stool)
- □ Vomiting _____ times in the last 24 hours

**Respiratory**
- □ Difficult or rapid breathing
- □ Severe coughing
- □ Child gets red or blue in the face
- □ Trouble swallowing or complained of sore throat
- □ Earache or signs that suggested earache (specify)_______

**Skin**
- □ Infected skin patches
- □ Crusty, bright yellow, dry, or gummy areas of skin
- □ Severe itching of body/scalp
- □ Unusual spots or rashes
- □ Head lice or nits

**Unusual behavior**
- □ Loss of appetite
- □ Child cries more than usual
- □ Child feels general discomfort
- □ Cranky or less active
- □ Just seems unwell

**Urine problem**
- □ Specify__________________________

**Other**
- □ Specify ________________________

Contact your health professional if there is
- □ Persistent fever (above 101°F [38.3°C]) and child seems very sick
- □ Breathing so hard child cannot play, talk, cry, or drink
- □ Severe coughing
- □ Earache
- □ Sore throat with fever
- □ Thick nasal drainage that lasts more than 10 days
- □ Rash accompanied by fever
- □ Persistent diarrhea (more than 1–2 days)
- □ Severe headache and stiff neck with fever
- □ Yellow skin and/or eyes
- □ Considerable confusion or difficult to arouse
- □ Rash, hives, or welts that appear quickly
- □ Severe stomachache that causes child to double over and scream
- □ No urination over 8-hour period; mouth and tongue look dry
- □ Black stool or blood mixed with stool
- □ Any child who looks or acts very ill or seems to be getting worse quickly

We are excluding your child from attendance at our facility/school until
- □ The signs or symptoms that required exclusion have resolved.
- □ The child can comfortably participate in normal activities.
- □ We can provide the level of care your child needs.
- □ Other
Symptoms or Suspected Illness—Sample B
(See alternate type of form on page 177.)

Name of facility/school

Child’s name

Date ___________________________ Symptom(s) ___________________________

When symptom began, how long it lasted, how severe, how often?

__________________________

Any change in child’s behavior?

__________________________

Child’s temperature _____________ Time taken _____________ (Circle one: Armpit Oral Rectal Ear canal)

How much and what type of food and fluid did the child take today?

__________________________

How many urine and bowel movements today and how typical/normal were they?

__________________________

Check the appropriate box(es) or write in other symptoms.

☐ Runny nose ☐ Sore throat ☐ Cough ☐ Diarrhea
☐ Wheezing ☐ Trouble breathing ☐ Stiff neck ☐ Trouble urinating
☐ Pain ☐ Itching ☐ Trouble sleeping ☐ Earache
☐ Headache ☐ Stomachache ☐ Rash ☐ Vomiting

Other symptoms

__________________________

Any medications today? (name, time, dose)

__________________________

Exposure to chemicals, animals, insects, soaps, or new foods

__________________________

Exposure to other people who were sick (what sickness?—for confidentiality reasons, please do not identify individuals)

__________________________

Child’s other problems that might affect this illness (eg, asthma, anemia, diabetes, allergy, emotional trauma)

__________________________

What has been done so far?

__________________________
Parent/Health Professional Release Form

Authorization for Release of Information

I, ____________________________, give permission for (parent/guardian)

______________________________ (health professional/facility)

to release to ____________________________ (facility/school) the following information:

______________________________ (screenings, tests, diagnoses, treatments, recommendations)

The information will be used solely to plan and coordinate the care of my child, kept confidential, and only shared with ______

______________________________ (staff title/name)

Name of Child ____________________________

Address ____________________________

City ____________________________ State _________ Zip _________

Date of Birth ____________________________

______________________________ Parent/Guardian Signature

______________________________ Witness Signature

Staff Member to Contact for Additional Information
## Authorization to Give Medicine

### PAGE 1—TO BE COMPLETED BY PARENT

### CHILD’S INFORMATION

<table>
<thead>
<tr>
<th>Name of Facility/School</th>
<th>___________________________________________________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Child (First and Last)</td>
<td>___________________________________________________________________________________</td>
</tr>
<tr>
<td>Name of Medicine</td>
<td>___________________________________________________________________________________</td>
</tr>
<tr>
<td>Reason medicine is needed during school hours</td>
<td>___________________________________________________________________________________</td>
</tr>
<tr>
<td>Dose</td>
<td>___________________________________________________________________________________</td>
</tr>
<tr>
<td>Route</td>
<td>___________________________________________________________________________________</td>
</tr>
<tr>
<td>Time to give medicine</td>
<td>___________________________________________________________________________________</td>
</tr>
<tr>
<td>Additional instructions</td>
<td>___________________________________________________________________________________</td>
</tr>
<tr>
<td>Date to start medicine</td>
<td>___________________________________________________________________________________</td>
</tr>
<tr>
<td>Stop date</td>
<td>___________________________________________________________________________________</td>
</tr>
<tr>
<td>Known side effects of medicine</td>
<td>___________________________________________________________________________________</td>
</tr>
<tr>
<td>Plan of management of side effects</td>
<td>___________________________________________________________________________________</td>
</tr>
<tr>
<td>Child allergies</td>
<td>___________________________________________________________________________________</td>
</tr>
</tbody>
</table>

### PRESCRIBER’S INFORMATION

| Prescribing Health Professional’s Name | ___________________________________________________________________________________ |
| Phone Number | ___________________________________________________________________________________ |

### PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

| Parent or Guardian Name (Print) | ___________________________________________________________________________________ |
| Parent or Guardian Signature | ___________________________________________________________________________________ |
| Address | ___________________________________________________________________________________ |
| Home Phone Number | Work Phone Number | Cell Phone Number |
Name of child ___________________________________________________________________________________________

Name of medicine ________________________________________________________________________________________

Date medicine was received _____/_____/_____

Safety Check


☐  2. Original prescription or manufacturer’s label with the name and strength of the medicine.

☐  3. Name of child on container is correct (first and last names).

☐  4. Current date on prescription/expiration label covers period when medicine is to be given.

☐  5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.

☐  6. Copy of Child Health Record is on file.

☐  7. Instructions are clear for dose, route, and time to give medicine.

☐  8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.

☐  9. Child has had a previous trial dose.

Y ☐  N ☐  10. Is this a controlled substance? If yes, special storage and log may be needed.

Caregiver/Teacher Name (Print)

Caregiver/Teacher Signature

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### Medication Log

#### PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER

<table>
<thead>
<tr>
<th>Name of child</th>
<th>Weight of child</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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</thead>
<tbody>
<tr>
<td>Medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
<tr>
<td>Actual time given</td>
<td>AM _______</td>
<td>AM _______</td>
<td>AM _______</td>
<td>AM _______</td>
<td>AM _______</td>
</tr>
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<td>PM _______</td>
<td>PM _______</td>
<td>PM _______</td>
<td>PM _______</td>
</tr>
<tr>
<td>Dosage/amount</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Route</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Staff signature</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
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<td>Date</td>
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</tr>
<tr>
<td>Actual time given</td>
<td>AM _______</td>
<td>AM _______</td>
<td>AM _______</td>
<td>AM _______</td>
<td>AM _______</td>
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<td>PM _______</td>
<td>PM _______</td>
<td>PM _______</td>
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<tr>
<td>Dosage/amount</td>
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<td></td>
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<td></td>
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<tr>
<td>Route</td>
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<td></td>
</tr>
<tr>
<td>Staff signature</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.**

<table>
<thead>
<tr>
<th>Date/time</th>
<th>Error/problem/reaction to medication</th>
<th>Action taken</th>
<th>Name of parent/guardian notified and time/date</th>
<th>Caregiver/teacher signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RETURNED to parent/guardian**

<table>
<thead>
<tr>
<th>Date</th>
<th>Parent/guardian signature</th>
<th>Caregiver/teacher signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ /</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DISPOSED of medicine**

<table>
<thead>
<tr>
<th>Date</th>
<th>Caregiver/teacher signature</th>
<th>Witness signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ /</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Medication Incident Report

| Date of report ____________________________ | School/center ____________________________ |
| Name of person completing this report ________________________________________________ |
| Signature of person completing this report ______________________________________________ |
| Child’s name __________________________________________________________________________ |
| Date of birth ____________________________ | Classroom/grade __________________________ |
| Date incident occurred ___________________ | Time noted ________________________________ |
| Person administering medication ____________________________________________________________________ |
| Prescribing health care provider ________________________________________________________________ |
| Name of medication __________________________________________________________________________________ |
| Dose ____________________________ | Scheduled time ____________________________ |
| Describe the incident and how it occurred (wrong child, medication, dose, time, or route?) __________________________________________________________________ |
| Action taken/intervention ____________________________________________________________ |
| Parent/guardian notified? Yes __________ No __________ Date __________ Time ________________ |
| Name of the parent/guardian that was notified ____________________________________________________ |
| Follow-up and outcome ____________________________________________________________ |
| Administrator’s signature ____________________________________________________________ |

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**UNIVERSAL CHILD HEALTH RECORD**

**SECTION I - TO BE COMPLETED BY PARENT(S)**

<table>
<thead>
<tr>
<th>Child’s Name (Last)</th>
<th>(First)</th>
<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Female</td>
<td></td>
</tr>
</tbody>
</table>

Does Child Have Health Insurance?  
- [ ] Yes  
- [ ] No

If Yes, Name of Child’s Health Insurance Carrier

Parent/Guardian Name  
Home Telephone Number  
Work Telephone/Cell Phone Number

Parent/Guardian Name  
Home Telephone Number  
Work Telephone/Cell Phone Number

I give my consent for my child’s Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date

This form may be released to WIC.  
- [ ] Yes  
- [ ] No

**SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER**

Date of Physical Examination:  
Results of physical examination normal?  
- [ ] Yes  
- [ ] No

Abnormalities Noted:

- Weight (must be taken within 30 days for WIC)
- Height (must be taken within 30 days for WIC)
- Head Circumference (if <2 Years)
- Blood Pressure (if ≥3 Years)

**IMMUNIZATIONS**  
- Immunization Record Attached  
- Date Next Immunization Due: ____

**MEDICAL CONDITIONS**

- Chronic Medical Conditions/Related Surgeries:  
  - List medical conditions/ongoing surgical concerns:
  - [ ] None  
  - [ ] Special Care Plan Attached  
  | Comments |

- Medications/Treatments:  
  - List medications/treatments:
  - [ ] None  
  - [ ] Special Care Plan Attached  
  | Comments |

- Limitations to Physical Activity:  
  - List limitations/special considerations:
  - [ ] None  
  - [ ] Special Care Plan Attached  
  | Comments |

- Special Equipment Needs:  
  - List items necessary for daily activities
  - [ ] None  
  - [ ] Special Care Plan Attached  
  | Comments |

- Allergies/Sensitivities:  
  - List allergies:
  - [ ] None  
  - [ ] Special Care Plan Attached  
  | Comments |

- Special Diet/Vitamin & Mineral Supplements:  
  - List dietary specifications:
  - [ ] None  
  - [ ] Special Care Plan Attached  
  | Comments |

- Behavioral Issues/Mental Health Diagnosis:  
  - List behavioral/mental health issues/concerns:
  - [ ] None  
  - [ ] Special Care Plan Attached  
  | Comments |

- Emergency Plans:  
  - List emergency plan that might be needed and the signs/symptoms to watch for:
  - [ ] None  
  - [ ] Special Care Plan Attached  
  | Comments |

**PREVENTIVE HEALTH SCREENINGS**

<table>
<thead>
<tr>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Record Value</th>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Note if Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hgb/Hct</td>
<td></td>
<td></td>
<td>Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead: [ ] Capillary  [ ] Venous</td>
<td></td>
<td></td>
<td>Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB (mm of Induration)</td>
<td>Dental</td>
<td></td>
<td>Developmental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Scoliosis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print)  
Health Care Provider Stamp:

Signature/Date
Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health and Senior Services, Immunization Program at 609-588-7512.
   - The Immunization record must be attached for the form to be valid.
   - “Date next immunization is due” is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.
   - **Medical Conditions**
     - Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.state.nj.us/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.
     - **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

   PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - **For lead screening state if the blood sample was capillary or venous and the value of the test performed.**
   - **For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.**
   - **Scoliosis screenings are done biennially in the public schools beginning at age 10.**

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permission slips for prescription and OTC medications.

c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.
Return to Group Care Form

Note: To be used when program staff have questions for a health professional, not for routine return of every excluded or ill child.

Dear Health Care Professional,

_____________________________ has been excluded from __________________________ for the following health reason(s):

Unable to participate in normal activities

Requires more care than the staff can provide

Has a specific acute illness that merits exclusion according to the American Academy of Pediatrics/American Public Health Association/National Resource Center for Health and Safety in Child Care and Early Education (available at http://nrc.uchsc.edu/CFOC/index.html)

Please assess this child by history and physical examinations (laboratory tests as needed) for
1. The presence of harmful communicable illness, such as enteric pathogens (eg, Salmonella, Shigella, Escherichia coli, Campylobacter, Giardia, hepatitis A), pertussis, measles, mumps, varicella, rubella, diphtheria, or tuberculosis
2. The presence of signs or symptoms of severe illness such as dehydration, respiratory distress, or lethargy
3. The presence of any condition that would preclude the child from returning to the routine program or, if a program for ill children is available, what the child needs in the way of care to be able to return while still ill

Please indicate

Harmful communicable disease  No _____  Yes _____
Signs of severe illness  No _____  Yes _____
Condition precluding return  No _____  Yes _____

If yes for any, may return once ______________________________________________________________________ resolves.

If no for all, may return once
1. Can participate fully in all activities
2. Does not require so much increased supervision that staff cannot properly care for child or other children in the program or school

Please complete the attached medication administration form if medication is necessary. Please consider the following suggestions:
• Include written recommendation for acetaminophen or ibuprofen (no medications can be given without orders).
• Avoid “as needed” (prn) orders (these may be confusing for caregivers/teachers); instead, describe the signs and symptoms teachers would see that determine when medication should be given.
• Include an asthma action plan for children with asthma.
• Include a care plan for any child with any other chronic condition.

Available at www.aap.org/bookstore

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide. Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for such changes.