MODULE 1

Background

- Introduction and reasons to give medication
- ADA, IDEA, state regulations
- Responsibility Triangle
- Types of medication
### Instructor's Planning Guide • Module 1
Medication Administration in Early Education and Child Care Settings

<table>
<thead>
<tr>
<th>Activity</th>
<th>Methods</th>
<th>Participant Materials</th>
<th>Other Materials or Supplies</th>
<th>Slide Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Warm Up</strong></td>
<td>Flip Chart Activity</td>
<td></td>
<td>9 sticky dots or Post-it® notes per participant</td>
<td>1</td>
</tr>
<tr>
<td><strong>Pre-test</strong></td>
<td>Test and Answer Key in Manual</td>
<td>Test in Manual</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>Why Give Medication in Child Care?</strong></td>
<td>Flip Chart Activity</td>
<td></td>
<td></td>
<td>8</td>
</tr>
</tbody>
</table>
**Flip Chart Activity: Welcome**

- Prepare flip chart pages with bullets from Welcome Activity in Module 1, Background of the *Instructor’s Manual*.
- Leave space between bullets.
- Give participants 9 “stickies” (sticky notes) when they come in and have them put initials on the stickies.
- Ask participants to place stickies next to activities that they do at their facility.
- Participants can write a question mark on the sticky if they are unsure if their facility does the activity.

**Background:**

- The opening slide for each module includes the module’s objectives.
Sources

- **Colorado**: Guidelines for Medication Administration: An Instructional Program for Training Unlicensed Personnel to Give Medication in Out-of-Home Child Care, Schools, and Camp Settings, Fifth Edition, 2008, developed by Healthy Child Care Colorado
- **New Jersey**: Medication Administration in Child Care developed by Healthy Child Care New Jersey
- **North Carolina**: Medication Administration in Child Care in North Carolina developed by the Quality Enhancement Project for Infants and Toddlers, with funding from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill
- **West Virginia**: Medication Administration: An Instructional Program for Teaching Non-Medical Personnel to Give Medication in Child Care Centers in West Virginia developed by Healthy Child Care West Virginia and the West Virginia Department of Health and Human Services
**Background:**

- The **full program** can be covered in 4-5 hours depending on how many activities are included and how much time is allowed for discussion.
- There are individual **objectives** for every module listed as well as these overall objectives.
- Outline your **schedule** for this course including hours, days, and modules covered.
- Review
  - Schedule
  - Location of rest rooms, drinking water
  - Roster: Did everyone sign in?
  - Turn off cell phones and pagers
- Have participants take the **Pre-test** found in Module 1, Background, in the **Participant’s Manual**
**Speaker’s Notes:**

- **Child’s clinical presentation** means the specifics for that particular child.
  - For example, some children might need a fever reducing medication even for low grade fevers because they are prone to febrile seizures. Their specific needs would guide the actual care that was given.
- Certain states, such as Connecticut, New York, Colorado, and Virginia, require certification for staff who administer medication. This curriculum does not necessarily fulfill those requirements.

**Background:**

- Your state regulations can be obtained at the National Resource Center for Health and Safety in Child Care and Early Education (NRC) Web site (http://nrckids.org/STATES/states.htm).
- Provide participants with the Web address for the NRC.
Speaker’s Notes:

Typical and routine medications for short-term use:
• Antibiotics
• Eye or ear drops
• Fever relievers and non-narcotic pain medications
• Ointments and creams used as a treatment for a skin condition
• Over-the-counter medications

Medications taken on a regular basis for chronic health conditions:
• Asthma medications, including inhalers and nebulizers will be covered in general, but further training on the specifics of asthma and using asthma medications is strongly encouraged.
• ADD/ADHD medications will be covered in general.
• Antidepressants
• Oral seizure medications
• Routine heart medications
• Medications for muscle spasms

Emergency medications:
• Antihistamines
Some medications need special knowledge and skills and are not covered in this program:

- Although training on the EpiPen® is important, it is best to take time to discuss what anaphylaxis is, how to recognize the symptoms, and what to do in addition to administering the EpiPen®. Further training on the specifics of anaphylaxis and using the EpiPen® is strongly encouraged. Resources on the EpiPen® are available in the Participant’s Manual, Additional Resources Section.

- Other subjects not covered include insulin, glucagon, and diabetes management for a child with diabetes at a facility. Training resources by diabetes educators often exist within diabetes centers and children’s hospitals.

- Some situations require a nurse, for instance, when giving a medication by injection.

- A nurse might also be necessary when clinical judgment is needed in giving a medication, such as heart medications based on heart rate.
Objectives

A. Knowledge: Each participant will be able to:
   1. Identify 3 reasons why medication is given in child care settings
   2. Identify common types of medication
   3. Describe ADA law and define liability
   4. Identify the members of the Responsibility Triangle
   5. Describe child care provider roles for giving medication in child care

B. Attitude: Each participant will be able to:
   1. State reasons that motivate child care providers to give medication
   2. State barriers that prevent child care providers from giving medication
   3. Express a desire to safely incorporate medical administration into their child care setting

C. Behavior: Each participant will:
   1. Take pre-test
   2. Participate in a brainstorm activity (Why Give Medication in Child Care?)
^^Flip Chart Activity:
**Why Give Medication in Child Care?**

- Engage participants in setting the stage for the training.

- Ask participants to provide examples of “Why should we give medication in child care”.

- Record suggestions on flip chart

- Include in the discussion societal public health issues that affect the health needs of children in child care.

- Potential Discussion Issues:
  - Children spending more hours in child care
  - Young children get sick more often than older children
  - Parents/guardians without child care alternatives
  - Inclusion and the Americans With Disabilities Act
  - Children with prematurity and other health needs who have been able to leave the hospital and are now surviving whereas they might not have
  - Increased incidence of asthma and food and other allergies
  - Some medications that were previously only available by prescription are now over-the-counter
  - Doctors’ and other health care professionals’ ability to diagnose and treat many conditions (eg, ADHD)
Additional examples:

• **Prevent illness**
  - Some asthma medications prevent an attack rather than treat it

• **Relieve symptoms**
  - Pain relievers
  - Antihistamines

• **Control or cure health problems**
  - **Short term**: Antibiotics for bacterial infections such as ear infections, pneumonia, or strep throat
  - **Emergency**: Epinephrine or antihistamines for allergic reactions
  - **Long term**: Insulin for diabetes

• Medication can be used for **more than one reason**.
  - For example, diaper cream can be preventative (like zinc oxide or petroleum-based creams) or therapeutic (like antifungal creams)
**Speaker's Notes:**

- These are the 3 main reasons for giving medication in the child care setting.
- All other medication should be given at home!

**CFOC, Standard 3.6.3.1:**

"The administration of medicines at the facility shall be limited to:

a) Prescription or non-prescription medication (over-the-counter [OTC]) ordered by the prescribing health professional for a specific child with written permission of the parent/guardian. Written orders from the prescribing health professional should specify medical need, medication, dosage, and length of time to give medication;

b) Labeled medications brought to the child care facility by the parent/guardian in the original container (with a label that includes the child’s name, date filled, prescribing clinician’s name, pharmacy name and phone number, dosage/instructions, and relevant warnings)."

**Background:**

- **CFOC** is a joint publication of the Maternal Child Health Bureau, the American Academy of Pediatrics, and the American Public Health Association which has been extensively researched and reviewed by multiple parties.

- Copies of **CFOC** can also be obtained at the NRC Web site (http://nrckids.org/CFOC/index.html) or print copies can be obtained through the AAP, National Association for the Education of Young Children, or Redleaf Press.

- It is recommended that the instructor have a copy of the **CFOC** on hand.

- It is recommended that the instructor have state-specific regulations available. For further questions on state regulations or to obtain your state regulations, go to the NRC Web site (http://nrckids.org/STATES/states.htm).
**Background:**

- CFOC, Standard 3.6.3.1 discusses this issue.
State Licensing Regulations

- Seek to ensure basic health and safety parameters
- Are minimal standards for a licensed program to operate legally

Best Practice Standards
- Are optimal standards to strive towards
- Publications, such as Caring for Our Children, attempt to set best practice standards

Speaker’s Notes:
- **State licensing regulations** are bottom line, non-negotiable, “do no harm” standards for the industry.

- Child care settings (centers and family child care homes) can always have policies and practices which exceed state licensing regulations, they just can’t operate below these limits.

- Regulations typically vary for family child care and center-based facilities.

- Regulations vary widely from state to state.

**Background:**
- Your state regulations can be obtained at the NRC Web site (http://nrckids.org/STATES/states.htm).
The American with Disabilities Act (ADA) is a federal law that does not require child care providers to give every medication, but does say that a child with special needs may not be excluded if reasonable accommodations to that child’s special needs can be made.

The Department of Justice maintains a toll-free line for technical assistance at 800/514-0301.

Providers can also refer to the ADA, Commonly Asked Questions About Child Care Centers and the Americans with Disabilities Act and the US Department of Justice, Child Care Centers and the Americans with Disabilities Act in Module 1, Background in the Participant’s Manual.
• Because of the increasing numbers of children in out-of-home child care settings today, child care providers are being asked more frequently to administer both prescription and over-the-counter drugs. This activity can involve liability, even when carried out properly.

• Standardized training, taught by licensed medical professionals, for designated staff, and well thought out policies, procedures, and documents all contribute to minimizing liability.

• Child care center directors and family child care providers should review their liability insurance policies for any stipulations relating to medication administration. (CFOC, Standard 9.4.1.1)
Speaker's Notes:

- Medication administration depends on **competence, caring, communication, and cooperation**.

- With ever increasing numbers of children in out-of-home settings, we need a **team effort** to reach this goal, and **communication is vital to this process**.

- The parent or guardian is usually the connection between the child care provider and the health care professional. A health consultant can explain and facilitate the process with parental permission.

- Health consultants are discussed in detail later in this module.

- Programs need written permission from parents to have health consultants access and discuss individual child’s health records and health issues.
Parent or Guardian Responsibilities

- Regular checkups and up-to-date immunizations
- Complete communication about child’s symptoms and health status
- Consulting with their child’s health care professional about diagnosis and care
- Compliance with medication policies and completion of forms
- Communication with health care professionals about the child care setting (environment, capabilities of staff, hours that the child attends)
Parent/Guardian Responsibilities, continued

- Asking the health care professional about whether medication can be given at home and NOT in child care
- Providing properly labeled medication and providing appropriate measuring devices
- Providing up-to-date emergency contact phone numbers
- Promptly picking up their child when notified of illness
- Arranging for back-up care
- Working constructively with child care providers to determine when it is appropriate to care for their child during mild illness
**Background:**
- *CFOC, Standard 3.6.3.3 recommends best practice for training in medication administration.*
Health Care Professional Responsibilities

- Complete all child care health forms legibly
- Discuss medication needs with parent or guardian and if needed, with child care providers, if parental permission is obtained
- Adapt medication schedules to meet the needs of children in child care and limit the number of doses that need to be given in child care
- Provide guidance and education as requested
- Promote disease prevention and good health practices
- Be accessible to child care staff for questions and concerns about their patients, with parental permission
Speaker’s Notes:

- All child care and school settings should have access to a health care professional who provides consultation and technical assistance on health issues in child care.
- Child Care Health Consultants are available in most states, but sometimes there is a fee associated with their services.
- In some states, there are limited numbers of Child Care Health Consultants available.
- In schools, this is usually a school nurse.
- Child care facilities often do not have an on-site health care professional, but, in many states, they can request child care health consultation from professionals with special expertise in topics as they relate to child care, such as:
  - infectious diseases
  - nutrition
  - socio-emotional development
  - emergency management
  - injury prevention
- The path for locating a health consultant varies from state to state.
- For more information, contact your local Child Care Resource & Referral Agency (CCR&R). To find your local CCR&R, visit www.naccrra.org.

**Background:**

- Discuss state-specific information on health consultants.
- Your state regulations can be obtained at the NRC Web site (http://nrckids.org/STATES/states.htm).

Speaker's Notes:

- Prescription medication, over-the-counter medication, and non-traditional/alternative medication can interact.
  - A health care professional should always supervise when these medications are given together.

- Prescription medications are often referred to as Rx.

- Over-the-counter medications are often referred to as OTC.
**Speaker's Notes:**

- **Authorized prescribers** vary by state and include physicians, nurse practitioners, and physician assistants.

- **Controlled substances** are discussed later in this curriculum. They include medications such as Ritalin® and phenobarbital.

- Sometimes families are given samples of medication by their health care professional. These samples should be properly labeled with the child’s name, the medication name and strength, and the expiration date, just as if they came from a pharmacy.
The Food and Drug Administration (FDA) decides whether a medication can be safely used by a consumer without the advice of a health care professional.

OTC medications are not harmless: Like prescription medications, OTCs can be very dangerous to a child if given incorrectly.

Best practice is that OTC medications administered in child care should have written authorization from the health care professional with prescriptive authority and parent or guardian written permission.

A prescription from an authorized health care professional is essential for any medication that does not have dosing information available. (This will be discussed further in Module 2).

Homeopathic Medication

• Active ingredients can be from plants, minerals, or animals.
• FDA regulates, but they are “exempt from manufacturing requirements, expiration dating and finished product testing for identity and strength.”

Herbal Medication

• Active ingredients from plants.
• Unregulated: no government standards for manufacturing or labeling.

Both Homeopathic and Herbal Medications

• Both homeopathic and herbal medications are sold over the counter, but dosage guidelines for young children do not exist.
• There is very little research on side effects/drug interactions.
• Homeopathic and herbal medications are not all regulated by the FDA and can have quality control issues. Some, especially those from outside of the country, have been found to have lead and other toxins. Your policy should address whether homeopathic and herbal medications will be administered given these concerns.
Speaker’s Notes:

- **Aspirin**
  - The National Reye’s Syndrome Foundation, the US Surgeon General, the United States Food and Drug Administration (US FDA), the Centers for Disease Control (CDC), and the American Academy of Pediatrics (AAP) recommend that aspirin and combination products containing aspirin not be given to children or teenagers who are suffering from influenza-like illnesses, chicken pox, and colds.
  - Child care providers should not be seeing aspirin alone or in combination products in child care.

**Background:**

- **Cough and Cold Medication**
  - In a given week, a cough and cold medication was used by 10% of US children. Children younger than 2 accounted for 5% to 10% of those children. Use of cough and cold medications declined during the study period from 1999-2006 from 12.3% to 8.4% [Source: Vernacchio L, et al. Cough and Cold Medication Use by US Children, 1999-2006: Results from the Slone Survey. Pediatrics. 2008;122(2):e323-e329.]
  - In January 2008, the AAP supported a public health advisory put out by the US FDA concerning cough and cold medications.
  - This advisory recommended that OTC cough and cold medications should not be used for infants and children under age 2 because of the risk of life threatening side effects.
  - For more information
    - [www.aap.org/publiced/BR_Infections.htm](http://www.aap.org/publiced/BR_Infections.htm)
    - [www.aap.org/publiced/BR_Medicine_OTC.htm](http://www.aap.org/publiced/BR_Medicine_OTC.htm)
Speaker’s Notes:

• Brand name medications are named by pharmaceutical companies.

• The names are often easier to say and remember than the generic names. For example:
  o Tylenol® = Acetaminophen
  o Motrin® = Ibuprofen
  o Benadryl® = Diphenhydramine
  o Zyrtec® = Cetirizine
  o Zithromax® = Azithromycin
  o Pulmicort® = Budesonide
  o Bactrim® or Septra® = Trimethoprim/sulfamethoxazole. (This is an example of 2 brand names and 1 generic name for the same medication.)

• Some medications are available as prescription and OTC as their brand name. They may also be available as a generic OTC at a lower cost.
  o Claritin® is an antihistamine which previously was only available by prescription.
  o Recently, it became available as OTC medication so now Claritin® can be purchased without a prescription.
  o Claritin’s® generic name is loratadine and it can be purchased OTC as well, usually at a lower price.
**Background:**

- Double click on the arrow icon to view video.
- The next 7 slides can be skipped if you watch the video or you can quickly review them to reinforce the video message.
- Having in-person equipment to demonstrate with is always helpful.
Speaker's Notes:

Tablets:
- **Coated and uncoated**: Swallow whole
- **Chewable**: Must be chewed, not swallowed whole
- **Scored**: May be cut in half

Capsules:
- **Swallow**: Do not crush or chew
- **Sprinkle**: Do so only with health care professional instruction

Coated and uncoated tablets (e.g., Advil® tablets).
Chewable tablets must be chewed and then swallowed (e.g., Tegretol®, amoxicillin).
Scored tablets may be split in 2 to give the appropriate dose. The tablet should be split in 2 by the pharmacist or parent (e.g., Ritalin®).
Un-scored tablets cannot always be divided evenly and the child would receive too much or too little medication.

Capsules:
- Capsules are taken by mouth and swallowed whole (e.g., antibiotics, Tamiflu®, cold medications).
- Sprinkles are contained in capsules. The contents are taken apart and sprinkled on food, as directed (e.g., Depakote® sprinkles which is a medication to prevent seizures).
**Speaker's Notes:**

**Liquids:**

- **Suspensions** are fluid substances with solid particles. They separate when left standing (e.g., amoxicillin and Ceclor®).

- **Syrup** or **Elixir** is a sweetened liquid that contains dissolved medication (e.g., Tylenol® elixir or prednisolone syrup).

- You **may** refrigerate oral liquid medication to make them taste more pleasant.
Speaker's Notes:

- Sublingual:
  - Speed of absorption varies by medication.
  - Some types of sublingual medication should not be swallowed whole.
  - Refer to the manufacturer's instructions.

- Melting strips and tablets:
  - Quick Dissolve strips are applied on top of tongue. They dissolve instantly when placed in a child's mouth (eg, Benadryl® Quick Dissolve Strip).
  - Quick Dissolving tablets also dissolve quickly when placed in the mouth (eg, Claritin® Redi-Tab).

- Gum applications (gels):
  - Rapid absorption; effects usually noted within 10 minutes.
  - This medication is rubbed directly on the gums inside the mouth.
  - Medication that is applied to the lips, such as lip balm, is not considered oral medication because it is not applied in the mouth or to the gums.
Speaker's Notes:

Topical:

- Includes eye drops, eye ointments, ear drops and ointments, creams and patches that are applied to the skin, and sprays.

- Medicated patches are devices that are applied to and remain on the skin that allow for the timed release of medication.
Speaker's Notes:

• Some drugs can be both prescription and OTC depending on their strength. They are considered OTC if the active ingredient is small in each dose.

• OTC ointments and creams that are used for preventive purposes, such as sunscreen, lip balm, skin creams, and diaper ointments, require parent written permission and all label instructions must be followed.
  - If the skin is broken or an allergic reaction is observed, discontinue use and notify the parent or guardian.
  - Include a statement on the parent written permission form that sunscreen or diaper ointment will not be applied to broken skin or in the presence of a severe or persistent rash without written authorization from the health care professional.
  - Check your state regulations.
  - CFOC, Standard 3.6.3.1.

• OTC ointments and creams used as a treatment for a skin condition such as broken skin, eczema, burn, or bleeding with severe diaper rash, require a written authorization from the health care professional and written parent permission.

**Background:**

• Your state regulations can be obtained at the NRC Web site (http://nrckids.org/STATES/states.htm).
Speaker's Notes:

• *Inhalants* are medication that are in a fine mist or powder which can be breathed into the body through the nose or mouth.

• *Metered dose inhalant* is propelled into the mouth by pressurized gas and is inhaled into the lungs.
  - The medication is better delivered if a spacer tube is used between the inhaler and the mouth.
  - The inhalant gas has been changed to HFA to be more environmentally friendly.

• A *nebulizer* machine turns liquid medication into a fine mist which is inhaled.

• *Powders* come in different devices where a set amount of medicated powder is inhaled or sucked in from the device.
  - The device often turns and clicks to drop the dose into place so it can be inhaled.

• *Nasal spray* delivers medication into the nose through a spray.
  - Medication is absorbed in the nasal cavity, effects will be noted within 10 to 15 minutes.
  - Children may complain of an unpleasant taste in their mouth after receiving nasal medication.
Speaker's Notes:

- **Injectable** medications are administered by a registered nurse (RN) or may be delegated to school or child care personnel and supervised by a RN or school registered nurse, depending on state regulation.

- **Emergency injectables**, such as the EpiPen® and EpiPen® Jr, are administered during a severe and life-threatening allergic reaction. A written health care plan is necessary. Consult your state regulations for guidelines about how EpiPen injection is taught and administered. Your state regulations can be obtained at the NRC Web site (http://nrckids.org/STATES/states.htm).

- **Other injectables**, such as insulin or glucagon, require an individualized written health care plan, individualized training, 1-to-1 delegation and supervision, as determined appropriate by the RN.

- The administration of injectable medication is not part of this curriculum.
**Speaker's Notes:**

- Rectal medications are inserted into the rectum and **require special monitoring**.
- Occasionally, suppositories will be designed to be inserted in areas other than the rectum.
- The administration of rectal medication is not part of this curriculum.

**Background:**

- Your state regulations can be obtained at the NRC Web site (http://nrckids.org/STATES/states.htm).
Welcome Activity

Prepare flip chart pages with the bullets below written on them. Leave space between the bullets. Participants should be handed 9 “stickies” (dots or Post-it® notes) when they come in and be instructed to put their initials on the stickies. Participants should be instructed to place the stickies next to the activity if they do that activity at their site. They can write a question mark on the sticky if they are unsure if they do the activity at their site. (If no stickies are available, the participants can write their initials on the flip chart).

Once the group has assembled, the instructor should note that these topics will all be discussed. This will create a good transition to the objectives slide.

- Give medications to enrolled children
- Have a child care health consultant
- Have a written medication administration policy
- Have a locked place to store medication at the facility
- Apply sunscreen to children before they play outside
- Have a program checklist that uses the “5 Rights” for giving medication correctly
- Use a separate medication administration record sheet for each child receiving medication
- Have a written policy/procedure to respond to medication errors/incidents
- Have a written policy/procedure to handle medication side effects or reactions
Medication Administration in Child Care Pre-test and Answer Key

Instructions: If select modules were presented, participants should only fill out the questions related to those modules. Have participants circle the letter of the choice that best completes the statement or answers the question.

MODULE 1

1. The Americans with Disabilities Act states that a reasonable accommodation includes:
   a. Giving medication ONLY if the child care facility receives federal funding
   b. Giving medication to children with ongoing special health needs
   c. Admitting a child with special health care needs but not giving medication
   d. None of the above

2. Medication available without a health care professional’s note or pharmacy label is called:
   a. Prescription medication
   b. Over-the-counter (OTC) medication
   c. Non-toxic medication
   d. None of the above

3. Matching: In the blanks next to each definition below, enter the number of the word that corresponds to the definition.

<table>
<thead>
<tr>
<th>Word List</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>3. Medication that is administered by breathing it into the respiratory system (for example, a mist or spray medication)</td>
</tr>
<tr>
<td>Topical</td>
<td>2. Medication in lotion, cream, ointment, spray, or other form for external application for skin or other medical problems</td>
</tr>
<tr>
<td>Inhalation</td>
<td>5. Form of medication that is inserted into the rectum</td>
</tr>
<tr>
<td>Injectable</td>
<td>1. Medication that is put into the mouth such as tablets, capsules, and liquid medication</td>
</tr>
<tr>
<td>Suppository</td>
<td>4. Medication that is put into the body with a needle or other device that rapidly puts the medication through the skin surface, such as the EpiPen®, Glucagon®, and insulin.</td>
</tr>
</tbody>
</table>
Module 2

4. Your facility policy should include all of the following:
   a. Who will administer medication and who the alternate person will be
   b. What medication will be given
   c. Where and how medication will be stored
   d. Procedure for medication error or incident
   e. All of the above

5. A mother brings in some chewable tablets that she took from a bottle of medication that she says her daughter’s health care professional prescribed the day before. The mother is keeping the main supply of the medication at home. She fills out the program forms to give permission to the staff to give the medication at noon to her child. What is the most appropriate thing for the child care provider to do?
   a. Call the health care professional immediately to see if it is okay to give the medication
   b. Give the medication to the child if it looks/smells okay
   c. Refuse to give the medication
   d. Don’t know

6. When receiving a medication you should:
   a. Match the label with permissions and instructions
   b. Ask the parent/guardian about successful techniques that he has used to administer the medication
   c. Ask the parent/guardian about when the medication was last administered
   d. All of the above

7. A guardian brings you medication for her child. After receiving the medication, your next step should be to:
   a. Sort the medication for ease of delivery
   b. Log in medication and store it
   c. Administer the medication within the next 3 hours
   d. Don’t know

8. All of the following are steps in the process of receiving medications EXCEPT:
   a. Match the label with the instructions
   b. Check if container is labeled child-resistant
   c. Check expiration date
   d. Ensure that the child receives a dose that same day
Module 3

9. Ways to tell if you have the Right child include all of the following EXCEPT:
   a. Knowing the child from your experience
   b. Asking the child if she is the name that appears on the label
   c. Having a photo of the child attached to the medication administration paperwork
   d. Having another staff member who is familiar with the child verify her identity

10. Administering the Right dose of medication involves all of the following EXCEPT:
    a. Checking the label and the permission form to see if they match.
    b. Using a measuring device
    c. Verifying the dose with the child
    d. Checking the measuring device at eye level

11. Which of the following is an example of an “as needed medication”?
    a. Tylenol® for fever
    b. Albuterol® for wheezing
    c. Amoxicillin for ear infection
    d. A and B
    e. All of the above

12. A child refuses to take her medication. In order to get the child to comply, you consider mixing the medication with her favorite beverage. Before doing so you should:
    a. Split the medication into 2 doses to ensure that the child takes her full dosage
    b. Check with the health care professional or pharmacist before mixing medications with food or beverages
    c. Give the child a small portion of the beverage prior to mixing the medication into it
    d. None of the above

13. A young toddler in your care is refusing to take a dose of antibiotic. You should:
    a. Mix it in the child’s bottle
    b. Hold his nose until he opens his mouth
    c. Refuse to give the child the medication
    d. Give the child the choice of what drink he wants after taking the medication
Module 4

14. **Please read the scenario and enter the information into the medication log below.**

   Scenario: Today, you give Nick one 125 mg capsule of Depakote® sprinkles at 12:00 PM.

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

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>AM</th>
<th>PM</th>
<th>AM</th>
<th>PM</th>
<th>AM</th>
<th>PM</th>
<th>AM</th>
<th>PM</th>
<th>AM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actual time given</th>
<th>AM</th>
<th>AM</th>
<th>AM</th>
<th>AM</th>
<th>AM</th>
<th>PM</th>
<th>PM</th>
<th>PM</th>
<th>PM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>PM</td>
<td>AM</td>
<td>PM</td>
<td>AM</td>
<td>PM</td>
<td>AM</td>
<td>PM</td>
<td>AM</td>
<td>PM</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dosage/amount</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Route</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff signature</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Module 5

15. Upset stomach, diarrhea, dry mouth, changes in mood, and drowsiness after taking a medication are all examples of:
   a. Effective medication
   b. Medication errors
   c. Side effects
   d. Overdose of medication

16. When calling Poison Control, you should have which of the following information available?
   a. The medication container
   b. The child’s current weight
   c. The child’s Emergency Contact Form
   d. All of the above
   e. None of the above

17. In which of the following situations should Poison Control be called:
   a. The child refuses to take his medication
   b. You give the wrong medication to a child
   c. You give a medication to the wrong child
   d. B and C

18. A child takes his medication in his mouth and then spits it out. What actions should be performed?
   a. Notify the parent/guardian
   b. Repeat the dose
   c. Fill out a medication incident report
   d. A and C
   e. All of the above

19. It is 2:00 PM and you realize that you forgot to give a dose of medication that was due at 12:00 PM. The first thing you should do is:
   a. Give the dose right away
   b. Document the missed dose and notify the parent
   c. Contact the child’s doctor
   d. Contact the pharmacy to get the pharmacist’s advice
Medication Administration in Child Care Pre-test

Instructions: Circle the letter of the choice that best completes the statement or answers the question.

MODULE 1

1. The Americans with Disabilities Act states that a reasonable accommodation includes:
   a. Giving medication ONLY if the child care facility receives federal funding
   b. Giving medication to children with ongoing special health needs
   c. Admitting a child with special health care needs but not giving medication
   d. None of the above

2. Medication available without a health care professional’s note or pharmacy label is called:
   a. Prescription medication
   b. Over-the-counter (OTC) medication
   c. Non-toxic medication
   d. None of the above

3. Matching: In the blanks next to each definition below, enter the number of the word that corresponds to the definition.

<table>
<thead>
<tr>
<th>Word List</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Oral</td>
<td>Medication that is administered by breathing it into the respiratory system (for example, a mist or spray medication)</td>
</tr>
<tr>
<td>2. Topical</td>
<td>Medication in lotion, cream, ointment, spray, or other form for external application for skin or other medical problems</td>
</tr>
<tr>
<td>3. Inhalation</td>
<td>Form of medication that is inserted into the rectum</td>
</tr>
<tr>
<td>4. Injectable</td>
<td>Medication that is put into the mouth such as tablets, capsules, and liquid medication</td>
</tr>
<tr>
<td>5. Suppository</td>
<td>Medication that is put into the body with a needle or other device that rapidly puts the medication through the skin surface, such as the EpiPen®, Glucagon®, and insulin.</td>
</tr>
</tbody>
</table>
Module 2

4. **Your facility policy should include all of the following:**
   a. Who will administer medication and who the alternate person will be
   b. What medication will be given
   c. Where and how medication will be stored
   d. Procedure for medication error or incident
   e. All of the above

5. **A mother brings in some chewable tablets that she took from a bottle of medication that she says her daughter’s health care professional prescribed the day before. The mother is keeping the main supply of the medication at home. She fills out the program forms to give permission to the staff to give the medication at noon to her child. What is the most appropriate thing for the child care provider to do?**
   a. Call the health care professional immediately to see if it is okay to give the medication
   b. Give the medication to the child if it looks/smells okay
   c. Refuse to give the medication
   d. Don’t know

6. **When receiving a medication you should:**
   a. Match the label with permissions and instructions
   b. Ask the parent/guardian about successful techniques that he has used to administer the medication
   c. Ask the parent/guardian about when the medication was last administered
   d. All of the above

7. **A guardian brings you medication for her child. After receiving the medication, your next step should be to:**
   a. Sort the medication for ease of delivery
   b. Log in medication and store it
   c. Administer the medication within the next 3 hours
   d. Don’t know

8. **All of the following are steps in the process of receiving medications EXCEPT:**
   a. Match the label with the instructions
   b. Check if container is labeled child-resistant
   c. Check expiration date
   d. Ensure that the child receives a dose that same day
Module 3

9. **Ways to tell if you have the Right child include all of the following EXCEPT:**
   a. Knowing the child from your experience
   b. Asking the child if she is the name that appears on the label
   c. Having a photo of the child attached to the medication administration paperwork
   d. Having another staff member who is familiar with the child verify her identity

10. **Administering the Right dose of medication involves all of the following EXCEPT:**
   a. Checking the label and the permission form to see if they match.
   b. Using a measuring device
   c. Verifying the dose with the child
   d. Checking the measuring device at eye level

11. **Which of the following is an example of an “as needed medication”?**
   a. Tylenol® for fever
   b. Albuterol® for wheezing
   c. Amoxicillin for ear infection
   d. A and B
   e. All of the above

12. **A child refuses to take her medication. In order to get the child to comply, you consider mixing the medication with her favorite beverage. Before doing so you should:**
   a. Split the medication into 2 doses to ensure that the child takes her full dosage
   b. Check with the health care professional or pharmacist before mixing medications with food or beverages
   c. Give the child a small portion of the beverage prior to mixing the medication into it
   d. None of the above

13. **A young toddler in your care is refusing to take a dose of antibiotic. You should:**
   a. Mix it in the child’s bottle
   b. Hold his nose until he opens his mouth
   c. Refuse to give the child the medication
   d. Give the child the choice of what drink he wants after taking the medication
14. Please read the scenario and enter the information into the medication log below.

Scenario: Today, you give Nick one 125 mg capsule of Depakote® sprinkles at 12:00 PM.

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<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>
<tr>
<td>Dosage/amount</td>
<td>PM ______</td>
<td>PM ______</td>
<td>PM ______</td>
<td>PM ______</td>
<td>PM ______</td>
</tr>
<tr>
<td>Route</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff signature</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name of child ____________________________ Weight of child ____________________________

Medication Log
PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER
Module 5

15. Upset stomach, diarrhea, dry mouth, changes in mood, and drowsiness after taking a medication are all examples of:
   a. Effective medication
   b. Medication errors
   c. Side effects
   d. Overdose of medication

16. When calling Poison Control, you should have which of the following information available?
   a. The medication container
   b. The child’s current weight
   c. The child’s Emergency Contact Form
   d. All of the above
   e. None of the above

17. In which of the following situations should Poison Control be called:
   a. The child refuses to take his medication
   b. You give the wrong medication to a child
   c. You give a medication to the wrong child
   d. B and C

18. A child takes his medication in his mouth and then spits it out. What actions should be performed?
   a. Notify the parent/guardian
   b. Repeat the dose
   c. Fill out a medication incident report
   d. A and C
   e. All of the above

19. It is 2:00 PM and you realize that you forgot to give a dose of medication that was due at 12:00 PM. The first thing you should do is:
   a. Give the dose right away
   b. Document the missed dose and notify the parent
   c. Contact the child’s doctor
   d. Contact the pharmacy to get the pharmacist’s advice
Flip Chart Activity: Why Give Medication in Child Care?

- Engage participants in setting the stage for the training.

- Elicit discussion regarding current practices and what they see as issues in their child care settings.

- Include in the discussion societal public health issues that affect the health needs of children in child care.

- Potential discussion issues:
  - Children spending more hours in child care
  - Young children get sick more often than older children
  - Parents/guardians without child care alternatives
  - Inclusion and the Americans With Disabilities Act
  - Children with prematurity and other health needs who have been able to leave the hospital and are now surviving whereas they might not have survived previously
  - Increased incidence of asthma and food and other allergies
  - Some medications that were previously only available by prescription are now over-the-counter
  - Doctors’ and other health care professionals’ ability to diagnose and treat many conditions (eg, ADHD)
AMERICANS WITH DISABILITIES ACT

COMMONLY ASKED QUESTIONS RELATED TO GIVING MEDICINE IN CHILD CARE

The Americans with Disabilities Act (ADA), passed July 26, 1990 as Public Law 101-336 (42 U.S.C. Sec. 12101 et seq.), became effective on January 26, 1992. The ADA requires that child care provider/directors not discriminate against persons with disabilities on the basis of disability, that is, that they provide children and parent/guardians with disabilities with an equal opportunity to participate in child care programs and services. Child care facilities must make reasonable modifications to their policies and practices, such as giving medicine, to integrate children with disabilities.

1. Q: Does the Americans with Disabilities Act -- or “ADA” -- apply to child care centers? What about family child care homes?

A: Yes. Almost all child care facilities, even small, home-based centers regardless of size or number of employees, must comply with title III of the ADA. Child care services provided by government agencies must comply with title II. The exception is child care centers that are actually run by religious entities such as churches, mosques, or synagogues. Activities controlled by religious organizations are not covered by title III.

2. Q: Our facility has a policy that we will not give medication to any child. Can I refuse to give medication to a child with a disability?

A: No. In some circumstances, it may be necessary to give medication to a child with a disability in order to make a program accessible to that child. Disabilities include any physical or mental impairment that substantially limits one or more major life activities including asthma, diabetes, seizure disorders, or attention deficit hyperactivity disorder (ADHD).

3. Q: What about children who have severe, sometimes life-threatening allergies to bee stings or certain foods? Do we have to take them?

A: Generally, yes. Children cannot be excluded on the sole basis that they have been identified as having severe allergies to bee stings or certain foods. A child care facility needs to be prepared to take appropriate steps in the event of an allergic reaction, such as administering a medicine called “epinephrine” that will be provided in advance by the child’s parents or guardians.

4. Q: What about children with diabetes? Do we have to admit them to our program? If we do, do we have to test their blood sugar levels?

A: Generally, yes. Children with diabetes should not be excluded from the program on the basis of their diabetes. Providers should obtain written authorization from the child’s parents or guardians and physician and follow their directions for simple diabetes-related care. In most instances, they will authorize the provider to monitor the child’s blood sugar – or “blood glucose”. The child’s parents or guardians are responsible for providing all appropriate testing equipment, training, and special food necessary for the child.

5. Q: What about children with asthma? Do we have to admit them to our program?

A: Generally, yes. Children with asthma should not be excluded from the program on the basis of their medical condition. Providers should obtain written authorization from the child’s parents or guardians and physician and follow their directions for asthma care.

6. Q: Are there any reference books or video tapes that might help me further understand the obligations of child care providers under title III?

A: Yes, the Arc published All Kids Count: Child Care and the ADA, which addresses the ADA’s obligations of child care providers. Copies are available by calling 1-800-433-5255. For general information child care providers may call the Department of Justice Information Line at 1-800-514-0301.

Source: The ADA Home Page: www.usdoj.gov/crt/ada/adahom1.htm

Adapted from © 2006 UNC-CH/MCH and NC DHHS/DCD. Reprinted with permission from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill.

For a similar resource in Spanish, please visit http://www.childcarelaw.org/documents/ADASpanishTranslation-October2012.pdf
Privately-run child care centers - like other public accommodations such as private schools, recreation centers, restaurants, hotels, movie theaters, and banks must comply with title III of the Americans with Disabilities Act (ADA). Child care services provided by State and local government agencies, such as Head Start, summer programs, and extended school day programs, must comply with title II of the ADA. Both titles apply to a child care center's interactions with the children, parents, guardians, and potential customers that it serves.

COMMONLY ASKED QUESTIONS ABOUT CHILD CARE CENTERS AND THE AMERICANS WITH DISABILITIES ACT

Coverage

1. Q: Does the Americans with Disabilities Act -- or "ADA" -- apply to child care centers?

A: Yes. Privately-run child care centers -- like other public accommodations such as private schools, recreation centers, restaurants, hotels, movie theaters, and banks -- must comply with title III of the ADA. Child care services provided by government agencies, such as Head Start, summer programs, and extended school day programs, must comply with title II of the ADA. Both titles apply to a child care center's interactions with the children, parents, guardians, and potential customers that it serves.

A child care center's employment practices are covered by other parts of the ADA and are not addressed here. For more information about the ADA and employment practices, please call the Equal Employment Opportunity Commission (see question 30).
2. Q: Which child care centers are covered by title III?

A: Almost all child care providers, regardless of size or number of employees, must comply with title III of the ADA. Even small, home-based centers that may not have to follow some State laws are covered by title III.

The exception is child care centers that are actually run by religious entities such as churches, mosques, or synagogues. Activities controlled by religious organizations are not covered by title III.

Private child care centers that are operating on the premises of a religious organization, however, are generally not exempt from title III. Where such areas are leased by a child care program not controlled or operated by the religious organization, title III applies to the child care program but not the religious organization. For example, if a private child care program is operated out of a church, pays rent to the church, and has no other connection to the church, the program has to comply with title III but the church does not.

General Information

3. Q: What are the basic requirements of title III?

A: The ADA requires that child care providers not discriminate against persons with disabilities on the basis of disability, that is, that they provide children and parents with disabilities with an equal opportunity to participate in the child care center's programs and services. Specifically:

- Centers cannot exclude children with disabilities from their programs unless their presence would pose a direct threat to the health or safety of others or require a fundamental alteration of the program.

- Centers have to make reasonable modifications to their policies and practices to integrate children, parents, and guardians with disabilities into their programs unless doing so would constitute a fundamental alteration.

- Centers must provide appropriate auxiliary aids and services needed for effective communication with children or adults with disabilities, when doing so would not constitute an undue burden.

- Centers must generally make their facilities accessible to persons with disabilities. Existing facilities are subject to the readily achievable standard for barrier removal, while newly constructed facilities and any altered portions of existing facilities must be fully accessible.

4. Q: How do I decide whether a child with a disability belongs in my program?

A: Child care centers cannot just assume that a child's disabilities are too severe for the child to be integrated successfully into the center's child care program. The center must make an individualized assessment about whether it can meet the particular needs of the child without fundamentally altering its program. In making this assessment, the caregiver must not react to unfounded preconceptions or stereotypes about what children with disabilities can or cannot do, or how much assistance they may require. Instead, the caregiver should talk to the parents or guardians and any other professionals (such as educators or health care professionals) who work with the child in other contexts. Providers are often surprised at how simple it is to include children with disabilities in their mainstream programs.
Child care centers that are accepting new children are not required to accept children who would pose a direct threat (see question 8) or whose presence or necessary care would fundamentally alter the nature of the child care program.

5. Q: My insurance company says it will raise our rates if we accept children with disabilities. Do I still have to admit them into my program?

A: Yes. Higher insurance rates are not a valid reason for excluding children with disabilities from a child care program. The extra cost should be treated as overhead and divided equally among all paying customers.

6. Q: Our center is full and we have a waiting list. Do we have to accept children with disabilities ahead of others?

A: No. Title III does not require providers to take children with disabilities out of turn.

7. Q: Our center specializes in "group child care." Can we reject a child just because she needs individualized attention?

A: No. Most children will need individualized attention occasionally. If a child who needs one-to-one attention due to a disability can be integrated without fundamentally altering a child care program, the child cannot be excluded solely because the child needs one-to-one care.

For instance, if a child with Down Syndrome and significant mental retardation applies for admission and needs one-to-one care to benefit from a child care program, and a personal assistant will be provided at no cost to the child care center (usually by the parents or though a government program), the child cannot be excluded from the program solely because of the need for one-to-one care. Any modifications necessary to integrate such a child must be made if they are reasonable and would not fundamentally alter the program. This is not to suggest that all children with Down Syndrome need one-to-one care or must be accompanied by a personal assistant in order to be successfully integrated into a mainstream child care program. As in other cases, an individualized assessment is required. But the ADA generally does not require centers to hire additional staff or provide constant one-to-one supervision of a particular child with a disability.

8. Q: What about children whose presence is dangerous to others? Do we have to take them, too?

A: No. Children who pose a direct threat -- a substantial risk of serious harm to the health and safety of others -- do not have to be admitted into a program. The determination that a child poses a direct threat may not be based on generalizations or stereotypes about the effects of a particular disability; it must be based on an individualized assessment that considers the particular activity and the actual abilities and disabilities of the individual.

In order to find out whether a child has a medical condition that poses a significant health threat to others, child care providers may ask all applicants whether a child has any diseases that are communicable through the types of incidental contact expected to occur in child care settings. Providers may also inquire about specific conditions, such as active infectious tuberculosis, that in fact pose a direct threat.
The ADA Home Page, which is updated frequently, contains the Department of Justice's regulations and technical assistance materials, as well as press releases on ADA cases and other issues. Several settlement agreements with child care centers are also available on the Home Page.

www.usdoj.gov/crt/ada/adahom1.htm

The Department of Justice also operates an ADA Electronic Bulletin Board, on which a wide variety of information and documents are available.

202-514-6193 (by computer modem)

There are ten regional Disability and Business Technical Assistance Centers, or DBTAC’s, that are funded by the Department of Education to provide technical assistance under the ADA. One toll-free number connects to the center in your region.

800-949-4232 (voice & TDD)

The Access Board offers technical assistance on the ADA Accessibility Guidelines.

800-872-2253 (voice)

800-993-2822 (TDD)

Electronic Bulletin Board

202-272-5448

Source: http://www.usdoj.gov/crt/ada/childq&a.htm

Note: Reproduction of this document is encouraged.

10/97
9. Q: One of the children in my center hits and bites other children. His parents are now saying that I can't expel him because his bad behavior is due to a disability. What can I do?

A: The first thing the provider should do is try to work with the parents to see if there are reasonable ways of curbing the child's bad behavior. He may need extra naps, "time out," or changes in his diet or medication. If reasonable efforts have been made and the child continues to bite and hit children or staff, he may be expelled from the program even if he has a disability. The ADA does not require providers to take any action that would pose a *direct threat* -- a substantial risk of serious harm -- to the health or safety of others. Centers should not make assumptions, however, about how a child with a disability is likely to behave based on their past experiences with other children with disabilities. Each situation must be considered individually.

10. Q: One of the children in my center has parents who are deaf. I need to have a long discussion with them about their child's behavior and development. Do I have to provide a sign language interpreter for the meeting?

A: It depends. Child care centers must provide effective communication to the customers they serve, including parents and guardians with disabilities, unless doing so poses an undue burden. The person with a disability should be consulted about what types of auxiliary aids and services will be necessary in a particular context, given the complexity, duration, and nature of the communication, as well as the person's communication skills and history. Different types of auxiliary aids and services may be required for lengthy parent-teacher conferences than will normally be required for the types of incidental day-to-day communication that take place when children are dropped off or picked up from child care. As with other actions required by the ADA, providers cannot impose the cost of a qualified sign language interpreter or other auxiliary aid or service on the parent or guardian.

A particular auxiliary aid or service is not required by title III if it would pose an *undue burden*, that is, a significant difficulty or expense, relative to the center or parent company's resources.

11. Q: We have a "no pets" policy. Do I have to allow a child with a disability to bring a service animal, such as a seeing eye dog?

A: Yes. A service animal is **not** a pet. The ADA requires you to modify your "no pets" policy to allow the use of a service animal by a person with a disability. This does not mean that you must abandon your "no pets" policy altogether, but simply that you must make an exception to your general rule for service animals.

12. Q: If an older child has delayed speech or developmental disabilities, can we place that child in the infant or toddler room?

A: Generally, no. Under most circumstances, children with disabilities must be placed in their age-appropriate classroom, unless the parents or guardians agree otherwise.

13. Q: Can I charge the parents for special services provided to a child with a disability, provided that the charges are reasonable?

A: It depends. If the service is required by the ADA, you cannot impose a surcharge for it. It is only if you go beyond what is required by law that you can charge for those services. For instance, if a child requires complicated medical procedures that can only be done by licensed medical personnel, and the center does not normally have such personnel on staff, the center would not be required to provide the
medical services under the ADA. If the center chooses to go beyond its legal obligation and provide the services, it may charge the parents or guardians accordingly. On the other hand, if a center is asked to do simple procedures that are required by the ADA -- such as finger-prick blood glucose tests for children with diabetes (see question 20) -- it cannot charge the parents extra for those services. To help offset the costs of actions or services that are required by the ADA, including but not limited to architectural barrier removal, providing sign language interpreters, or purchasing adaptive equipment, some tax credits and deductions may be available (see question 24).

Personal Services

14. Q: Our center has a policy that we will not give medication to any child. Can I refuse to give medication to a child with a disability?

A: No. In some circumstances, it may be necessary to give medication to a child with a disability in order to make a program accessible to that child. While some state laws may differ, generally speaking, as long as reasonable care is used in following the doctors' and parents' or guardians written instructions about administering medication, centers should not be held liable for any resulting problems. Providers, parents, and guardians are urged to consult professionals in their state whenever liability questions arise.

15. Q: We diaper young children, but we have a policy that we will not accept children more than three years of age who need diapering. Can we reject children older than three who need diapering because of a disability?

A: Generally, no. Centers that provide personal services such as diapering or toileting assistance for young children must reasonably modify their policies and provide diapering services for older children who need it due to a disability. Generally speaking, centers that diaper infants should diaper older children with disabilities when they would not have to leave other children unattended to do so.

Centers must also provide diapering services to young children with disabilities who may need it more often than others their age.

Some children will need assistance in transferring to and from the toilet because of mobility or coordination problems. Centers should not consider this type of assistance to be a "personal service."

16. Q: We do not normally diaper children of any age who are not toilet trained. Do we still have to help older children who need diapering or toileting assistance due to a disability?

A: It depends. To determine when it is a reasonable modification to provide diapering for an older child who needs diapering because of a disability and a center does not normally provide diapering, the center should consider factors including, but not limited to, (1) whether other non-disabled children are young enough to need intermittent toileting assistance when, for instance, they have accidents; (2) whether providing toileting assistance or diapering on a regular basis would require a child care provider to leave other children unattended; and (3) whether the center would have to purchase diapering tables or other equipment.

If the program never provides toileting assistance to any child, however, then such a personal service would not be required for a child with a disability. Please keep in mind that even in these circumstances, the child could not be excluded from the program because he or she was not toilet trained if the center can make other arrangements, such as having a parent or personal assistant come and do the diapering.
**Issues Regarding Specific Disabilities**

17. Q: Can we exclude children with HIV or AIDS from our program to protect other children and employees?

A: No. Centers cannot exclude a child solely because he has HIV or AIDS. According to the vast weight of scientific authority, HIV/AIDS cannot be easily transmitted during the types of incidental contact that take place in child care centers. Children with HIV or AIDS generally can be safely integrated into all activities of a child care program. Universal precautions, such as wearing latex gloves, should be used whenever caregivers come into contact with children's blood or bodily fluids, such as when they are cleansing and bandaging playground wounds. This applies to the care of all children, whether or not they are known to have disabilities.

18. Q: Must we admit children with mental retardation and include them in all center activities?

A: Centers cannot generally exclude a child just because he or she has mental retardation. The center must take reasonable steps to integrate that child into every activity provided to others. If other children are included in group sings or on playground expeditions, children with disabilities should be included as well. Segregating children with disabilities is not acceptable under the ADA.

19. Q: What about children who have severe, sometimes life-threatening allergies to bee stings or certain foods? Do we have to take them?

A: Generally, yes. Children cannot be excluded on the sole basis that they have been identified as having severe allergies to bee stings or certain foods. A center needs to be prepared to take appropriate steps in the event of an allergic reaction, such as administering a medicine called "epinephrine" that will be provided in advance by the child's parents or guardians.

The Department of Justice's settlement agreement with La Petite Academy addresses this issue and others (see question 26).

20. Q: What about children with diabetes? Do we have to admit them to our program? If we do, do we have to test their blood sugar levels?

A: Generally, yes. Children with diabetes can usually be integrated into a child care program without fundamentally altering it, so they should not be excluded from the program on the basis of their diabetes. Providers should obtain written authorization from the child's parents or guardians and physician and follow their directions for simple diabetes-related care. In most instances, they will authorize the provider to monitor the child's blood sugar -- or "blood glucose" -- levels before lunch and whenever the child appears to be having certain easy-to-recognize symptoms of a low blood sugar incident. While the process may seem uncomfortable or even frightening to those unfamiliar with it, monitoring a child's blood sugar is easy to do with minimal training and takes only a minute or two. Once the caregiver has the blood sugar level, he or she must take whatever simple actions have been recommended by the child's parents or guardians and doctor, such as giving the child some fruit juice if the child's blood sugar level is low. The child's parents or guardians are responsible for providing all appropriate testing equipment, training, and special food necessary for the child.

The Department of Justice's settlement agreements with KinderCare and La Petite Academy address this issue and others (see question 26).
21. Q: Do we have to help children take off and put on their leg braces and provide similar types of assistance to children with mobility impairments?

A: Generally, yes. Some children with mobility impairments may need assistance in taking off and putting on leg or foot braces during the child care day. As long as doing so would not be so time consuming that other children would have to be left unattended, or so complicated that it can only be done by licensed health care professionals, it would be a reasonable modification to provide such assistance.

The Department of Justice's settlement agreement with the Sunshine Child Center of Gillett, Wisconsin, addresses this issue and others (see question 26).

**Making the Child Care Facility Accessible**

22. Q: How do I make my child care center's building, playground, and parking lot accessible to people with disabilities?

A: Even if you do not have any disabled people in your program now, you have an ongoing obligation to remove barriers to access for people with disabilities. Existing privately-run child care centers must remove those architectural barriers that limit the participation of children with disabilities (or parents, guardians, or prospective customers with disabilities) if removing the barriers is readily achievable, that is, if the barrier removal can be easily accomplished and can be carried out without much difficulty or expense. Installing offset hinges to widen a door opening, installing grab bars in toilet stalls, or rearranging tables, chairs, and other furniture are all examples of barrier removal that might be undertaken to allow a child in a wheelchair to participate in a child care program. Centers run by government agencies must insure that their programs are accessible unless making changes imposes an undue burden; these changes will sometimes include changes to the facilities.

23. Q: We are going to build a new facility. What architectural standards do we have to follow to make sure that our facility is accessible to people with disabilities?

A: Newly constructed privately-run child care centers -- those designed and constructed for first occupancy after January 26, 1993 -- must be readily accessible to and usable by individuals with disabilities. This means that they must be built in strict compliance with the ADA Standards for Accessible Design. New centers run by government agencies must meet either the ADA Standards or the Uniform Federal Accessibility Standards.

**Tax Provisions**

24. Q: Are there tax credits or deductions available to help offset the costs associated with complying with the ADA?

A: To assist businesses in complying with the ADA, Section 44 of the IRS Code allows a tax credit for small businesses and Section 190 of the IRS Code allows a tax deduction for all businesses.

The tax credit is available to businesses that have total revenues of $1,000,000 or less in the previous tax year or 30 or fewer full-time employees. This credit can cover 50% of the eligible access expenditures in a year up to $10,250 (maximum credit of $5,000). The tax credit can be used to offset the cost of complying with the ADA, including, but not limited to, undertaking barrier removal and alterations to improve accessibility; provide sign language interpreters; and for purchasing certain adaptive equipment.
The tax deduction is available to all businesses with a maximum deduction of $15,000 per year. The tax deduction can be claimed for expenses incurred in barrier removal and alterations.

To order documents about the tax credit and tax deduction provisions, contact the Department of Justice's ADA Information Line (see question 30).

**The Department of Justice's Enforcement Efforts**

25. **Q: What is the Department of Justice's enforcement philosophy regarding title III of the ADA?**

**A:** Whenever the Department receives a complaint or is asked to join an on-going lawsuit, it first investigates the allegations and tries to resolve them through informal or formal settlements. The vast majority of complaints are resolved voluntarily through these efforts. If voluntary compliance is not forthcoming, the Department may have to litigate and seek injunctive relief, damages for aggrieved individuals, and civil penalties.

26. **Q: Has the United States entered into any settlement agreements involving child care centers?**

**A:** The Department has resolved three matters through formal settlement agreements with the Sunshine Child Center, KinderCare Learning Centers, and La Petite Academy.

- In the first agreement, Sunshine Child Center in Gillett, Wisconsin, agreed to: (1) provide diapering services to children who, because of their disabilities, require diapering more often or at a later age than nondisabled children; (2) put on and remove the complainant's leg braces as necessary; (3) ensure that the complainant is not unnecessarily segregated from her age-appropriate classroom; (4) engage in readily achievable barrier removal to its existing facility; and (5) design and construct its new facility (planned independently of the Department's investigation) in a manner that is accessible to persons with disabilities.

- In 1996, the Department of Justice entered into a settlement agreement with KinderCare Learning Centers -- the largest chain of child care centers in the country -- under which KinderCare agreed to provide appropriate care for children with diabetes, including providing finger-prick blood glucose tests. In 1997, La Petite Academy -- the second-largest chain -- agreed to follow the same procedures.

- In its 1997 settlement agreement with the Department of Justice, La Petite Academy also agreed to keep epinephrine on hand to administer to children who have severe and possibly life-threatening allergy attacks due to exposure to certain foods or bee stings and to make changes to some of its programs so that children with cerebral palsy can participate.

The settlement agreements and their attachments, including a waiver of liability form and parent and physician authorization form, can be obtained by calling the Department's ADA Information Line or through the Internet (see question 30). Child care centers and parents or guardians should consult a lawyer in their home state to determine whether any changes need to be made before the documents are used.
27. Q: Has the Department of Justice ever sued a child care center for ADA violations?

A: Yes. On June 30, 1997, the United States filed lawsuits against three child care providers for refusing to enroll a four-year-old child because he has HIV. See United States v. Happy Time Day Care Center, (W.D. Wisc.); United States v. Kiddie Ranch, (W.D. Wisc.); and United States v. ABC Nursery, Inc. (W.D. Wisc.).

28. Q: Does the United States ever participate in lawsuits brought by private citizens?

A: Yes. The Department sometimes participates in private suits either by intervention or as amicus curiae -- "friend of the court." One suit in which the United States participated was brought by a disability rights group against KinderCare Learning Centers. The United States supported the plaintiff's position that KinderCare had to make its program accessible to a boy with multiple disabilities including mental retardation. The litigation resulted in KinderCare's agreement to develop a model policy to allow the child to attend one of its centers with a state-funded personal assistant.

Additional Resources

29. Q: Are there any reference books or video tapes that might help me further understand the obligations of child care providers under title III?

A: Through a grant from the Department of Justice, The Arc published All Kids Count: Child Care and the ADA, which addresses the ADA's obligations of child care providers. Copies are available for a nominal fee by calling The Arc's National Headquarters in Arlington, Texas:

800-433-5255 (voice)

800-855-1155 (TDD)

Under a grant provided by the Department of Justice, Eastern Washington University (EWU) produced eight 5-7 minute videotapes and eight accompanying booklets on the ADA and child care providers. The videos cover different ADA issues related to child care and can be purchased as a set or individually by contacting the EWU at:

509-623-4246 (voice)

TDD: use relay service

30. Q: I still have some general questions about the ADA. Where can I get more information?

A: The Department of Justice operates an ADA Information Line. Information Specialists are available to answer general and technical questions during business hours on the weekdays. The Information Line also provides 24-hour automated service for ordering ADA materials and an automated fax back system that delivers technical assistance materials to fax machines or modems.

800-514-0301 (voice)

800-514-0383 (TDD)