child care health
connections

A HEALTH AND SAFETY NEWSLETTER FOR CALIFORNIA CHILD CARE PROFESSIONALS

Published by the California Childcare Health Program (CCHP), a program of the University of California, San Francisco School of Nursing (UCSF)

CALIFORNIA CHILDCARE HEALTH PROGRAM

vol. 20 no. 6
November + December 2007

Pandemic Flu and Child Care Programs

Pandemic flu is a new flu virus that spreads rapidly around the world and affects many people. Right now, there is no pandemic flu. However, there is concern among public health officials about a virus seen in Asia and parts of Europe that has spread from birds to people (bird flu or avian flu.) It's possible that this flu could change into a virus that can easily spread from person to person. In that case, there could be a pandemic.

Why prepare for pandemic flu?

Child care programs, schools and large public gatherings provide opportunities to spread viruses that cause flu. In the event of a pandemic, exclusion policies for children, staff members and those who have ill family members will become stricter. In addition, schools and child care programs could be closed by public health officials for weeks or longer.

To prepare your program:

Contact your local health department about your community's plan for pandemic flu. Find out who will have the authority to close child care programs.

Watch for public health advisories about the flu, program closings and other recommendations.

Encourage families to have a backup plan for child care if your program is required to close or if their child is ill.

Take actions to prevent the spread of disease such as handwashing and coughing into your sleeve. Get a yearly flu vaccination and make sure the children in your program are immunized. Provide routine cleaning and sanitizing of toys and surfaces.

Plan for staff absences; this should include custodial services, waste management, food services and transportation.

Pandemic Flu, continued on page 4

inside

health + safety tips

Coping with colds in child care

It's not the child care provider's fault or family's fault that children get colds. It's a fact of life. However, there are coping strategies you can use to minimize the number of colds in your program.

- Make sure that both children and adults practice good hand washing.
- Teach children to cough into their elbow rather than in their hands, and away from people.
- Wipe noses with clean disposable tissues; dispose of tissues properly, wash hands after using.
- Routinely clean the environment; wash mouthed toys daily.
- Don't share food, bottles, toothbrushes or toys that can be put in the mouth.
- Play outdoors often and open windows to let fresh air into your program daily.
- Avoid contact with saliva: don't kiss children on the mouth; discourage kissing among children.

child care health
connections

Child Care Health Connections is a bimonthly newsletter published by the California Childcare Health Program (CCHP), a community-based program of the University of California, San Francisco School of Nursing, Department of Family Health Care Nursing. The goals of the newsletter are to promote and support a healthy and safe environment for all children in child care reflecting the state's diversity; to recreate linkages and promote collaboration among health and safety and child care professionals; and to be guided by the most up-to-date knowledge of the best practices and concepts of health, wellness and safety. Information provided in *Child Care Health Connections* is intended to supplement, not replace, medical advice.

Major support for this publication is provided by the California Department of Education/Child Development Division.

Six issues of *Child Care Health Connections* are published each year in odd-numbered months at the subscription rate of $25/year.

Newsletter articles may be reprinted without permission if credit is given and a copy of the issue in which the reprint appears is forwarded to the California Childcare Health Program at the address below.

Subscriptions, Renewals, Inquiries
Contact CCHP at (800) 333-3212 or cchp@ucsfchildcarehealth.org.

CCHP Program Office
1950 Addison St., Suite 107
Berkeley, CA 94704
T (510) 204-0930
F (510) 204-0931

California Child Care Healthline
(800) 333-3212 (California only)
healthline@ucsfchildcarehealth.org

www.ucsfchildcarehealth.org

Newsletter Editors
A. Rahman Zamani, MD, MPH
Judy Calder, RN, MS
Bobbie Rose, RN
Victoria Leonard, RN, FNP, PHD
Mara Gendell

ask the nurse

Constipation in Young Children

Q **How can I help a child who is constipated?**

A When a child has infrequent hard stool that is difficult to pass, it's called constipation. Constipation in children is common. There are a number of possible reasons for a child's constipation. A diet that is high in refined sugars, starches and milk products, but low in vegetables, fruits and whole grains (fiber) can contribute to constipation. Drinking too little fluid, especially on hot days or when a child has a fever, can make a child constipated. A decrease in activity due to an injury or illness, or certain medications, can also cause the problem.

Sometimes constipation starts when one hard stool has caused pain. The child may respond by "holding back" and resisting the urge. This makes the problem worse and a vicious cycle can begin. Toilet learning can cause a change in bowel habits. If the child who is constipated is learning to use the toilet and is "holding back," put him back in diapers until he is ready to try again.

To prevent constipation, offer plenty of foods high in fiber such as fruits and vegetables (apricots, pears, plums, peaches, berries, avocados, carrots, broccoli, peas, beans) and whole grains (oats, brown rice, whole wheat.) Make sure that young children have fluids at meals and throughout the day. Water is a good choice to quench thirst and provide hydration. Ask the parents about the child's diet at home. Provide information about a healthy diet that includes lots of fruits and vegetables. If the child is a "picky eater" remember that a food may need to be offered 10 times before a child will try it.

Sometimes a child may need help from a health professional for constipation. A pediatrician may recommend stool softeners or laxatives and will evaluate for other problems. Ask the parents to call their health care provider if the child has not had a bowel movement in more than three days or if the discomfort becomes worse.

by Bobbie Rose, RN

What to Expect From a Preemie in the First Year

Typically, a baby grows in the womb for 40 weeks before being born. These babies are called "full-term." If a baby is born earlier than 37 weeks, that baby is called "premature." Some premature babies are the right size for their age when they are born and some are called "small for gestational age," that is, they weigh less than they should for their age.

What causes babies to be born prematurely?

Sometimes babies are born prematurely because of health problems in the mother. Prematurity may also be caused by problems in the baby. But, for many preemies, there is no known cause of their prematurity.

What should I expect of a preemie?

The majority of preemies develop into healthy children, but some, especially those born small for gestational age or those who experience injuries to their brains after birth, may have special needs. The earlier a "preemie" is born, the more problems he is likely to have. Preterm infants respond less predictably, they tend to be harder to console, are less adaptable to changes, and more likely to cry.

Developmental delays during the first two years of a preemie's life are to be expected. They usually hit milestones later than their full-term peers. Think of a preemie's progress in terms of "adjusted age" until they are 2 years old. For example, if the baby was 8 weeks early, adjust your expectations down by two months. Most preemies who are normal weight for their age at birth catch-up to their peers in growth by age 3. For very small preemies, catch-up may take longer. A delay in expressive language may be seen in infants before 18–24 months adjusted age.

It is important to observe preemies for signs of developmental delay or physical problems because many of these problems can be helped by early intervention. Common problems seen in some preemies are

- hearing loss
- vision problems
- speech, muscle or learning delay
- fine motor-coordination difficulties
- auditory processing problems
- attention deficit disorder

Preemies, especially very premature babies, require close follow-up during their first years. It is very important that all preemies have a regular health care provider and a "medical home." The American Academy of Pediatrics recommends that preemies should receive their immunizations at their chronological age regardless of how premature or small they were at birth. Preemies are more susceptible to infections than other newborns; respiratory syncytial virus (RSV) in particular. Preemies born at less than 34 weeks should receive a vaccine during their first winter to help protect them against RSV. Preemies should also receive flu vaccine starting at 6 months chronological age.

If you are caring for a preemie and observe anything that concerns you about the baby, talk with the baby's parents. You can also report behavior that concerns you to the infant's health care provider using CCHP's *Information Exchange on Children with Health Concerns* form (see reference below).

Parenting a preemie can be stressful and parents often feel anxious and overwhelmed by the care of a preemie. ECE professionals are an important source of support and guidance for these families and have the ability to improve parents' responsiveness to and care of their premature infant. ECE professionals can also provide invaluable information to other professionals about how the baby is growing and developing.

Resources

The *Information Exchange on Children with Health Concerns* form at www.ucsfchildcarehealth.org/pdfs/forms/InfoExchange.pdf.

The Preemie Parents' Companion, by Susan L. Madden.

www.prematurity.org.

What to Expect From a Preemie in the First Year, a CCHP Health & Safety Note available online at www.ucsfchildcarehealth.org/html/pandr/hsnotes main.htm.

by Vickie Leonard, RN, FNP, PhD

Dietary Fiber and Young Children

Fiber (also called bulk or roughage) refers to those parts of plants that we eat and are not digested. Although fiber is not absorbed, it plays an important role in a healthy diet.

Western diets, especially those of young children, often do not have enough fiber. Since fiber is not found in foods from animal sources, diets that are based mostly on meat, dairy and eggs will not provide enough. There is little fiber in most convenience or "junk" foods such as cookies, crackers, candies, cakes and chips.

Health benefits of dietary fiber

Obesity occurs less often in people who eat plenty of fiber. When people eat low-density foods that have lots of fiber, they feel full sooner, and consume fewer calories. Diets with more fiber can also lower fat and cholesterol in the blood and reduce the risk of heart disease. Eating fiber can reduce the risk of colon cancer. When combined with drinking adequate fluids, high-fiber food helps digestion and prevents constipation.

A diet that includes more fiber

Fruits, vegetables, legumes and whole grain cereals and breads are the usual sources of dietary fiber. Food labels on canned and packaged foods list the food's fiber content. When choosing food for snacks and meals in your program, include a variety of items from plant sources. A child's daily intake from all sources of fiber should total the age of the child plus 5, measured in grams (AAP). For example, for a 4-year-old, 4 + 5 = 9 grams. Here's an idea of 9 grams of fiber:

½ cup oats = 2 grams
¼ cup green peas = 2 grams
3 strawberries = 1 gram
¼ cup lentils = 4 grams

Children will enjoy plums, peaches, pears, tomatoes, carrots, peas, beans, oats, barley and many other foods that are plant-based. Although dietary fiber is healthful, it must be noted that children need a varied diet that provides the necessary vitamins and minerals from other foods. A diet that emphasizes high-fiber, low-calorie foods, and excludes other food groups, is not recommended for children.

Ideas for increasing fruits, vegetables and whole grains:

- Introduce (one at a time) small servings of iron-fortified cereals, fruits, vegetables and legumes for infants from 6 to 12 months.
- As the child gets older, provide a more varied diet and gradually increase fiber over time.
- Incorporate lessons about how food grows into your daily activities.
- Teach children self-help skills of cutting fruits and vegetables (with supervision.)
- Make pancakes with whole-grain flour and top with fruit.
- Add wheat bran when preparing baked goods.
- Serve oatmeal, brown rice and whole wheat bread for snacks.
- Top banana pieces with wheat germ.
- Have children prepare fruit kabobs.
- Limit crackers and cookies.

References and Resources

AAP, Pediatric Nutrition Handbook, Fifth Edition, 2004.

Fiber and Your Child, Nemours at http://kidshealth.org/parent/nutrition_fit/nutrition/fiber.html.

USDA National Nutrient Data Base, 2006, Nutrient Data Laboratory, www.ars.usda.gov/Services/docs.htm?docid=13726.

by Bobbie Rose, RN

Pandemic Flu, continued from page 1

Keep several days' supplies of soap, paper towels, tissues and cleaning products. If your program provides meals, keep a backup supply of non-perishable and canned foods.

For more detailed information about planning for pandemic flu see the CCHP Health & Safety Note, *Preparing for Pandemic Flu in Child Care Programs,* at www.ucsfchildcarehealth.org or call the Healthline at (800) 333-3212.

References and Resources

Pandemic Flu Checklist for Child Care Agencies and Preschools www.cde.ca.gov/ls/he/hn/documents/preschpflucheck.doc

PandemicFlu.gov at www.Pandemicflu.gov.

by Bobbie Rose, RN

Safety and Effectiveness of Cough and Cold Medicine in Children

The Food and Drug Administration (FDA) is warning parents not to give children age 2 and younger over-the-counter cough or cold medicines unless directed by a health care provider. This advisory is in response to the popular medicines being blamed for infant deaths and serious and life-threatening side effects. Safety experts asked the FDA to consider an outright ban on such products.

Cough and cold products do not work in children

Most pediatricians are against giving over-the-counter cough and cold medication to young children. Studies suggest that there is not any evidence that over-the-counter cough and cold medicines are effective in making children well sooner. These products only treat the symptoms of the common cold. Cold symptoms include runny nose, sore throat, coughing or sneezing, watery eyes, chills and fever. These symptoms are generally mild and self-limited in healthy children. In other words, children get better with time. Many comfort measures like vaporizers work to make children feel better without side effects.

Why aren't they safe?

Most of the serious bad events associated with the use of cough and cold products are caused by two ingredients:

1. Dextromethorphan, which is listed as "DM" in many preparations. DM can cause neurological problems including abnormal movements and hallucinations, even in standard doses.
2. Pseudoephedrine, which is a decongestant that has been associated with increased blood pressure, arrhythmia (irregularity in the rhythm or force of the heartbeat) and infant deaths.

Problems are usually the result of giving too much medicine

Overdose may happen when you give:

- More than the recommended amount of medicine.
- Two different products with the same active ingredients—not realizing that both contain identical medicines.
- The medicine too often.

Cough and cold medicines come in many different names and strengths

To avoid giving too much medicine to your child, carefully follow the directions for use of the product. For more accurate dosing, determine your child's dose based on his weight rather than his age. If a measuring device is not included with the product, you may purchase one at the pharmacy. Make sure that the dropper, dosing cup or dosing spoon has markings on it that match the dosing that is in the package label, or is recommended by the child's health care provider. If you are confused, or do not understand the instructions on the product or how to use the dosing device, consult your pharmacist or health care provider.

FDA's Safety Tips about using cough and cold products in children

- Do not use cough and cold products in children under 2 years of age unless directed by a health care provider.
- Do not give children medicine that is packaged and made for adults.
- If other medicines (over-the-counter or prescription) are being given to a child, the child's health care provider should review and approve their combined use.
- Read the label to know the active ingredients and the warnings.
- Follow the directions. Do not give the medicine more often or in greater amounts than is stated on the package.
- For liquid products use the measuring device that is packaged with each different medicine and that is marked to deliver the recommended dose. A teaspoon or tablespoon is not an appropriate measuring device for giving medicines to children.
- If a child's condition worsens or does not improve, stop using the product and immediately take the child to a health care provider for evaluation.

Resources and References

FDA's Public Health Advisory on Cough and cold medicine online at www.fda.gov/CDER/drug/advisory/cough_cold.htm.

Over-the-Counter Drugs, a CCHP Fact Sheets for Families available online at www.ucsfchildcarehealth.org/html/pandr/factsheetsmain.htm.

Medication Administration in Child Care Programs, a CCHP Health & Safety Note available online at www.ucsfchildcarehealth.org/html/pandr/hsnotesmain.htm.

Infant Deaths Associated with Cough and Cold Medications, CDC MMWR available online at www.cdc.gov/MMWR/preview/mmwrhtml/mm5601a1.htm.

by A. Rahman Zamani, MD, MPH

CALIFORNIA CHILDCARE HEALTH PROGRAM

Health & Safety Notes

Nutrition and Activity for Young Children: Raising Physically Fit and Well Nourished Children

CHILDCARE HEALTHLINE

Childhood obesity trends

Over the past two decades, the number of obese and overweight children has doubled. For the first time ever, the current generation of young children may have shorter life spans than their parents. Considering the many health problems associated with obesity, it is important for parents, teachers and caregivers to take measures to reverse this troubling situation.

Factors contributing to childhood obesity:

Diets consisting of processed convenience foods that are high in calories, fat and salt have become the norm for many families. Fast foods and super sized meals provide more calories and less nutrition than children need. As serving sizes have increased, so has the obesity rate. Meal patterns have also changed; fewer meals are prepared at home and eaten as a family. At the same time, our children have become more sedentary. Electronic media have, in many cases, taken the place of outdoor active play. Many children spend several hours a day behind one screen or another. In addition, the school day has become less active. With pressures to excel in academics, less time is spent on physical fitness. Fewer children walk to school and many children are driven everywhere they go.

Fortunately, Early Care and Education (ECE) programs are in a key position to promote change. An environment and routine that respect children's needs for good food and healthy activity will benefit children now and for a lifetime.

Healthy food habits for young children

Breastfeeding

An infant's first food should be breast milk. The American Academy of Pediatrics (AAP) believes that breastfeeding is the optimal source of nutrition through the first year of life and recommends exclusively breastfeeding for the first six months. Encourage breastfeeding in your program whenever possible.

First Foods

At about six months, it is recommended that infants start on solid food. The first should be iron-fortified cereal. Healthy brain development depends on dietary iron. Offering a variety of iron rich foods such as leafy green vegetables, fruits and grains without added sugars or salt is a healthy start. Round, firm foods such as whole grapes are a choking hazard. Completely chop all table foods for young children. (AAP)

Feeding styles of parents and caregivers

Research shows that caregiver feeding styles affect the development of children's eating habits. A child centered feeding style has the best outcomes. This style allows children to choose among appropriate foods that are offered. Children benefit when caregivers and parents discuss food with the them, arrange food to make it interesting, respect preferences that a child might have and allow children to stop eating when they feel full. It is very important that children learn to pay attention to internal cues of feeling hungry and feeling full.

Feeding styles should not be "permissive" (allowing children to consume any food or drink in any amount, at any time). Nor should caregivers be "authoritarian." An authoritarian style shows disapproval when the child does not eat, warns the child that food will be taken away if not eaten, begs the child to eat, and/or uses food as a reward, comfort or incentive. Most young children prefer familiar foods. A child may need to be offered a food many times before trying it. Try not to be discouraged

by this, and continue to offer a variety of healthy choices.

Family style meals

When children eat in a group in ECE programs, they see others enjoying food and are more likely to try new foods. Teachers have the opportunity to role model healthy eating and meaningful conversations with children. Mealtime is not a time for TV, reading books or playing with toys. Make extended conversation the focus of your mealtime. Involve children in planning meals, setting the table and preparing food.

Drinks and milk

Consuming soft drinks is associated with obesity in children. Young children should only be offered milk, water, and limited amount of fruit juice. AAP recommends that fruit juice not be given to infants under six months of age. For children age one to six, limit fruit juice to small servings (4 to 6 ounces/day) of 100% fruit juice. Never put soft drinks or juice in a bottle. Too much milk should also be avoided, as it can lead to a reduced intake of iron rich foods and iron deficiency. For children under age two, limit milk to 24 ounces of whole mile per day; at age two, change to low fat or skim milk. (AAP)

Healthy activity for young children

Daily schedule

Plan more time for active play. According to the National Association of Sport and Physical Education (NASPE), young children need both structured and unstructured physical activity every day and should not be still for more than 60 minutes at a time unless they are asleep. Children are naturally active and curious. For most children, it is harder to sit still than be active. Encourage these natural traits!

Arrangement of space, equipment and materials

Create an environment that supports the development of gross motor skills. Infants and toddlers need to be able to explore their environment in safe settings that do not restrict movement. Provide "tummy time" for infants who sleep on their backs.

Active outdoor play

Encourage vigorous outdoor play. Note that this requires active adult supervision. Most injuries in child care settings happen outdoors. Maintain a safe environment and appropriate staffing rather than limiting outdoor play for fear of injury.

Include physical skill building in your curriculum. Young children who learn physical skills such as jumping, running, throwing and catching will have the foundation to participate in physical activities and sports as older children. Remember that physical skills may come easily to some children while others may need more adult guidance. Research shows that preschool children who have a foundation of physical skills will participate more fully in elementary school sports. Look for ideas to increase physical skills at www.pecentral.org and http://fitsource.nccic.acf.hhs.gov/fitsource

Work with parents

Many working families struggle with hurried schedules. They often rely on inexpensive fast foods and TV or video games to keep their children occupied. Many have long commutes to work. Be sensitive to this situation. Include parents in your efforts to improve nutrition and activities by providing resources, ideas and opportunities for active family fun.

More tips for your program:

- Have a policy that fundraisers and celebrations will focus on nonfood or healthy food items.
- Replace food rewards with a special privilege or sticker.
- Provide a clean drinking fountain
- Work to improve local parks and recreation

by Bobbie Rose

References and Resources:

American Academy of Pediatrics Web Site at www.aap.org

Strategic Alliance ENACT at www.preventioninstitute.org/enact/childcare/index.html

Hughs, Sheryl et al, The Benefits of Authoritative Feeding Styles, Appetite, 2005

Active Start, Physical Activity Guidelines for Children Birth to Five Years, 2002, NASPE

03/07

California Childcare Health Program • 1950 Addison Street, Suite 107 • Berkeley, CA 94704-1182
Telephone 510–204-0930 • *Fax* 510–204-0931 • *Healthline* 1-800-333-3212 • www.ucsfchildcarehealth.org

Children with Spina Bifida in Child Care Settings: Part II

Spina Bifida is not one condition; it is a whole host of problems that affect how a child thinks, acts, moves, learns and feels. No two children with Spina Bifida (SB) are ever the same. It has been said that SB is the most complex developmental defect compatible with life. Inclusion of a child with SB in the Early Care and Education (ECE) setting requires careful accommodation in many areas.

Abnormalities in the early formation of the spine are often accompanied by problems in the formation of the brain, the legs and feet, the kidneys and the bladder. Thus, children with SB have problems with learning, with mobility, and with bowel and bladder control. A special health care plan is essential for children with SB and all of these areas of functioning must be addressed before a child can be enrolled in the ECE setting.

What accommodations should be planned for when enrolling a child with SB?

Learning: Children with SB often have problems with learning. For preschool children, neuropsychological evaluation may provide invaluable insight into how a child's brain is working and best ways that he learns. Common neuropsychological difficulties found in children with SB include problems with paying attention, perceptual-motor processes, reasoning and problem solving, organization and sequencing skills, and memory tasks. These problems may also affect the child's relationships with other children. These difficulties must be kept in mind when children with SB are having trouble in the classroom. Knowing the nature of a child's learning problems before she starts school can help with developing an Individualized Education Program (IEP) and can make school entry a smoother process.

Bowel and bladder care: Most children with SB cannot control their bowel or bladder. Because incomplete emptying of the bladder puts children at risk for urinary tract infections, clean, intermittent catheterization must be performed about five times a day. This involves inserting a small plastic tube into the child's urethra and emptying the bladder of urine. Catheters can be safely washed and re-used. Most children with spina bifida can learn to do the procedure themselves, but not until after they start elementary school and parents must make arrangements for this procedure to be performed in the ECE setting by a trained person if they cannot do it themselves. The special health care plan must specify who this person will be. Most of these children also follow a bowel program that is focused on strategies that prevent constipation, a common problem, and bowel accidents.

Latex allergies: Children with SB are at very high risk of developing latex allergies and must be protected from exposure to latex. For children who have a latex allergy, it is often life-threatening and a plan for dealing with anaphylaxis must be an essential part of the care plan. Latex is very common in the environment but parents of a child with SB are usually very good at helping providers identify materials that contain latex.

Mobility: Children with SB have mobility problems and the severity is determined by the location of the spinal lesion. They frequently use walkers or wheel chairs and it is important to make accommodations that allow the child access to developmentally appropriate play materials and to peers.

The child with SB should receive medical care from a subspecialty clinic that can provide advice and resources for the ECE community. Parents are also often experts in their child's condition and knowledgeable about how best to care for the child. Use this expertise as you develop your special health care plan.

Resources

The Spina Bifida Association, www.sbaa.org.

Children with Spina Bifida—a Resource Page for Parents, www.waisman.wisc.edu/~rowley/sb-kids/index.html.

by Vickie Leonard, RN, FNP, PhD

Important Legal Settlement Involving Diabetes Care in California K–12 Public Schools

A lawsuit filed by the American Diabetes Association (ADA) to improve care for children with diabetes in California public schools was recently settled, resulting in new rules on the legal rights of children with diabetes in K–12 schools.

Some of the key rights affirmed by the court are:

- Schools must evaluate a child for eligibility under federal law Section 504 of the Rehabilitation Act and/or the Individuals with Disabilities Education Act (IDEA) if a parent requests an evaluation, and must provide appropriate services if the child is found eligible.
- A child has the right to receive needed diabetes health care (including insulin and glucagon administration and blood glucose monitoring) from a school nurse or other appropriately trained school personnel when the child cannot do these things him/herself. Please note that it would require an amendment to the Health and Safety Code and the Business and Professions Code (BPC) to allow insulin administration in licensed child care settings. Currently, only family members, medical professionals and children capable of administering their own injections are permitted by licensing to administer insulin in ECE settings.
- A school cannot refuse to provide medically necessary services for any of the following reasons: because trained personnel are not available, because of a policy restricting the type of care to be provided or the location where it will be provided, or because of the burden of providing the care.
- A child cannot be sent to a different school because the district refuses to provide care at the school he/she would normally attend.

While this ruling applies only to K–12 schools, families of preschool children with diabetes will want to do anticipatory planning before starting kindergarten. There are several important steps parents should take to best ensure that their child with diabetes receives the care he/she needs. These include:

1. Obtaining medical orders from the child's health care provider, and then,
2. Meeting with the school nurse and other key school personnel before school begins to discuss how the care plan will be implemented.

Two model documents from the American Diabetes Association website at www.diabetes.org/schooldiscrimination can help with this planning:

- **Diabetes Medical Management Plan (DMMP)**
  - The child's treating physician can use this form to specify the child's treatment regimen.
- **Section 504 Plan**
  - Parents can use this sample plan as they work with the school to determine how needed services will be provided.

In addition, a great deal of additional information about a child's rights at school is available from The American Diabetes Association at www.diabetes.org/schooldiscrimination.

BOX OF FUN

Freeze Dance

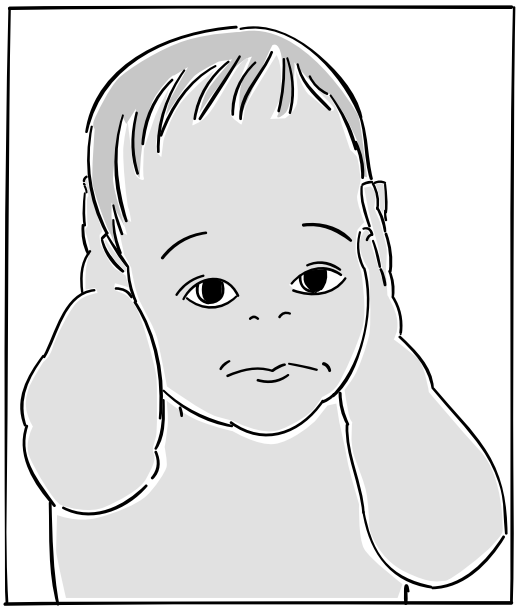
This is a fun indoor activity for children and adults. You will need a way to play music that you can turn on and off.

- Turn on the music and have the children move to the rhythm.
- Make sure each child has enough room to avoid collision.
- Turn the music off and ask the children to "freeze."
- Resume playing music and give the command "dance."
- Repeat.

Try different kinds of music. Choose a theme such as ethnic music, holiday music, classical music or folk music. Try handing out ribbons and streamers for children to wave as they move about to the music.

Ear Infections can affect Language Development

Ear infection, also called otitis media, is the most common childhood illness and the most common cause of hearing loss in children. Children with chronic hearing loss associated with repeated ear infections can develop language delays and have difficulty learning what they can't hear. Thus, prevention and management of ear infections is important not only to deal with the illness, but also to avoid language and learning problems.



How do speech and language normally develop?

The first three years of life, a period when the brain is developing and maturing, is the most important period for speech and language development. It is during this period that nerve connections and networks are forming and speech centers are developing in the brain. This is the period in which the brain can best learn language.

Scientists are working to understand the relationship between exposure to speech and language, brain development and communication skills. Speech and language skills appear to develop best in an environment that is rich with sounds, sights, and exposure to speech and language. Therefore, if hearing is affected, a key area of the brain that is related to speech will not develop properly.

How can language learning be affected by ear infection?

Ear infections often interfere with hearing. The space in the middle ear behind the ear drum usually contains air. When there is fluid in this space, the bones in the middle ear will not vibrate properly and this can cause hearing loss.

Ear infections come in several varieties.

- Otitis media with effusion (OME) is the name for fluid in the middle ear without other symptoms. It is sometimes called silent otitis media, but it can still cause hearing loss.
- Acute otitis media (AOM) refers to fluid in the middle ear accompanied by signs or symptoms of an ear infection such as fever, pain, redness, or a bulging eardrum.

The middle ear is connected to the back of the nose by the eustachian tube. The primary function of this tube is to ventilate the middle ear, ensuring near normal pressure inside the ear. The secondary function of this tube is to drain any accumulated secretions, infection, or debris from the middle ear space. When bacteria or viruses make their way into the middle ear, they are supposed to be flushed out through the tube. When the tube is blocked, or isn't functioning properly, bacteria- or virus-containing fluid can become trapped in the middle ear causing an infection that can lead to temporary hearing loss. Hearing should return to normal 4–6 weeks after the infection clears, but some children have fluid in their middle ear for prolonged periods of time and this can affect the development of speech and language.

When you have concerns about a child's language development

Assess the child to find out whether she is achieving developmental milestones for language. Talk to the child's parent about your concerns and refer the child to her health care provider. Early intervention is very important for children with speech and language delays and can help the child catch up to her peers before she suffers any lags in academic achievement.

The potential impact of repeated ear infections in the first few years of life on language and learning is enormous. Follow-up care after ear infections, especially for those children who shows signs of persistent hearing loss or language delay, is an essential part of treatment.

Resources

Ear Infections (Otitis Media) and Hearing Loss in Young Children online at http://ucsfchildcarehealth.org/pdfs/healthandsafety/earinfen081803.pdf.

National Institute on Deafness and Other Communication Disorders, National Institutes of Health. Speech and Language Developmental Milestones at www.nidcd.nih.gov/health/voice/speechandlanguage.asp.

by A. Rahman Zamani, MD, MPH and Tahereh Garakani, MA ED

Seasonal Flu Vaccine

Influenza (flu) is a contagious respiratory illness that can cause mild to severe illness and can lead to death. The best way to protect against the flu is by getting a flu vaccination each year. There are two types of vaccines. Children and adults can either receive the "flu shot" which contains killed virus or the nasal spray (made with live, weakened flu viruses that do not cause the flu. The nasal spray is only approved for healthy children ages 2–4 years old and healthy persons ages 5–49 years who are not pregnant.

Who Should Get Vaccinated?

In general, anyone who wants to reduce their chances of getting the flu can get vaccinated. However, people who should get vaccinated each year are:

1. ***People at high risk for complications from the flu, including*** children aged 6 months until their 5th birthday, pregnant women, people 50 years of age and older, people of any age with certain chronic medical conditions, and people who live in nursing homes and other long term care facilities.
2. ***People who live with or care for those at high risk for complications from flu,*** including household contacts of persons at high risk for complications from the flu (see above), household contacts and out of home caregivers of children less than 6 months of age (these children are too young to be vaccinated) and healthcare workers.

Resources

Centers for Disease Control and Prevention. www.cdc.gov/flu/.

Whooping Cough and Flu Vaccination

If you take care of children protect yourself and the children in your care. Child Care Providers need a flu vaccine every year and a Tdap (combined Tetanus, Diphtheria and Pertussis or whooping cough) booster. For more information call your local health department or the Centers for Disease Control Hotline at (877) 554-4625.

health + safety calendar

Multilingual Health and Safety Training for ECE Professionals in Alameda County

The California Childcare Health Program (CCHP) is pleased to announce a new training opportunity for Early Care and Education (ECE) professionals in Alameda County. The three-day training is supported by Every Child Counts (First Five Alameda County), and will be provided in two separate languages:
Farsi—November 17, November 24, December 1, 2007
English—February 9, February 16 and February 23, 2008

In addition to complimentary training registration, participants will also receive:
1. Training Curriculum (18 modules, 800 pages).
2. Resource binder of Health & Safety materials to share.
3. Resource CD of California Childcare Health Program's Health & Safety materials.
4. One year free subscription to the Child Care Health Connection's newsletter.
5. Gift package of eco-friendly environmental cleaning products.
6. Certificate of Child Care Health Advocate (CCHA) training.

CARES credit may also be available through the local First 5 commission. For more information please call 510-204-0939.

آموزش رایگان صحی و سلامتی
برای کارمندان نگهداری و آموزش اولیه کودکان
در کونتی الامیدا

به زبان فارسی

- روز اول: شنبه هفدهم (۱۷) نوامبر ۲۰۰۷
- روز دوم: شنبه بیست و چهارم (۲٤) نوامبر
- روز سوم: شنبه اول دسامبر ۲۰۰۷

health + safety resources

Toy Safety
The American Academy of Pediatrics has Toy Safety Guidelines at www.aap.org/new/toyrecall.htm and the Consumer Product Safety Commission has a complete list of toys that have been recalled at www.cpsc.gov/cpscpub/prerel/category/toy.html.

Model Health and Safety Policies
The Indiana Child Care Health Consultant Program has model health and safety policy templates and forms on their website for adaptation: www.iu.edu/~cchealth/resources/policyTemplates/policies.php.

Child Health USA 2006
This annual report documents the health status and service needs of the target population of infants, children, adolescents, children with special health care needs, and women of childbearing age. The report presents data for more than 50 health status and health care indicators, provides both graphical and textual summaries of data, and addresses long-term trends. Online at www.mchb.hrsa.gov/chusa_06/.

Using Evidence to Improve Outcomes in Learning, Behavior and Health
A framework for using evidence to improve outcomes in learning, behavior and health for vulnerable children is authored by the National Forum on Early Childhood Program Evaluation and the National Scientific Council on the Developing Child. It draws on neuroscience, behavioral and developmental science, economics, and decades of early childhood research to guide better policies and practice. Available online at www.developingchild.net/pubs/persp/pdf/Policy_Framework.pdf.

Basic Facts about Low-Income Children
The National Center for Children in Poverty's (NCCP) most popular fact sheets, Basic Facts About Low-Income Children, with the most recent Census data. The fact sheets track U.S. children who live in low-income families by age: birth to age 18, birth to age 6, and birth to age 3. Online at http://nccp.org/publications/pub_762.html.

Updated 50-State Demographic Information
National Center for Children in Poverty (NCCP) has updated state and national demographic data on our state profiles and in the 50-State Demographics Wizard. The updated data reveal that:

- 39% of all children live in low-income families (28.6 million children).
- 43% of young children (under age 6) live in low-income families (more than 10 million children).
- Rates of children living in low-income families vary dramatically across the states, from 21% in New Hampshire to 53% in Mississippi.

Online at http://nccp.org/tools/demographics/.

University of California, San Francisco
Child Care Health Connections
School of Nursing
Department of Family Health Care Nursing
San Francisco, CA 94143-0606

CHANGE SERVICE REQUESTED

Nonprofit Org.
U.S. POSTAGE
PAID
San Francisco, CA
Permit No. 8285