Health Services Purpose

The Head Start & Pre-K program emphasizes the importance of early identification of health problems. Since many preschool children of low-income families may have never seen a doctor or dentist, the program arranges for every child to receive, if needed, comprehensive health care, including medical, dental, mental health, and nutrition services. The program will follow all EPSDT guidelines for infants and toddlers.

A. **Physical and Oral Health** – Head Start/Pre-K children receive a complete well-child examination annually including vision and hearing tests, identification of disabling conditions, immunizations, and a dental exam. Follow-up is provided for identified problems when funding permits for Head Start children. Staff work closely with parents to schedule follow-up appointments and stress importance of keeping these appointments. Pre-K parents are encouraged to follow up on their child's medical and dental needs.

Health

Each child enrolled in the Head Start & Pre-K program will have the following:

1. up-to-date immunizations (prior to first day of attendance) and a physical examination (within 30 days of enrollment)
2. a dental screening and follow-up if needed
3. a completed health history
4. a nutritional assessment
5. a screening for potential speech and language development problems
6. hearing screening and follow-up if necessary
7. charted growth assessment of height, weight and age
8. vision screening
9. a hematocrit/hemoglobin screening (within 45 days of entry)
10. proof of a negative tuberculin test if indicated by a physician or by state law
11. lead screening/lead blood score
12. referrals and follow-up for specific health problems
13. behavioral observation(s)
14. multi-disciplinary staffing at least twice annually
15. have van to assist families in keeping scheduled appointments when transportation availability is an issue.

Due to the high level of concern about lead in toys and other supplies for children, we recommend that parents regularly access the website for the Consumer Product Safety Council www.CPSC.gov for updates. The council also provides information on the safety of furniture such as cribs and other products.

B. **Nutrition** - In the program, children in Head Start/Pre-K classrooms are served two meals daily. The Health and Safety Specialist will supervise the nutrition activities of the program and help the staff develop a nutrition program to teach families how to select healthy foods and prepare well-balanced meals. FA staff assist parents with SNAP and other community assistance when needed.

Health Procedures

All children must have a dental exam within the first 90 days after enrollment. A physical exam must be completed within 30 days because of WV Child Care Licensing requirements. EPSDT requires that a physical be conducted annually. Immunizations must be completed prior to first day of class. A hematocrit must also be completed on each child within the first 90 days. Each child will be screened for speech, hearing, vision, social/emotional, lead, and developmental within 45 days of enrollment.

All health and dental information and forms will be submitted to the assigned Family Advocate Specialist or Family Advocate Staff for review, follow-up and filing. Forms related to behavioral needs will be submitted to the Mental Health Consultant who will follow up on them through referrals, etc. Screening results, except for speech and hearing, will be submitted to the assigned Family Advocate staff member for review, follow-up and filing. Speech and hearing screening results will be submitted to the assigned Child Development/ Disabilities Manager or Specialist who will also conduct the follow-ups and do the necessary filing.

Expiring Health Events

1. Thirty (30 days prior to expiring physical or dental examination, Family Advocate will send a reminder letter to parent.

2. If no response from parent within fifteen (15) days, Family Advocate will call parent and discuss expiring health event and assist with scheduling an appointment. (Document the phone call in writing)

3. Family Advocate and Health Specialist(s) should be contacted in writing, using the EPIC Family Service/Health referral form. Assistance from Specialists will be offered for help with phone calls/home visits.

4. After thirty (30) days and little or no communication from parent, Family Advocate can schedule a home visit with parent. "Unscheduled" visits are recommended if staff continues to have difficulty getting, in touch with parent. (Document the home visit in writing and on database).

Health Follow Up

Child's Head Start & Pre-K Physical Form

Each child must have a well-child examination annually or according to the WV EPSDT schedule. Staff will track children's files and follow up with parents when another physical exam is required. Staff will review the child's physical form for any follow-up treatment that may be needed. **All staff are to read any comments made by the physician or nurse before placing in child's file**. Unresolved follow-up of health issues noted on physical will be documented on a referral form and give to the Health Specialist. Concerns should be addressed with the Health Specialist and during child's staffing times and as needed to assure the provision of services in a timely manner.

Child's Dental Form

Dental forms are to be followed-up upon for treatment needed. Documentation must be in writing that parent/guardian was informed. (A note and/or phone call should be sent/ made to parent/guardian). Staff can also help arrange appointment times/date with Health Specialist to ensure follow-up work will be completed.

Height and Weight

This data is collected 3 times per school year on every Head Start/Pre-K. Height/weight due dates (usually due in October, January, and May) are on the staff calendar.

Within thirty days of a child's enrollment, the child will be weighed and measured.

Referrals should be by Family Advocates to the Health Specialist when a child is either below the 5th percentile for height/weight or above the 95th percentile for height/weight (on or off the weight for stature chart).

Some children are normally small or large for their 3-5 years. Staff will examine their family history, including parent's heights and weights and sibling's heights and weights. Concerns need to be documented and shared with the Health Specialist. Staff may need to contact the physician for information and help. The WIC Program can also be a referral source.

Hematocrit/Hemoglobin

This is a required Head Start screening which is usually completed during the child's physical exam. The test involves a finger prick and measures the amount of iron in the blood stream. WV EPSDT requires this test to be completed at 12 and 24 months of age. Results can be documented from an earlier screening or if child is receiving WIC, staff can obtain results from the WIC program.

Normal hemoglobin ranges are 11.1% and higher. Please refer ranges lower than 33% and 11% to Family Advocates and the Health Specialist. The physician or clinic will be contacted (with family's permission) if there is not documentation elsewhere on physical form noting concern.

The WIC Program also conducts this screening and will share the information with the Head Start Program.

Immunizations

Please refer to the most recent immunization schedule. Head Start is required to have an immunization record for each child prior to the first day of class. The staff will work with the family on updating their child's immunization record, however, we do need documentation that immunizations have been given. Sometimes the family cannot locate the immunization record. The Family Advocate will work with the family, helping them to find out where the last immunizations were given. In rare cases, the child may need to begin a new series of shots if the original immunization record is not located. The child immunization record must be received prior to entering the classroom or a catch up plan must be in place.

Nutrition Form

This form is to be completed by the teaching and family service staff during an initial home visit. It is very important to ask all questions on the nutrition screening form. Staff need to know if the child has any food allergies or is on a special diet. These issues need to be shared with teachers, family services staff and the center manager prior to the child eating at the center. Children who may require a special diet must have written documentation from their physician. This documentation (special dietary form) is then shared with the cafeteria and if the school can accommodate the special diet, the cooks will work with the family. Sometimes it is necessary for the family to provide a packed meal (breakfast or lunch) for their child, but only under special circumstances.

Lead Risk Assessment Form

This questionnaire form is used to interview the parent/guardian concerning lead risks that their child may have obtained.

After the questionnaire is completed, please refer child back to their family physician or clinic if any questions are answered "yes" on the form. Head Start & Pre-K Family Advocate will contact the child's physician using the lead letter form and ask the physician or clinic to follow-up with a blood test. The physician will either proceed with the blood test or send documentation that they feel it is not necessary. Head Start/Pre-K staff usually has to follow up with this by phone contact and/or a release of information with parent/guardian signatures.

Lead Blood Test Score

Children receive a lead blood test at 12 and 24 months.

Family Advocate staff will work with parents to check if this blood test was performed. This blood test is not routinely performed at 36 and 48 months but previous scores are acceptable. If enrolled Head Start children have not had this test preformed, staff will contact physician to see if test is necessary and will obtain decision in writing (from health care professional).

To assess each child's vision, hearing, and speech/language development

Hearing/Vision:

- Vision- To be completed by trained to use the vision machine, usually done by Family Advocate staff. Results provided to Family Advocate staff who updates myHeadStart, file's original, updates screening summary, and scans a copy to Manager.
- Hearing- To be completed by someone trained to use the audiometer, usually done by the County SLP. Results provided to Family Advocate staff who updates myHeadStart, file's original, updates screening summary, and scans a copy to Manager.
- Rescreens should be done within 30 days. If 2nd screening is a retest, should refer instead.
- CNT- note reason and retest within 30 days; if Dual Language Learner or shy- see if parent, teacher, etc., can assist. If not, refer.

Referrals:

- Vision: Family Advocate staff will contact parent and EPIC's vision/hearing referral letter. Follow-up within 30 days. Copy of letter goes in child's file. Discuss with family that child had difficulty completing the vision screening and it would be best to follow up with the child's pediatrician or an optometrist to rule out vision problems. Make an effort to have face-to-face contact with families first.
- Hearing: Family Advocate staff will contact parent and send EPIC's vision/hearing referral letter. Follow-up within 30 days. Copy of letter goes in child's file. Discuss with family that child had difficulty hearing/responding to the screening and it would be best for the child to be seen by an audiologist in the community to rule out any hearing problems. Make an effort to have face-to-face contact first.

Speech:

- To be completed by Speech Language Pathologist (SLP) from LEA or EPIC Staff if SLP is unavailable. Results provided to Manager who updates myHeadStart, file's original, updates screening summary.
- Rescreens will be done within 30 days. If 2nd screening is a retest, should refer instead.
- CANNOT say "rescreen in Kindergarten, 1st, or 2nd ". Must be pass, fail, or rescreen.
- CNT- note reason and retest within 30 days; if DLL or shy- see if parent, teacher, etc., can assist.
- Referrals- Follow process for your county. Copies of all paperwork go in child's file after first going to the Child Development Manager.
- If you notice missing paperwork, or follow-up is needed, notify manager to follow up with SLP.

Follow Up: ALL STAFF ARE RESPONSIBLE FOR COORDINATING EFFORTS FOR FOLLOW-UP ON SCREENINGS.

- Follow-up must occur at least every 30 days, until the issue has been resolved and there is documentation of the outcome is in child's individual file.
- *ALL screenings must be recorded on the EPIC Head Start Screening Summary in the child's file. All screenings must be recorded on the Manager's Screening Tracking form. A copy of the individual child screening forms must go to the county manager and the original is placed in the child's file.
- ** The EPIC Head Start Screening Summary will be shared with parents at each Parent-Teacher Conference. The parent/guardian and staff will sign and a copy will be provided to the parent/guardian.
- ALL STAFF who have contact with the child/child's file are responsible for ensuring the screening procedure and timelines are followed!

myHeadStart Entries:

Family Advocate Staff will enter: Physicals, Dentals, Vision, Hearing, Heights and Weights, Lead, Hematocrits, Immunizations.
Managers will enter: Disabilities, Speech, Brigance Developmental, Brigance Self Help Social/Emotional

Health Screening Referral

Child's Name ______________________ Parent/Guardian Name ______________________

Site/Classroom ______________________ Family Advocate ______________________

Date _____/_____/_____

EPIC Head Start's screenings are designed to assist the staff in assessing whether your child may need a complete evaluation by a medical professional. Please do not be alarmed if the screening indicates that further testing is needed.

Screening: ☐ Vision ☐ Hearing Screening Date _____/_____/_____

Result ____

____

____

____

____

It is recommended that upon receiving this referral you proceed with the following:

1. Schedule an examination with a medical professional and inform your Family Advocate of the date.
2. Take your child to the doctor's office for the examination.
3. Follow the doctor's suggestions.
4. Provide documentation of the examination from the doctor's visit to your Family Advocate.

If you have any questions or need assistance with scheduling an appointment, please contact your Family Advocate and they will be happy to help.

Health Follow Up

Child's Name ______________________________ Parent/Guardian Name ______________________________

Site/Classroom ______________________________ Family Advocate ______________________________

Date ______/______/______

There are many ways that you can keep your child healthy. Well child checks on a regular basis, keeping immunizations up to date and scheduling a dental visit (when your child is old enough) are just some ways you maintain your child's health.

EPIC Head Start works together with parents by maintaining a record of these visits and immunizations as well as supporting parents when any follow up is necessary.

While reviewing your child's records we noticed that he/she needs:

_____ Physical examination, expired/will expire ________________

_____ Dental examination, expired/will expire ________________

_____ Immunizations ________________

_____ HCT/HGB ________________

_____ Lead blood score: ________________

_____ Heights/Weights follow up

_____ Vision screening follow up

_____ Hearing screening follow up

_____ Other ____

Once these items are obtained, please provide the results to your Family Advocate or classroom teachers. Please contact your Family Advocate if you need assistance with these items or if you currently have an appointment scheduled. This information is a West Virginia Licensing Requirement.

WEST VIRGINIA EPSDT/HEALTHCHECK PROGRAM PERIODICITY SCHEDULE

	INFANCY							EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE									
AGE[1]	Newborn[2]	3-5 days[3]	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 yr	4 yr	5 yr	6 yr	7 yr	8 yr	9 yr	10 yr	11 yr	12 yr	13 yr	14 yr	15 yr	16 yr	17 yr	18 yr	19 yr	20 yr
HISTORY (Initial/Interval)	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																														
Length/Height and Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference	•	•	•	•	•	•	•	•	•	•	•																			
Weight for Length	•	•	•	•	•	•	•	•	•	•																				
Body Mass Index[4]											•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Blood Pressure[5]	★	★	★	★	★	★	★	★	★	★	★	★	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING																														
Vision Screen[6]	★	★	★	★	★	★	★	★	★	★	★	★	•	•	•	•	★	•	★	•	★	•	★	★	•	★	★	★	★	★
Hearing Screen[7,8]	•	•	—	→	★	★	★	★	★	★	★	★	★	•	•	•	★	•	★	•	←	—	•	→	←	•	→	←	•	→
DEVELOPMENTAL/BEHAVIORAL ASSESSMENTS																														
Maternal Depression Screening[9]			•	•	•	•																								
Developmental and Autism Surveillance	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Developmental Screening[10]							•			•		•																		
Autism Spectrum Disorder Screening[11]								★	★	•	•																			
Psychosocial/Behavioral Screening[12]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Depression Screening[13]																					•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol, or Drug Use Risk Assessment[14]																					★	★	★	★	★	★	★	★	★	★
PHYSICAL EXAMINATION	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES																														
Newborn Metabolic Screen[15]	•	•	—	→																										
Newborn Bilirubin Screen[16]	•																													
Critical Congenital Heart Defect Screen[17]	•																													
Immunizations[18]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Anemia Risk Assessment[19]					★				★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Hemoglobin or Hematocrit Screen[20]								•																						
Lead Risk Assessment[21]						★	★		★	★		★	★	★	★	★														
Blood Lead Screen[22]								•			•		—	—	—	→														
Tuberculosis Risk Assessment[23]			★			★		★			★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Risk Assessment[24]											★			★		★		★	★	★	★	★	★	★	★	★	★	★	★	★
Fasting Lipoprotein Profile[25]																			←	•	→						←	•	—	→
Sexually Transmitted Infections (STI) Risk Assessment[26]																					★	★	★	★	★	★	★	★	★	★
HIV Risk Assessment																					★	★	★	★	★	★	★	★	★	★
HIV Screen[27]																									←	—	•	→		
Hepatitis C Virus Infection[28]																												•	—	→
ORAL HEALTH[29,30]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Fluoride Varnish[31]						←	—	—	—	•	—	—	—	—	→															
Fluoride Supplementation Assessment[32]						★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★				
ANTICIPATORY GUIDANCE	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

KEY: • = to be performed ★ = risk assessement to be performed with appropriate action to follow, if positive ← • → = range during which a service may be provided

The HealthCheck Program works to equip West Virginia's Medicaid providers with the necessary tools and knowledge to carry out EPSDT services appropriate to the American Academy of Pediatrics' (AAP) standard for pediatric preventive health care, *Bright Futures, Guidelines for Health Supervision of Infants, Children and Adolescents* ([illegible]). HealthCheck stresses the importance of continuity of care in the medical home and the need to avoid fragmentation of care.

(1) If a child comes under the care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.
(2) Newborns should have an evaluation after birth and breast feeding should be encouraged (instruction and support should be offered).
(3) Newborns should have an evaluation within 3-5 days after birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" ([illegible]). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" ([illegible]).
(4) Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" ([illegible]).
(5) Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" ([illegible]). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
(6) A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" ([illegible]) and "Procedures for the Evaluation of the Visual System by Pediatricians" ([illegible]).
(7) Newborn hearing screening should be completed according to WV state law ([illegible]). Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" ([illegible]).
(8) Screen with audiometry including 6000 and 8000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" ([illegible]).
(9) Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" ([illegible]).
(10) Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" ([illegible]).
(11) Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" ([illegible]).
(12) This assessment should be family centered and include an assessment of child social emotional health, caregiver depression, overall stressors and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" ([illegible]) and "Poverty and Child Health in the United States" ([illegible]).
(13) Patient Health Questionnaire (PHQ) 2 recommended questions on the Preventive Health Screening forms. If positive, perform PHQ 9 ([illegible]) or other tool available in the GLAD-PC toolkit and at [illegible].
(14) If positive for tobacco, alcohol and/or drug use, complete recommended screening tool CRAFFT available at ([illegible]) or Substance Abuse and Mental Health Services Administration (SAMHSA) -Screening, Brief Intervention, and Referral to Treatment (SBIRT) ([illegible]).
(15) Newborn metabolic screening should be completed according to State law ([illegible]). Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel ([illegible]), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations ([illegible]) establish the criteria for and coverage of newborn screening procedures and programs.
(16) Confirm initial screening was completed, verify results, and follow up as appropriate. See "Hyperbilirubinemia in Newborn Infant ≥ 35 Weeks' Gestation: An Update with Clarifications" ([illegible]).
(17) Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from hospital. Refer to the Bureau for Public Health policy at ([illegible]).
(18) Every visit should be an opportunity to update and complete a child's immunizations. See Immunization Schedules for Providers ([illegible]).
(19) Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).
(20) Hemoglobin or Hematocrit screen to be completed at 12 months.
(21) For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" ([illegible]) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" ([illegible]).
(22) All children should be screened for lead at 1 year and again at 2 years of age and children 36 months to 72 months of age who have not been screened previously. ([illegible]).
(23) Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
(24) See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" ([illegible]).
(25) Screening for dyslipidemia (fasting lipoprotein profile) should occur once between 9 and 11 years of age and once between 17 and 21 years of age to be consistent with guidelines of the National Heart, Lung, and Blood Institute.
(26) Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
(27) Adolescents should be screened for HIV according to the US Preventive Services Task Force (USPSTF) recommendations ([illegible]) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
(28) All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF ([illegible]) and Centers for Disease Control and Prevention (CDC) recommendations ([illegible]) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.
(29) Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment ([illegible]) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" ([illegible]).
(30) Perform a risk assessment ([illegible]). See "Maintaining and Improving the Oral Health of Young Children" ([illegible]).
(31) See USPSTF recommendations ([illegible]). Once teeth are present, fluoride varnish may be applied to all children every 3 to 6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" ([illegible]).
(32) If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" ([illegible]).

WEST VIRGINIA
Department of
Health & Human Resources
BUREAU FOR PUBLIC HEALTH
West Virginia HealthCheck Program

Iron-Deficiency/Anemia Risk Factors

- Low birthweight or preterm birth
- Non-iron-fortified formula
- Cow's milk before age 12 months
- Diet low in iron, inadequate nutrition
- Low in iron due to special health needs
- Environmental factors (poverty, limited access to food)
- Meal skipping, frequent dieting
- Heavy/lengthy menstrual periods or recent blood loss
- Intensive physical training or participation in endurance sport
- Pregnancy or recent pregnancy

Lead Risk Factors

- Live in or visit a home or child care facility with an identified lead hazard
- A home built before 1960 that is in poor repair or has been recently renovated
- Live near a heavily traveled highway or battery recycling plant or live with an adult whose job or hobby involves exposure to lead
- Has a sibling or playmate who has or did have lead poisoning

Tuberculosis (TB) Risk Factors

- Radiographic findings suggesting TB
- Contact with persons with confirmed or suspected TB
- Immigrant from high prevalence areas (e.g., Canada, Australia, New Zealand, or Western European countries)
- Travel to high prevalence areas
- Infected with human immunodeficiency virus (HIV)

Dyslipidemia Risk Factors

- Positive family history is defined as a history of premature (≤ 55 years of age in male or < 65 years in female) cardiovascular disease in a parent, grandparent, aunt or uncle, or sibling
- Positive family history, elevated blood cholesterol ≥ 240 mg/dl
- Unknown family history, adopted
- Cigarette smoking
- Elevated blood pressure
- Overweight/Obesity (BMI ≥ 95%)
- Diabetes mellitus
- Physical inactivity
- Poor dietary habits

Sexually Transmitted Infections (STI) Risk Factors

- Multiple or anonymous sex partners
- Sex in conjunction with illicit drug use
- Sex with partners who have sex with multiple or anonymous partners and/or use illicit drugs
- Those in adult correctional facilities

Human Immunodeficiency Virus (HIV) Risk Factors

- Males who have sex with males
- Active injective drug users
- Unprotected vaginal or anal sex
- Sexual partners who are HIV infected
- Exchange sex for drugs or money
- Acquired or tested for STIs

For more information contact the HealthCheck Program at 1-800-642-9704 or visit our website at www.dhhr.wv.gov/healthcheck.

WVDHHR/BPH/OMCFH/HealthCheck revised July 2021

EPIC Early Head Start/Head Start/Pre-K
109 S. College Street
Martinsburg, WV 25401
phone - 304-267-3595
fax - 304-267-3599

BIRTH HISTORY – CHILD

Child's Name: ______________________ D.O.B__________

Completed by: Name: ______________________

Date Completed: ___/___/___

PRENATAL HISTORY

Time mother received prenatal care:
- ☐ First 3 months of pregnancy ☐ Middle 3 months of pregnancy ☐ Last 3 months of pregnancy
- ☐ No prenatal care received ☐ Don't know

Complications mother experienced during pregnancy (*check all that apply*):

☐ Don't know	☐ Stress	☐ Diabetes (insulin dependent)
☐ Abdominal Pain	☐ Swelling	☐ Pregnancy-induced hypertension
☐ Headaches	☐ Chronic Fatigue	☐ Low Birth Weight
☐ Hypertension	☐ Vaginal Bleeding (after 12 wks)	☐ Pre-term labor
☐ Uterine Irritability	☐ Anemia (Hgb<10 or Hct<30)	☐ C-section
☐ Anxiety	☐ Sickle cell anemia	☐ Other, specify __________

Prenatal Exposure to Drugs:
- ☐ Don't know
- ☐ Alcohol ☐ Non-prescription Drugs, specify __________
- ☐ Caffeine ☐ Prescription Drugs
- ☐ Cigarettes/Tobacco ☐ Other, specify __________

BIRTH HISTORY

Delivery location: ☐ Hospital ☐ Birthing Center ☐ At home ☐ Don't know
☐ Other, specify __________

Type of delivery: ☐ Vaginal ☐ C-Section ☐ Don't know

Length of infant hospital stay:
- ☐ Don't know
- ☐ Routine Stay ☐ One week to one month ☐ Over 1 month
- ☐ Non-routine (less than 1 wk)

Reason for non-routine hospital stay:______________________

Observable birth defects:______________________

____

Does child have tubes in their ears? __________

Comments:______________________

EPIC Head Start
Nutritional Screening Interview

Child's Name: ______________________ Interviewer: ______________________

Date: ______________

Please answer YES or NO for each question as it applies to your child.

Question		
Does your child have a health problem (do not include colds or flu)? If yes, what is it?	YES	NO
Is your child: small for age? ____ Too thin?____ too heavy? _____ (if you check any of the above, please circle YES)	YES	NO
Does your child have feeding problems? If yes, what are they?	YES	NO
Is your child's appetite a problem? If yes, describe:	YES	NO
Is your child on a special diet? If yes, what type of diet?	YES	NO
Does your child take medicine for a health problem (do not include vitamins, iron, or fluoride)? Name of medicine(s):	YES	NO
Does your child have food allergies? If yes, to what foods?	YES	NO
Has your child ever been stung by an insect? If yes, has he/she had allergic reaction?	YES	NO
Does your child have a feeding tube or other special feeding method? If yes, explain:	YES	NO
Circle YES if your child has problems with (check all that apply) Sucking ___ Swallowing ___ Chewing ____ Gagging ____	YES	NO
Does your child eat clay, paint chips, dirt, or any other things that are not food? If yes, what?	YES	NO
Does your child refuse to eat, throw food, or do other things that upset you at mealtime? If yes, explain:	YES	NO
Favorite cultural food preferences:		

Parent Signature: ______________________________

Entire Panhandle Instructional Cooperative
EPIC

Health and Screening Timelines

Screening	Initial Screening Due	Rescreen Due	Referral Due	Referral Form/Letter	Follow-up
Physical	30 days		Immediately if indicated	Health Follow Up	30 days prior to expiration and then as needed
Height and Weight	October January May		Immediately for concerns	Health Follow Up	30 days of referral and then as needed
Dental	45 days		Immediately if indicated	Health Follow Up	30 days prior to expiration and then as needed
Immunizations Catch-up Plan	Prior to entry 30 days		Immediately for Catch Up Plan if not up to date	Health Follow Up	30 days of referral and then as needed
Vision	45 days		Immediately	Health Screening Referral	30 days of referral and then as needed
Hearing	45 days	30 days	Immediately	Health Screening Referral	30 days of referral and then monthly as needed
Speech	45 days	30 days	Immediately	LEA sends notification	30 days of referral and then monthly as needed
Developmental	45 days	30 days	Immediately	CD Manager will follow individual County LEA process in place	30 days of referral and then monthly as needed
Self Help / Social Emotional	45 days	30 days	Immediately	Self Help/Social Emotional Referral	30 days of referral and then monthly as needed
Nutritional	30 days		Immediately for concerns	Health Follow Up	30 days of referral and then monthly as needed
Lead	30 days		Immediately for high risk	Health Follow Up	30 days of referral and then as needed
HCT/HGB	30 days		Immediately for high risk	Health Follow Up	30 days of referral and then as needed

***Initial Screening Due dates will be calculated from each child's Enrollment Date (1st day attended) using calendar days.**
***Rescreen Due dates will be calculated from the Initial Screening Due date using calendar days.**
***All screenings, rescreens, referrals, follow-up will be documented in myHeadStart and in the child's file.**

Eastern Panhandle Instructional Cooperative
EPIC

Screening Summary

Child's Name ______________________________ Date of Birth _____/_____/_____

Disability Summary ☐ Did not qualify

☐ Entered program with IEP IEP Date _____/_____/_____

☐ Referred after program entry Referral Date _____/_____/_____

☐ Speech
☐ Developmental
☐ Other ______________________

Mental Health Summary ☐ Did not qualify

☐ Referred Date _____/_____/_____

☐ Accepted ☐ Community Referral

Screening	Initial Date mm.dd.yy	Initial Result		Rescreen Date mm.dd.yy	Rescreen Result		Referral Date mm.dd.yy	Completed Date mm.dd.yy	Follow-up Notes
		Score	Outcome		Score	Outcome			
Vision			☐ Pass ☐ Rescreen ☐ Refer			☐ Pass ☐ Rescreen ☐ Refer			
Hearing			☐ Pass ☐ Rescreen ☐ Refer			☐ Pass ☐ Rescreen ☐ Refer			
Speech			☐ Pass ☐ Rescreen ☐ Refer			☐ Pass ☐ Rescreen ☐ Refer			
Developmental		☐ ANL/WNL ☐ BNL	☐ Pass ☐ Rescreen ☐ Observation Dt _____ ☐ Refer		☐ ANL/WNL ☐ BNL	☐ Pass ☐ Rescreen ☐ Observation Dt _____ ☐ Refer			
Self Help / Social Emotional		SH _____ ☐ AA ☐ A ☐ BA SE _____ ☐ AA ☐ A ☐ BA	☐ Pass ☐ Rescreen ☐ Refer		SH _____ ☐ AA ☐ A ☐ BA SE _____ ☐ AA ☐ A ☐ BA	☐ Pass ☐ Rescreen ☐ Refer			

Reviewed with parent/guardian at 1st Parent Conference: **Date** _____/_____/_____

Parent/Guardian Signature ______________________________

Staff Signature ______________________________

Reviewed with parent/guardian at 2nd Parent Conference: **Date** _____/_____/_____

Parent/Guardian Signature ______________________________

Staff Signature ______________________________

EPIC Head Start & Pre-K
Lead Risk Assessment

Child's Name: ______________________________________ Date of Birth: ______________________

How long has child lived at current address? ______________________________

Lead Risk Assessment Questionnaire: - Circle YES or NO
Has the child ever:

- Lived in or regularly visited a house with peeling or chipping paint built before 1978? (includes day care centers, preschool, baby sitter, relatives, etc.) YES NO
- Lived in or regularly visited a house built before 1978 that was, or is being, renovated or remodeled?
  YES NO
- Lived in a house with plumbing made of lead pipes or copper with lead solder joints?
  YES NO
- Taken any home or folk remedies which might have contained lead; eaten or drank from pottery or dishes which were homemade or made in another country that might have contained lead? YES NO
- Had a brother, sister, housemate, or playmate being followed or treated for lead poisoning (blood lead 10 mg/dl or more)?
  YES NO
- Lived with, or had frequent contact with, an adult whose job or hobby involved exposure to lead?
  YES NO

Has the child had a blood test for lead? ________ **If yes: Where** ________________ **When** ____________

Rate the child HIGH RISK if there are one or more YES answers to the above. Rate the child LOW risk if all answers are NO. A child at low risk will be reassessed at the next screening. (Retain this form in the child's medical record.)

Date Completed Lead Risk

(3 yrs) 36 months: ________________ High Low (4 yrs) 48 months: ______________ High Low

Hematocrit/Hemoglobin Screening

CHILDREN 2 to 12 YEARS

☐ Diet low in iron
☐ Limited access to food
☐ Neglect
☐ History of iron deficiency or anemia
☐ Children with special health needs (conditions that suppress appetite or interfere with iron absorption, restricted diets, chronic infections, etc.)
☐ No needs at this time

_______________________________ _______________________________
Parent Signature/Date Head Start Staff Signature/Date

4/8/2022 updated

EPIC Head Start/Pre-K Individualized Health Plan

ROUTINE CARE

Today's Date: ____________________ Review no later than: ______________________

Child's Name: ____ Birthdate: _______________

Parent(s) or Guardian(s): ____

Phone number: ______________________________

Diagnosis: 1.____________________________ 2.________________________________

3.____________________________________

Regularly Scheduled Medications

Medication	Schedule (When)	Dose (How Much)	Route (How)	Possible Side Effects

Describe accommodations the child needs in daily activities	Check whether accommodations needed at:	
	HOME	SCHOOL
Diet or Feeding:		
Classroom Activities:		
Naptime/Sleeping:		
Toileting		
Outdoor Activities/Field Trips:		
Transportation		
Other:		

Parent(s) or Guardian(s) Signatures: ____

Primary Health Care Provider Signature: ____

EPIC Head Start/Pre-K Staff Signature: ____

Updated May 2018

EPIC HEAD START/PRE-K
MEDICATION ADMINISTRATION POLICY

PURPOSE:

This policy define the requirements and procedures for administering medications to children enrolled in the EPIC Head Start/Pre-K program.

Only authorized staff who have successfully completed a Medication Administration Training will administer medications.

Because administration of medication poses an extra burden for staff, and having medication in the facility is a safety hazard, families are asked whenever possible to arrange with their child's medical provider to schedule medications at times that do not include the hours the child is in the child care facility.

***The first dose of any medication must be given at home to be sure that the child does not have an unexpected reaction to the medication.**

Parents or guardians may administer medication to their own child during the child care day.

PROCEDURE:

Qualified Center staff will administer medications only if the parent or legal guardian:

- Has provided written consent
- The medication is in the original prescription or over the counter container properly labeled.
- The Center has on file the written instructions of a health care provider for administration of the specific medication.

1. For prescription medications, parents or legal guardians must provide care givers with the medication in the original, child-resistant container that is labeled by a pharmacist with the child's first and last name; the name of the medication; the date the prescription was filled; the name of the health care provider who wrote the prescription; the medication's expiration date; and administration, storage and disposal instruction.

2. For over the counter medications, EPIC Early Head Start/Head Start/Pre-K requires a written prescription for all over the counter medications.

3. Instructions for the dose, frequency, method to be used, and duration of administration must be provided to the child care staff in writing by a signed note or a prescription label. This requirement applies both to prescription and over the counter medications.

4. Children with recurring or ongoing health needs must have a health care plan with instructions from the prescribing physician for administration of specific medications based on need. The instructions must include the child's first and last name, the name of the medication; the dose; the method of administration; how often the medication may be given; the conditions for use; and any precautions to follow. Where required, staff must have additional, specific training and authorization to administer emergency or other special medications. (See additional information below specific to WV).

5. Medications and medication supplies must be stored in a clean, secure and locked area in a cool, dry place. This may be a locked strong box or cabinet that **is not within reach of children.** Medications requiring refrigeration must be kept in a secure, leak-proof container in a designated area of the refrigerator, if a separate refrigerator in not available.

6. Controlled substances such as Ritalin® shall be counted with the parent when received and then daily and documented on a log for that purpose, as per Center policy on Management of Controlled Medications.

6. Controlled substances such as Ritalin® shall be counted with the parent when received and then daily and documented on a log for that purpose, as per Center policy on Management of Controlled Medications.

7. Medications shall not be used beyond the date of expiration noted on the container or beyond any expiration of the instructions supplied by the prescribing health care provider. Expired medications will be returned to the parents. All disposed medications will be documented per Center policy on Disposal of Medications.

8. A medication log for each child will be maintained by the Center's designated Medication Administration Staff to record the instructions for giving medications; consent from the parent or guardian; amount, time and method of administration; the signature of the staff administering the medication; and any observations, comments related to administration of the medication. Spills, reactions and refusal to take medication will be noted on the log.

9. Medication errors will be handled and documented as per Center policy (Serious Occurrence Form) on Medication Errors, Injuries and Significant Incidents.

* American Academy of Pediatrics, Model Child Care Health Policies, "Medication Policy" 4th Edition, September 2002 pg., 7-8

THE SEVEN RIGHTS OF MEDICATION ADMINISTRATION

These seven rights are a safety check to help reduce the chance of making a mistake in medication administration.

1. **RIGHT CHILD -** Protect Confidentiality
   - Is this the right child? Double Check, even if you think you know the child to whom you're giving the medication
   - Check the name on the medication label against the permission form
   - Confirm the child's identity with another person
   - Ask the child his name
   - Verify the child's identity with the child's picture if available

2. **RIGHT MEDICATION**
   - Medications must be given from a properly labeled original bottle
   - Compare the prescribing practitioner's written authorization form to the pharmacy label and medication log
   - <u>Read the label three times</u>
     - First, when it is removed from the secured cabinet
     - Second, when the medicine is poured
     - Third, when returning the medication to the secured cabinet

3. **RIGHT DOSE**
   - Give the exact amount of medicine specified by the order from the health care provider and pharmacy label
   - Use standard measuring devises for medications
   - **Do Not Use Kitchen Utensils.** These do not provide accurate measurements
     - 1milliter = 1cc
     - 5 milliters or 5 cc = 1 teaspoon

4. **RIGHT TIME**
   - Check with the parent/guardian the time when the medication was last given at home
   - Check the medication log for the time the medicine needs to be given by child care staff
   - Check to see if the medicine has already been given for the current day or dosage
   - Plan to give medication at time ordered; Up to 30 minutes before or 30 minutes after the time scheduled is allowed before it is considered a medication error

5. **RIGHT ROUTE**
   - Check the medication order and the pharmacy label for the route the medication is to be given e.g., by mouth, inhaled, ear drops, eye drops, topical

6. **RIGHT REASON**
   - Check that medication is being given for right reason (e.g. cough preparation for cough, Tylenol® for fever).

7. **DOCUMENTION**
   - Maintain a record of all medication administered to children
   - Document only medication you have administered
   - Administer only medication you have prepared
   - Remember

IF IT ISN'T WRITTEN - IT DIDN'T HAPPEN

TRIPLE CHECK THESE SEVEN R'S EVERY TIME YOU GIVE MEDICATION

EPIC EARLY HEAD START/HEAD START/PRE-K
Medication Administration
Instructions for Health Care Provider

Medication will be administered by Staff of Early Head Start/Head Start/Pre-K only when this form is completed and signed by the child's health care provider and parent/guardian.

Parent/guardian **must** administer the initial dose of ALL medications, **not** program staff.

Over the counter, non-prescription medications must follow the same procedure as prescription medications.

HEALTH CARE PROVIDER
Please provide the following information

Childs first and last name: ______________________________

Medical Condition being treated: ______________________________

Medication: ______________________________

Dosage: ______________ Frequency/Time: ______________ Route: ______________

Duration of Treatment: (use dates) From: ______________ To: ______________

Comments or Specific Instructions: ______________________________

____

____

______________________________ ______________
Health Care Provider Signature **Date**

Health Care Provider's Name: ______________________________

[Please print] Address: ______________________________

______________________________ ______________
Parent/Guardian Signature **Date**

Medication Permission and Documentation Form

Name of Child: ________________________________ D.O.B.: __________ Today's Date: ______________

Name of Medication: ____

Reason for Medication: ____

Dose: _________________________ Time/Frequency: ____

Route: ☐ Oral ☐ Topical Inhaled Injection Other

Date to start: ____________________ Date to stop: _____________________ Expiration: _______________

Additional Instructions/Comments: ____

____

Known side effects: ____

____

FOR PRESCRIPTON MEDICATION

Prescribing Health Care Provider: ____

Phone Number: ______________________________

FOR CONTROLLED SUBSTANCES

Amount of Medication Received ____

Staff Member Signature: ____

Staff Member Signature: ____

I authorize EHS/HS/PK program personnel to administer to administer the medication named above to my child in the manner as stated. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions.

Parent/Guardian printed name: ________________________________ **Date Signed:** _____________

Parent/Guardian signature: ____

RETURN OR DISPOSAL OF MEDICATION

Return Date: _______________ Parent Signature: ____

Disposal Date: _______________ Staff Signature: ____

Witness to Disposal: ____

Child's Name: ____________________________ Name of Medication: _____________________ Child's Classroom/Teacher: _______________________

ALWAYS review the written Parent/Guardian medication instructions and Health Care Provider's medical order (when necessary according to regulation) prior to EVERY administration. Instructions should be attached to this sheet.

7 Rights **MUST** be performed with **EVERY** dose! Right **child**, Right **medication**, Right **dose**, Right **route**, Right **time**, Right **reason**, Right **documentation**

Date Given	Time Given	Dose Given	Route Given	Time last dose was given by Guardian	Comments/Reactions	Controlled Substances				Staff Signature	Quality Check
						# on Hand	# Given	# Remain	Staff Signature		

Safety Check:

1. Child resistant container
2. Name of child on container
3. Name and phone number of health care provider who ordered medication
4. Original prescription or manufacturer's label and health provider's directions for use.
5. Current date on prescription/expiration label

RECORD OF EMERGENCY MEDICATION ADMINISTRATION

Child's name ______________________ Parent/guardian name ______________________

Allergies ______________________ Phone (home) ______________________

Date ______________________ Phone (work) ______________________

Time of occurrence ____

Symptoms ____

____

____

____

Medication/s administered ______________________ Dose ______________

Route ____

If pre-measured EpiPen®/EpiPen® Jr., location where injection was given.

Time ____________ 911 called ____________ Parent/guardian called ____________

(time) (time)

Side effects

____

____

____

Disposition of child (e.g. taken by ambulance to hospital/clinic, etc.)

____

____

____

Signature ______________________________ Date ______________

EPIC EARLY HEAD START / HEAD START / PRE-K
CONTROLLED SUBSTANCE LOG

NAME OF CHILD receiving controlled substance ____________________________________

Name of controlled substance ______________________ Strength and Route _______________

Number Received __________________ Date Received __________________

____
Signature of Child Care Staff receiving substance Date

____
Witness Signature of Child Care Staff receiving substance Date

____
Signature of Parent/Guardian providing substance Date

Date	Amount Given/Route	Time Given	Number/Amt. on Hand	Number/Amt. Given	Number/Amt. Remaining	Signature/s

EPIC EARLY HEAD START / HEAD START / PRE-K

MEDICATION DISPOSAL LOG

Head Start Classroom ______________________________

DATE / TIME	CHILD'S NAME	MEDICATION / FORM	AMOUNT	STAFF / PARENT SIGNATURE	HOW DISPOSED (i.e. given to parent / guardian, flushed down toilet, etc.)

Health Care Plan

SEVERE ALLERGY TO: ____________________________

Child's Name: ____________________________ Birth Date: ____________________

Center: ____________________________ Classroom: ____________________

EMERGENCY TREATMENT

For Mild Symptoms

- Several hives
- Itchy Skin

OR if an ingestion (or sting) is suspected:

- Swelling at site of an insect sting

Treatment

1. **Contact** the parent/guardian or emergency contact person
2. **Stay** with the child; keep child quiet, monitor symptoms until parent/guardian arrives
3. **Watch** student for more serious symptoms listed below.

Dosage ____________________ **Time** ____________________

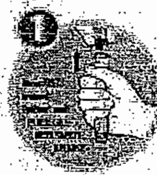
Severe Symptoms can cause a Life Threatening Reaction

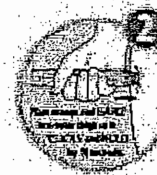
- Hives spreading over the body
- Wheezing, difficulty swallowing or breathing
- Swelling of face/neck, tingling or swelling of tongue
- Vomiting
- Signs of shock (extreme paleness/grey color, clammy skin)
- Loss of consciousness

Treatment

1. Use, pre-measured EpiPen®/EpiPen®Jr. immediately, place against child's upper outer thigh, through clothing if necessary.
2. **CALL 911** (or local emergency response team) immediately. ***911 (emergency response team) should always be called if EpiPen®/EpiPen® Jr. is given.**
3. Contact parent/guardian or emergency contact person. If parent/guardian unavailable, center staff should accompany the child to the hospital.

Directions for use of EpiPen®/EpiPen® Jr.:





1. Pull off grey cap.
2. Place black tip against child's upper outer thigh.
3. Press hard into outer thigh, until it clicks.
4. Hold in place 10 seconds, then remove.
5. Discard EpiPen®/EpiPen® Jr. in impermeable can. Dispose of per center policy or give to emergency care responder. Do not return to holder.

Special Instructions (for health care provider to complete)

Prescribing Practitioner Signature ______________________________ Date ____________

Parent / Guardian Signature ______________________________ Date ____________

Using Pre-measured EpiPen®/EpiPen® Jr.

In the event of anaphylaxis, an allergic reaction that may be triggered by **asthma**, an **insect bite**, a **medication allergy**, or a **food allergy**, pre-measured **EpiPen®/EpiPen® Jr.** would be used **ONLY** for the **child for whom it was prescribed.** In addition, this **child would also have an individual health care plan** as well as **parent/guardian's written permission** on file.

Allergic Reactions

Mild symptoms may include	**Rash** **Itching** **Hives**
Moderate symptoms may include above plus	**Breathing difficulty** **Wheezing**
Severe symptoms may include above plus	**(Anaphylactic shock)** **Severe breathing difficulty** **Shock (vascular collapse)** **Laryngeal swelling (throat closing)** **Cardiac arrest**

If any of the above symptoms occur:

1. **Call 911.** Call for staff to assist with child and/or to call parent/guardian.
2. **Get EpiPen®/EpiPen® Jr.** Put on disposable gloves if available.
3. **Remove protective covering** of EpiPen®/EpiPen® Jr. (auto-injector).
4. **Give child quick explanation** of what you are going to do.
5. Have assistant **help hold child securely.**
6. Make a **fist around the auto-injector with black tip facing down.**
7. **DO NOT REMOVE THE SAFETY CAP UNTIL READY TO USE THE AUTO-INJECTOR.**
8. **Pull off gray safety cap.**
9. **Once gray cap is removed, auto-injector is ready for use.**
10. **NEVER PUT YOUR FINGERS OVER THE BLACK TIP WHEN REMOVING THE SAFETY CAP OR AFTER SAFETY CAP HAS BEEN REMOVED.**
11. Place **black part of syringe against skin of child's upper outer thigh, through clothing if necessary.**
12. **DO NOT PUT YOUR THUMB OVER THE END OF AUTO-INJECTOR.**
13. **Press hard** (holding at 90 degree angle to skin) until you **hear a click** at which point the auto-injector **releases the medication.**
14. At this point, **child will feel a pinch.**
15. **Keep** auto-injector **in place for count of 10** so that all **medication is delivered.**
16. **Remove** and **massage area for 10 seconds—apply band aide.**
17. **Dispose of entire auto-injector** in coffee can or give to EMS staff.
18. **Document medication was given on medication administration log or Emergency Medication** Sheet (if used in center).
19. **If parent/guardian unavailable, accompany child to hospital/clinic.**
20. **Remind** parent/guardian—must provide "new" **EpiPen®/EpiPen® Jr. for child.**

STEPS TO FOLLOW DURING AN ASTHMA EPISODE

1. Give medication as listed in **Asthma Health Care Plan.**
2. Encourage child to relax with slow deep breaths.
3. Offer sips of warm water to relax and refocus the child's attention.
4. **Contact parent/guardian** if no improvement after 15-20 minutes.
5. **See emergency medical care or call 9-1-1** if the student has any of the following:
   - No improvement 15-20 minutes after initial treatment with medication and a emergency contact person cannot be reached.
   - Difficulty breathing with:
     - chest and neck "pulling in" with breathing
     - child is hunched over
     - child is struggling to breathe
   - Trouble walking or talking
   - Stops playing and can't start activity again due to breathing difficulties.
   - Lips or fingernails turn gray or blue
   - Decreasing or loss of consciousness

ASTHMA EMERGENCY PLAN

Emergency action is necessary when the child has symptoms such as

____

or has a peak flow reading at or below ____________

Steps to take during an asthma episode:

1. Check peak flow reading (if child uses a peak flow meter).
2. Give medications as listed below.
3. Check for decreased symptoms and/or increased peak flow reading.
4. Allow child to stay at child care setting if: ____________

   ____

5. Contact parent/guardian
6. See emergency medical care if the child has any of the following:

→ No improvement minutes after initial treatment with medication.
→ Peak flow at or below————
→ Hard time breathing with:
- ▶ Chest and neck pulled in with breathing.
- ▶ Child hunched over.
- ▶ Child struggling to breathe.

→ Trouble walking or talking.
→ Stops playing and cannot start activity again.
→ Lips or fingernails are gray or blue.

IF THIS HAPPENS,

←GET EMERGENCY→

HELP NOW!

Child is allergic to: ____________

____

____

Steps to take during an allergy episode:

1. If the following symptoms occur, give the medications listed below.
2. Contact Emergency help and request epinephrine.
3. Contact the child's parent/guardian.

Symptoms of an allergic reaction include:

(Health Care Provider, please circle those that apply)

→ Mouth/Throat: itching & swelling of lips, tongue, mouth, throat; throat tightness; hoarseness; cough
→ Skin: hives; itchy rash; swelling
→ Gut: nausea; abdominal cramps; vomiting; diarrhea
→ Lung*: shortness of breath; coughing; wheezing
→ Heart: pulse is hard to detect; "passing out"
*If child has asthma, asthma symptoms may also need to be treated.

Emergency Asthma Medications:

	Name	Amount	When to Use
1			
2			
3			
4			

Emergency Allergy Medications:

	Name	Amount	When to Use
1			
2			
3			
4			

Special Instructions:

____

____

Special Instructions:

____

____

Health Care Provider Signature Date

Parent/Guardian's Signature Date

Child Care Provider's Signature Date

Medication Administration in School or Child Care
Nebulizer Treatments or Inhaled Medications

Parent or Guardian Permission

The parent/guardian of ______________________ ask that school/child care staff give the following

medication ______________________ at ______________
(Name of medicine and dosage) (Time)

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

- The Program agrees to administer medication prescribed by a licensed health care provider.
- It is the parent/guardian responsibility to furnish the medication and equipment and to keep daily emergency contact information up to date.

By signing the document, I give permission for my child's health care provider/clinic to share necessary information regarding the care of my child's health condition with Program staff.

______________________ ______________________ ____________
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

______________________ ______________________
Home Phone Work Phone

Health Care Provider Authorization

Child's Name ______________________ Birthdate: ____________

Name of inhaled medication: ______________________

Dosage: ____________

To be given in school/child care at the following time(s): ______________________

<u>Note to health care provider</u>: Specific time and/or interval must be indicated on this form in order for non-medical persons in school/child care to administer medication

Start Date: ____________ End Date: ____________

Usual (baseline) respiratory rate for this child: ____________

Comments: ______________________

<u>Seek Emergency Medical Care if the child has any of the following:</u>

- Respiratory rate greater than ______
- Coughs constantly
- Hard time breathing with:
  - Chest and neck pulled in with each breath
  - Struggling or gasping for breath
- Trouble walking or talking
- Lips or fingernails are grey or blue
- Other

______________________ ____________
Signature of Health Care Provider with Prescriptive Authority Phone

NEBULIZER TREATMENT LOG

Center ______________________________

Child's Name ____________________________________

Classroom ______________________________

Medication and dosage 1.______________________________

Time(s) to be given ______________________________

2.______________________________

Start date ____________ End date ____________

Special Instructions:____

Daily reminder: Ask the parent/guardian the time of the last treatment. Nebulizer treatments should not be given more than every 4-6 hours. Be sure to follow written instructions provided by the health care provider.

Date	Time	Breath rate per minute: before	Breath rate per minute: after	**Observations** (Cough, skin color, secretions, any discomfort, activity level, etc.)	Staff Initials

Comments:

Staff Signature and Initials:______________________________ ______________________________

______________________________ ______________________________

Normal breathing rate at rest:

Infant < one year: 20-40 breaths/minute **Toddler:** 18-30 breaths/minute **School age child**: 16-25 breaths/minute

EPIC Early Head Start/Head Start & Pre-K
Communicable Disease Procedure

When an outbreak of any communicable illness occurs, EPIC Early Head Start/Head Start & Pre-K shall exclude a child from our centers if a licensed health care provider determines that the child is contributing to the transmission of the illness.

Children who are not immunized against vaccine-preventable communicable diseases shall be excluded from our centers until a licensed health care provider determines that the risk for transmission of the communicable disease has passed.

Any child that has been excluded from our center due to a communicable disease shall be readmitted only after the parent or guardian provides a signed note from a licensed health care provider that the risk of transmission has passed and that the child is now well enough to return to the center.

Our policy on communicable diseases is taken directly from the Child Care Center Licensing Regulations from DHHR. (15.4.f)

The EPIC Early Head Start/Head Start & Pre-K Program requires that all families have their child immunized. If you have any concerns regarding our policy, or the importance of immunizing your child, please feel free to contact our Health and Safety Specialist at 304-267-3595.

When to Keep Your Child at Home or Cancel Home Visit

Children with the following symptoms should be at home and the home visit should be cancelled:

- Yellowish eyes or skin
- Severe coughing
- Difficult or rapid breathing
- Diarrhea
- Pinkeye

If the child has a fever above 100.4 degrees and any of the following symptoms, the child should be kept at home and the home visit should be cancelled.

- Spots or rashes
- Sore throat or trouble swallowing
- Infected skin patches
- Unusually dark or tea-colored urine
- Gray or white stool
- Headache or stiff neck
- Vomiting
- Unusual behaviors such as:
  crankiness, continuous crying or low activity
- Loss of appetite
- Severe itching of body or scalp

-- From the Center for Disease Control

When may Students Return to School after an Illness?

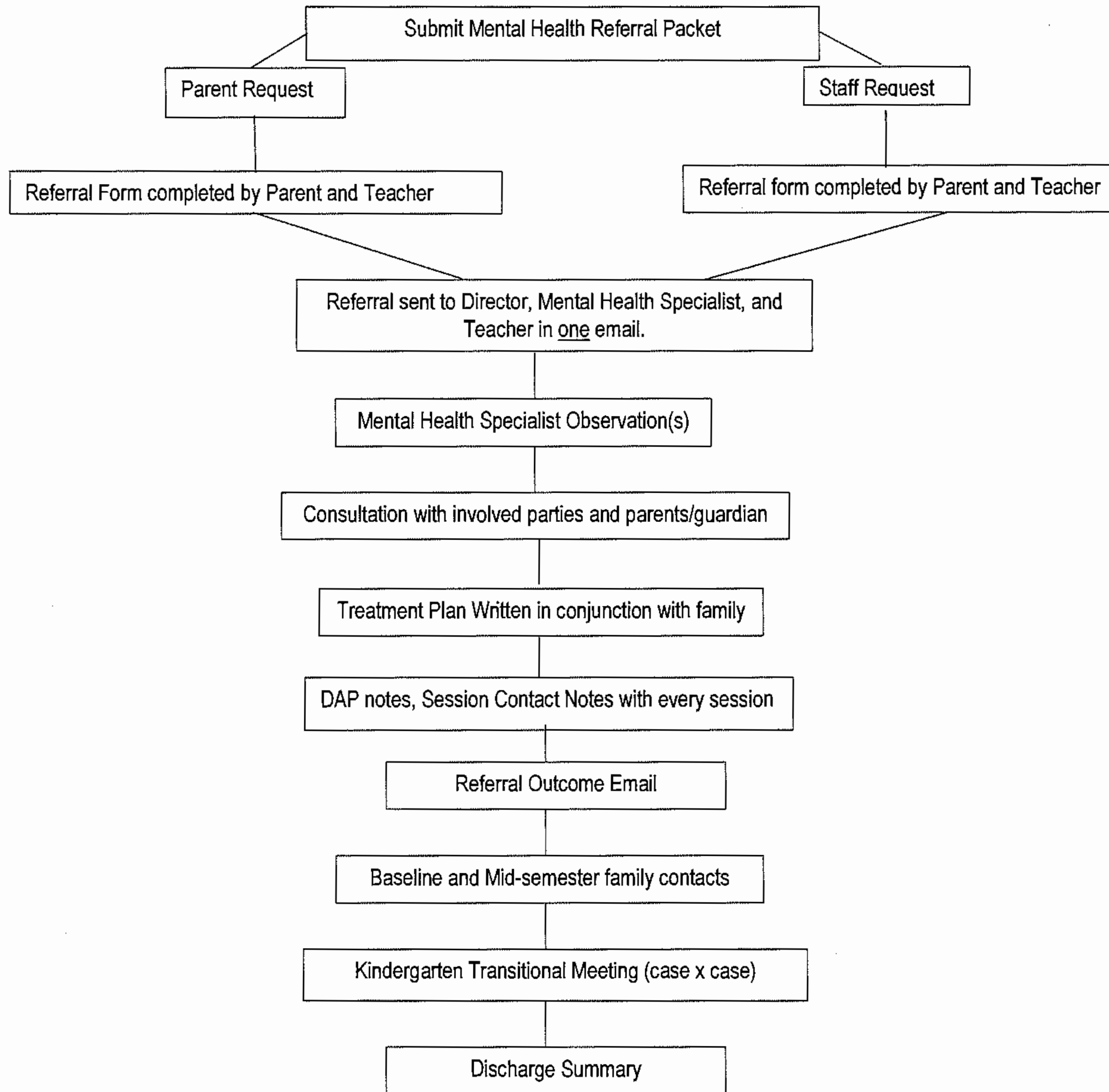
The following guidelines are provided to help you determine if your student is ready to return to school after an illness.

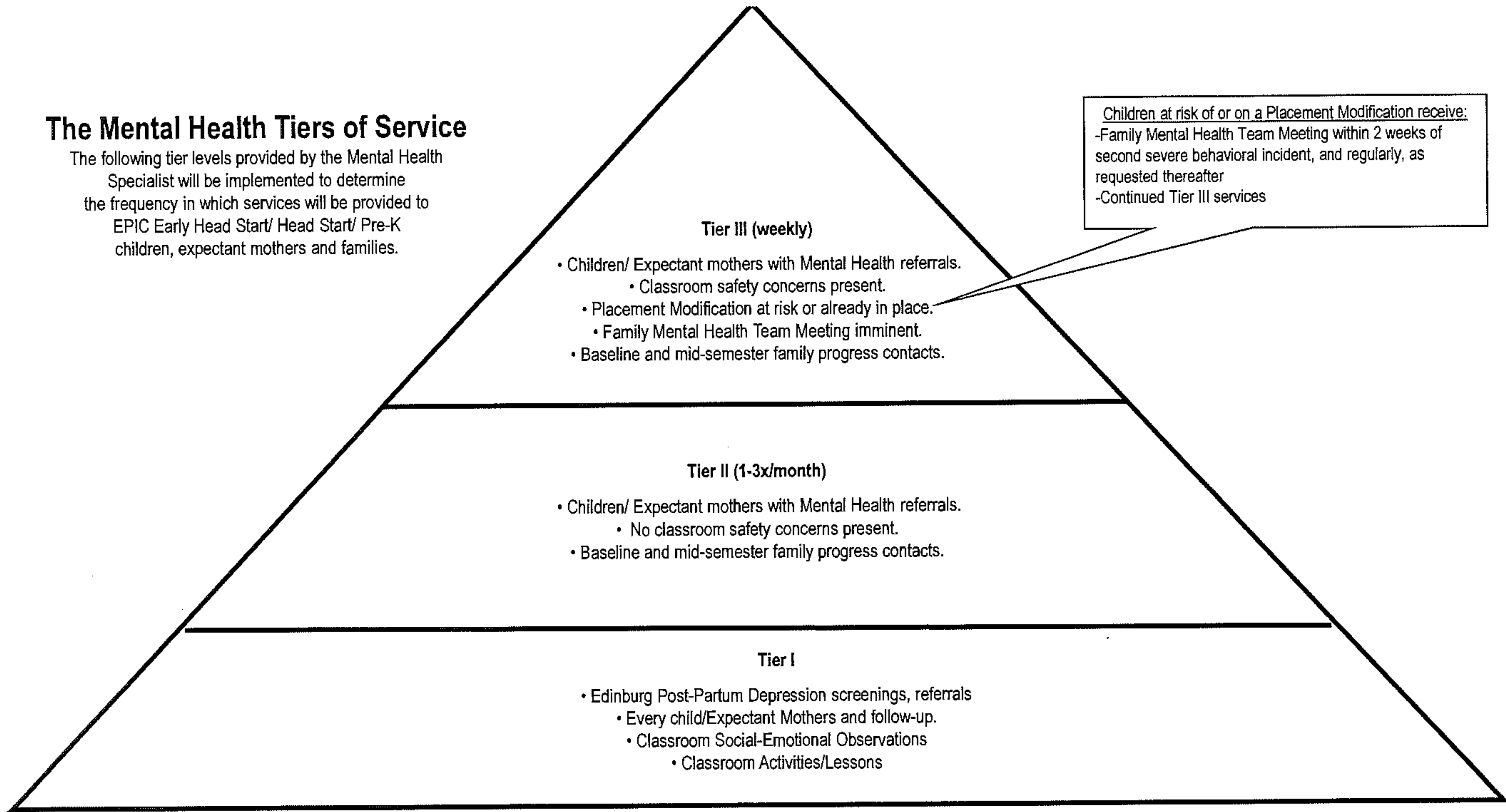
- Fever free for the past 24 hours without the use of fever-reducing medications such as Tylenol. A fever is defined as a temperature ≥ 100.4°.
- No vomiting or diarrhea within the past 24 hours.
- After at least 24 hours of antibiotic therapy for bacterial illnesses such as strep throat, pneumonia, etc.
- The child's appetite and activity level have returned close to normal.
- Cold symptoms that are mild enough so as not to interfere with your child's ability to participate in the activity of a normal school day or infect other students. Please remember that cold and cough medicines, including cough drops cannot be given to students by school and staff without a doctor's order.
- If your child was sent home with a rash, they may return when the rash is resolved or with a doctor's note stating they are not contagious.
- If your child's doctor has prescribed medication that will need to be given during the school day, please remember that an order from the doctor is necessary. Most area physicians have these forms. If not, we would be happy to fax one to their office.
- During your child's visit to the doctor, please remember to obtain a note so that your child will be medically excused.

If you have any questions as to whether your child may return to school after an illness, please feel free to call your teacher, or center manage. They will be happy to assist you in deciding what is best for your child.

Reviewed and endorsed by Berkeley County Health Department

The Mental Health Observation Map




The Mental Health Tiers of Service
The following tier levels provided by the Mental Health Specialist will be implemented to determine the frequency in which services will be provided to EPIC Early Head Start/ Head Start/ Pre-K children, expectant mothers and families.
Children at risk of or on a Placement Modification receive:
-Family Mental Health Team Meeting within 2 weeks of second severe behavioral incident, and regularly, as requested thereafter
-Continued Tier III services
Tier III (weekly)
• Children/ Expectant mothers with Mental Health referrals.
• Classroom safety concerns present.
• Placement Modification at risk or already in place.
• Family Mental Health Team Meeting imminent.
• Baseline and mid-semester family progress contacts.
Tier II (1-3x/month)
• Children/ Expectant mothers with Mental Health referrals.
• No classroom safety concerns present.
• Baseline and mid-semester family progress contacts.
Tier I
• Edinburg Post-Partum Depression screenings, referrals
• Every child/Expectant Mothers and follow-up.
• Classroom Social-Emotional Observations
• Classroom Activities/Lessons

MENTAL HEALTH REFERRAL PROCESS

*****Mental Health Referrals will not be submitted within the first 2 weeks of the school year to allow children to adjust to the classroom environment, unless an exception is provided by the Mental Health Specialist.**

***The following process will be of respectful nature and family-friendly language will be implemented throughout. ***

STEPS TOWARDS SUBMISSION OF A MENTAL HEALTH REFERRAL:

1. Discussion between Teacher and Manager.
2. Staff and/or parent complete the mental health referral packet requesting services regarding behavioral or social/emotional concerns.
3. Complete the entire Mental Health Referral Packet:
    - A. Cover Page (pg 1)
    - B. Referral Information Form (pgs 2-3)
    - C. Permission to Observe/Work With (pg 4)
    - D. Informed Consent (pg 5 of 5)
  - b. Ensure all signatures are present.
  - c. Leave nothing blank.
4. Once the five pages of the Mental Health Referral Packet are complete, scan and email the pdf with a "high importance red exclamation point" indicator with "MH Referral" in the email subject line to:
    - A. Director
    - B. Mental Health Specialist
    - C. Manager
5. If a child received Mental Health services in the prior school year, a new Mental Health Referral is needed as several psychosocial and developmental changes may have occurred. Thus, complete Steps 1-4 of the Mental Health Referral Process.

AFTER A MENTAL HEALTH REFERRAL IS SUBMITTED:

1. **Within 15 business days, the Mental Health Specialist will then conduct an *Initial Observation-Functional Behavior Assessment*** of receiving a completed Mental Health Referral Packet and will document such on the *Mental Health Initial Observation-Functional Behavior Assessment Form.* The number of observations will be left to the discretion of the Mental Health Specialist.
    - a. **Up to 10 business days, after completion of *the Initial Observation-Functional Behavior Assessment,*** parent/guardian contact is made to inform of the outcome of the observation, conduct further assessment, determine treatment goals/plan, refer to a community mental health agency, or both (internal/external service referral), inform of Tiered Level Assignment, planned session days to optimize school attendance, and expectations.
    - b. At this time, Tier Level Assignment and the *Treatment Plan* are developed and written in conjunction with the family. A copy of the Treatment Plan will be emailed to the teacher for parent/guardian signatures. Then, the signed Treatment Plan will be emailed to the Mental Health Specialist.
    - c. After Mental Health Specialist receives scanned/emailed Treatment Plan from Parent/Guardian, Mental Health Specialist will inform the following Team members: Director, and referring Manager and Teacher/Staff:
        - i. Tiered Service Level Assignment

ii. Service Initiation Date
iii. External referral (or both—Tiered Service + External referral)

d. Tier Level Assignment and Treatment Plan goals will be reviewed and updated as needed.
e. Consistent contact with the family must be maintained according to the tier expectations to ensure their active participation and involvement in the process.

2. If it is determined that the concern is NOT mental health related, the Manager will:
   a. Develop a *Child / Family Support Plan* with input from all of the individuals involved
   b. Submitting the completed *Child / Family Support Plan* to the Child Development Specialist.
3. If Tiered services will be provided by the Mental Health Specialist:
   a. The Mental Health Specialist will consult with parents to determine options available for services (either internal services or external referral or both).
      i. A Kindergarten Transitional Meeting with the receiving School Principal will be completed on a case by case basis at the conclusion of the school year.
      ii. A *Mental Health Discharge Summary* will be written by the Mental Health Specialist at the end of the school year or upon termination of services.
   b. If an external referral is provided:
      i. Communication via email or mail to parents with resources
4. Miscellaneous contacts or attempts will be documented on a *Mental Health Communication Log*.
5. For strategies/tips on managing behavior, explore the electronic Mental Health Resource Bank.

Mental Health Records

1. Mental Health records/Protected Health Information are held to the strictest confidentiality and include:
   a. Mental Health Referral Packet
   b. Initial Observation-Functional Behavior Assessment Form
   c. DAP notes
   d. Treatment Plan
   e. Placement Modification Form
   f. Family Mental Health Team Meeting Report Forms
   g. Behavior Tracking Forms
   h. Discharge Summary
   i. Communication Logs
   j. Contact Notes
2. The aforementioned documents will be only shared with the designated Manager in a highly secure and protected manner.
3. Release of Mental Health Records are not permitted in any circumstance and can not be referred to in any fashion for example, verbally, in the written form, etc. Special circumstances regarding the release of mental health records require review by the Mental Health Specialist and Director, and with signed Release of Information specifying the release of Mental Health documentation from the Parent/Guardian.

Eastern Panhandle
Instructional Cooperative

EPIC

Serving the educational needs
of the entire community

109 South College Street • Martinsburg, WV 25401
304.267.3595 • Fax: 304.267-3599

EPIC Early Head Start / Head Start

Mental Health Referral Packet

Client Name: ____________________

Mental Health Referral Information Form

Date:______________________

Program: ☐ EHS ☐ HS ☐ PK County: ☐ Jefferson ☐ Berkeley ☐ Morgan Site: ______________________

Teacher/Assistant: ______________________________________ Family Advocate/Home Visitor: ______________________

Client Name:________________________________ Child's DOB:__________ Child's Age (years, months):__________

If child, name of parent/guardian____

Kindergarten eligible: ☐ Yes ☐ No IEP: ☐ Yes ☐ No

Address:____

Phone Number(s):____

Email address: ____

Referral Questions (To be completed by Staff): ☐ No classroom issues

1. Primary reason(s) for referral____

____

____

____

2. Select which, if any, challenging behaviors are observed in the classroom (check all that apply):
   ☐ Running in the classroom ☐ Hitting ☐ Kicking ☐ Screaming ☐ Biting ☐ Spitting ☐ Emotional outbursts
   ☐ Difficulty staying seated ☐ Rolling on floor ☐ Refusal to participate ☐ Throwing toys/objects ☐ Choking
   ☐ Other(s____

   ____

   ____

3. Are there specific activities when challenging behavior is more likely to occur?
   ☐ Breakfast ☐ Large Group ☐ Small Group ☐ Choice Time ☐ Transitions
   ☐ Lunch ☐ Rest time ☐ Outdoor play ☐ Bus
   ☐ Other(s): ____

   ____

<u>Items 4-5 To be completed with the parent/guardian:</u>

4. Do the parents/caregivers/guardian(s) observe the same/different challenging behaviors at home?

   ____

   ____

   ____

   ____

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5. What does the child like to do at home? ______________________________

6. What are the child's strengths? ______________________________

7. What items / activities / hobbies does the child engage with in the classroom? ______________________________

8. Additional notes/information: ______________________________

9. Please describe what would support you (Parent/Guardian and/or Staff):

____

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<u>Required attachments:</u>

- ☐ Brigance Developmental/Self-help
- ☐ Classroom schedule

<u>If applicable, attach:</u>

- ☐ Parent complaint(s) about referred child; no identifiers)
- ☐ Accident report form(s) regarding referred child; no identifiers)
- ☐ Brief Behavior Tracking Form (for physical behaviors only)

Referral Source (Circle one: Parent/Teacher/Home Visitor):______________________________

Email:______________________________ Phone:______________________________

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EPIC Early Head Start / Head Start / Pre-K
Permission to Observe / Work with Child

Date:________________

Program: □ EHS □ HS □ PK County: □ Jefferson □ Berkeley □ Morgan Site: ____________________

Referrer Name (Parent/ Guardian/Teacher):____

I, ______________________________, give permission for the Mental Health Specialist/Consultant to □observe □work
(Parent/Guardian printed name)

with my child, ____, during the EPIC Early Head Start/Head Start/Pre-K
(Child's printed name)

centers/socializations/home visits. I understand that all sessions / information obtained will remain confidential.

____
Parent / Guardian Signature Date

4/2022 COMPLETED BY THE PARENT/GUARDIAN

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EPIC Early Head Start / Head Start / Pre-K
INFORMED CONSENT

You have agreed to receive mental health services with________________________________, Mental Health Specialist/Consultant, contracted by the Early Head Start / Head Start / Pre-K program. This document will inform you about the mental health process, rules, how we can work together and what your responsibilities will be as a client / parent. Please read this form and prior to signing, ask any questions that you may have.

The mental health process is facilitated to assist you in resolving problems which may be troublesome to you and/or your child. You, the program staff and the Mental Health Specialist/Consultant will work together to identify behaviors that cause problems and discuss alternative behaviors which may help to have a better outcome.

The Mental Health Specialist/Consultant-Client relationship is a unique one. Under West Virginia Law, I am mandated to protect our Mental Health Specialist/Consultant-Client relationship. That is, without your express written permission or by order of a court, the EHS/ HS/ Pre-K program and myself are forbidden to disclose any information about our sessions or about you except in the following instances: 1) that I suspect that you / your child may do harm to yourself or to others; 2) that you / your child tell me of or I suspect any abuse, neglect or molestation to a child, elderly person, or disabled person; 3) I or your records are ordered by a court of law; 4) you waive your right to confidentiality in writing. Confidentiality will be respected in all cases, except as noted, and in those additional cases where, in the Mental Health Specialist/Consultants clinical judgment, the maintenance of confidentiality may be destructive to the client. In these cases, the Mental Health Specialist/Consultant will inform you of their judgment and you will have the final decision as to whether confidentiality is maintained.

You will participate in the development of you / your child's treatment plan and together, with the EHS / HS / Pre-K program, we will review it regularly.

________________________________ Child's printed name

________________________________ Client / Parent / Guardian printed name

________________________________ Client / Parent / Guardian signature

________________________________ Date

________________________________ Mental Health Specialist

________________________________ Date

4/2022 COMPLETED BY PARENT/GUARDIAN/MENTAL HEALTH SPECIALIST

EPIC Early Head Start / Head Start / Pre K
Mental Health Observation Form

Child's Name:______________________________ Center Name:____________________

Date:__________ Time:__________ Activity:______________________________

Was **physical harm** caused (of could have been caused) by the child's behavior in this incident? [ ] Yes [ ] No

Describe challenging behavior(s):______________________________

Behaviors observed as reported on referral: [ ] Yes [ ] No If yes, describe: ____________________

____

What happened before?

- □ Asked to do something
- □ Removed an object
- □ Not a preferred activity
- □ Difficult Task
- □ Other student provoked
- □ Playing alone
- □ Attention given to others
- □ Told "No", "Don't", "Stop"
- □ Moved activity / location to another
- □ Transitional Time
- □ Changed or ended activity
- □ Object out of reach
- □ Child requested something
- □ Other (specify)__________

What happened after?

- □ Given social attention
- □ Given an object/activity/food
- □ Given assistance/help
- □ Time away
- □ Removed from Classroom
- □ Removed from an activity/area
- □ Ignored by classmates
- □ Redirected
- □ Other (specify)__________

Purpose of Behavior:

To Get or Obtain:

- □ Activity
- □ Attention
- □ Object
- □ Food
- □ Person
- □ Place
- □ Other (specify)__________

To Get Out Of, Avoid, or Delay:

- □ Activity
- □ Attention
- □ Object
- □ Food
- □ Person
- □ Place
- □ Demand / Request
- □ Other (specify)__________

Replacement Behavior:

- □ TPOT
- □ Use Kind Words
- □ Use Walking Feet
- □ Use Gentle Hands
- □ Use choices
- □ Go to Safe Place
- □ Use breathing exercises
- □ One to one guidance
- □ Other (specify)______________________________

Comments:____

____

____

Recommendations:____

____

____

____

____

Staff Signature:______________________________ Date:____________________

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Observations

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EPIC Early Head Start / Head Start / PreK
Mental Health Team Meeting Form

Child:______________________________ Age:____________________

Members Present: (MH Specialist)__________________ (Parent)__________________________

(Teacher)______________________________ (Parent)__________________________

(Family Advocate)________________________ ______________________________

(Manager)______________________________ ______________________________

Date of Meeting:__________________________ Location: _______________________

Presenting Problem:

Family History:

Prior Behavioral/Mental Health Intervention:

Medical History/ Physical Development:

Social-Emotional Development:

A. Self Help Skills

B. Peer Interaction

C. Response to Adults

D. Behavioral Concerns

Team Recommendations:

Date of Next Meeting:

EPIC Early Head Start/ Head Start / PreK DAP Note

Name:______________________________ Date:______________________________

Services:
[ ] Individual Child
[ ] Parent/Guardian
[ ] Family
[ ] Group
[ ] Expectant Mother
[ ] Classroom Presentation/Activity/Lesson

Location:
[ ] Home
[ ] Classroom
[ ] Center
[ ] Other:________

TIER
[ ] 1
[ ] 2
[ ] 3

Classroom/Site______________________ Teacher/HV________________ Observer (if applicable):________________

Session Goal:____

____

____

Description:____

____

____

____

____

____

____

Assessment:____

____

____

____

____

____

____

Plan:____

____

____

____

____

____

Mental Health Specialist/Consultant Signature:____

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Mental Health Communication Log

DATE	COMMUNICATION NOTES

EPIC Early Head Start / Head Start / Pre-K
Treatment Plan

Child/ Adult____________________________________ **Date**______________________

Teacher / Home Visitor________________________ **Family Advocate**________________________

Program: [ ] HS [ ] PK [ ] EHS Classroom / Site_________________ **TIER OF SERVICE: [ ] 1 [ ] 2 [ ] 3**

Summary of Referral, Meeting, and Concerning Behaviors:

A Mental Health Referral submitted on ________ as requested by Parent/Teacher.

Initial observation/Functional Behavior Assessment completed on:_______.

Goals:

1.)

Child will: (do this, when)

Parent will: (do this, when)

Staff will:(do this, when)

Mental Health Specialist will:(do this, when)

2.)

Child will: (do this, when)

Parent will: (do this, when)

Staff will: (do this, when)

Mental Health Specialist will: (do this, when)

____

____________________________________ ______________________

Parent/Guardian Signature **Date**

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4/2022 COMPLETED BY MENTAL HEALTH SPECIALIST, EMAILED TO TEACHER TO PRINT/SEND HOME FOR PARENT/GUARDIAN SIGNATURES; PARENT/GUARDIAN TO SIGN/RETURN; TEACHER TO SCAN/EMAIL TO MENTAL HEALTH SPECIALIST

EPIC Early Head Start / Head Start/ Pre-K
MENTAL HEALTH DISCHARGE SUMMARY

Child / Adult name: ________________________________ Date: ____________

Beginning Tier: 1 2 3 Ending Tier: 1 2 3

Other participants (name and relationship):

Reason(s) for discharge:

____
____
____
____

Symptom/impairment still present:

____
____
____
____
____

Goal progress and improvement:

____
____
____
____
____

Remaining needs/recommendations for additional services: (including specific referrals made at time of discharge)

____
____
____
____
____
____

☐ Information / Concerns shared with the Guidance Counselor or Administrative Staff at child's receiving school.

Mental Health Specialist Signature __________________________ Date ________________

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The Social Emotional Observation Form included is completed by our Mental Health Specialist, in each classroom within the first few weeks of school. Any concerns are addressed with the teacher and asst. teacher within the week completed.

We utilize Conscious Discipline and are beginning the process of implementing ECPBIS program wide. Our leadership team has met once and we are in process of developing our implementation plan.

EPIC Head Start/Pre-K
Social Emotional Observation Form
Pre-K Ages 3 to 5

Classroom ____________________ Teacher ____________________ Date __________

	Observed		
	Yes	No	Focus for Training
Environment is positive and respectful • Evidence of relationships being formed – greets children on arrival, participates in play when appropriate, etc. • Communication (verbal and body language) is clear, supportive, delivered in developmentally appropriate manner (demonstrates active listening with children, communicates at child's eye level, not raised voice yelling across room)			
Classroom staff are responsive to individual children and the group.			
Aware of situations that require adult guidance and respond in a timely manner.			
Create opportunities for decision making, problem solving and working together.			
There is evidence of a clear schedule/routine for children.			
Establish and enforce clear rules, practice these expectations and frequently reinforce appropriate behavior.			
Transitions from one activity to the next are smooth and appropriate prompts are provided if necessary.			
Children <u>do</u> <u>not</u> wait idle between activities or for a turn.			
Large groups do not exceed 15 minutes (all children must be engaged). If not, staff adapt and adjust accordingly.			
Staff demonstrate an understanding that challenging behaviors are conveying some type of message • display an equal acceptance of all children. • develop and implement strategies for dealing with disruptive/unsafe behaviors			
Engages in ongoing supervision of children			

Severe Behavior Intervention Policy and Procedures

EPIC Head Start will limit suspension and expulsion in accordance to *Head Start Performance Standard § 1302.17 Suspension and expulsion, and § 1302.45 Child Mental health and social and emotional well-being.* Staff will work with their Manager, Child Development Specialist, Mental Health Specialist, and the parent/guardian to provided reasonable modifications to reduce or eliminate serious safety threats, using research-based early childhood best practices. In extraordinary circumstances, when a child's behavior creates a serious safety issue to him/herself and others and/or seriously disrupts the stable environment in the classroom repeatedly (after more than one occurrence), the *Severe Behavior Intervention Procedure* will be implemented upon approval of the Mental Health Specialist and Child Development Specialist.

Severe behavior is defined as more than one occurrence of the following:

- Violence toward persons or property with behavior sufficient to put themselves or others in danger of immediate harm
- Threats to inflict harm to others verbally or with gestures or specifically targeting individuals
- Possession of or use of any object for a weapon with the intent to do harm to persons or property.
- Seriously disrupts the teaching / learning process for self and others
- Repeated refusal to respond to basic directions regarding safety

Procedure:

1. Teaching Staff will immediately report severe behavior to their Manager and the Manager will determine which steps need to be taken to allow the classroom to return to a normal and safe environment and report the incident to the Mental Health Specialist and Child Development Specialist.
2. At the end of the day, Teaching Staff will meet with their Manager to document details of the incident and discuss researched-based behavioral strategies to utilize moving forward. Documentation will be filed in the Mental Health section of the file.
3. **Within 2 weeks of the second severe behavioral incident occurring**, a Family Mental Health Team Meeting, including Teaching Staff, Manager, Child Development Specialist, Mental Health Specialist, and the parent/guardian will be scheduled to develop a plan for the child.
4. The plan will be documented on the *Family Mental Health Team Meeting Report Form* and may include:
   a. Classroom observations
   b. Implementation of a PBIS BIP
   c. Parental classroom visits to assist in facilitating positive behavior guidance
   d. External referrals for evaluation utilizing community resources such as Child or Behavior Modification Therapist, Local Education Agency, Health professional and other appropriate specialists or resources as needed.
   e. Additional staff and parent guidance in positive behavior practices.
   f. Placement Modification may include any of the following and must be approved by the Mental Health and Child Development Specialist
      - Modified (shortened) schedule, with a plan to gradually increase the schedule pending observable positive behavior.
      - Alternate placement in another classroom or temporary home-based service within our program.
      - External placement, including facilitating transition assistance.
5. Two subsequent Family Mental Health Team Meetings will occur to review progress, regularly, as needed.
6. The Mental Health Specialist will continue to provide services and parent communication based on the tier service level requirements.

EPIC Head Start / Pre-K
Behavior Intervention Plan (BIP)

Student: ______________________________ Classroom: ______________________________

Date of Plan: ____________________ Person Completing: ______________________________

Definition of targeted maladaptive behavior: ______________________________

____

Circle hypothesized function of behavior

Automatic/Sensory **Escape** **Attention** **Access to tangible item/activity**

Desired replacement behavior: ______________________________

____

Behavioral Goal: During the ______ school year, within the school environment, ______________ will
(current year) *(student)*

increase / decrease instances of ______________________________ to
(circle one) *(defined maladaptive behavior or replacement behavior)*

________ per hour / day / week / month as measure across ________ consecutive weeks .
(desired #) *(circle one)* *(desired #)*

****IF THE STUDENT RECEIVES SPECIAL EDUCATION SERVICES, THEN THE GOAL WILL NOW MATCH THE IEP BEHAVIOR GOAL SECTION****

Intervention Strategies

Setting	Antecedent manipulations	Teaching desired behavior	Consequence manipulations

Behavior Intervention Plan data must be reviewed by the Case Manager **every 9 weeks** and progress listed below:

Date:									
Progress Code:									

Progress codes: ***I – Insufficient Progress*** ***R- Revise*** ***D- Discontinue*** ***P- Progress*** ***A-Achieved***

EPIC Early Head Start/ Head Start/ Pre-K
Placement Modification Approval Form

Date:_______________________________

Child's Name:______________________________ Parent Name:______________________________

Site/Classroom:________________________ Teacher:____________________ FA:_______________

Please select and describe in detail which of the following have occurred:
□ Mental Health Referral: ____
□ Mental Health Observation-Functional Behavior Assessment:______________________________________
□ Family Mental Health Team Meeting____
____
____

□ Follow Through on Suggestions Given by Mental Health Specialist, Mental Health Professional, Child Development Specialist or Manager: ____
____
____

□ Previous Modifications____
____
____

Please select your request and provide details of the plan:
□ Change in Classroom Assignment____
____
____

□ Modified Schedule____
____
____

□ Temporary Alternative Environment____
____
____

□ Referral to Local Education Agency
____
____
____

Approved By:

____ _______________________
Mental Health Specialist Date

____ _______________________
Child Development Specialist Date

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Family Style Meal Service
EPIC Early Head Start/Head Start/Pre-K

Family style dining is being implemented based on the discretion of the county school systems.

Children establish eating habits as early as age 2! Therefore, it is important Head Start programs partner with families to build healthy eating habits early. One way to do this is to serve meals family-style. Family-style meals is a great way to introduce healthy foods, model healthy behaviors, and provide opportunities for nutrition education.

Serving family-style meals means serving foods in dishes and eating together at the table. It is also an opportunity for children to have meaningful conversations with adults and develop social relationships. Head Start standards require all toddlers and preschool-age children and assigned classroom staff, including volunteers, eat together family-style and share themselves or to serve themselves with an adult's help.

Following are some reasons it is important to serve family-style meals in the Head Start programs. Serving family-style meals:

- Introduces healthy foods to children and encourages them to try new ones
- Provides opportunities for nutrition education such as teaching serving sizes or talking about healthy foods and food groups
- Allows children to see adults model healthy eating
- Teaches food safety by encouraging hand washing and the use of serving utensils
- Builds independence by allowing children to make decisions and take responsibility
- Develops fine and gross motor skills by asking children to pour, pass, serve, and share food
- Enhances language and social skills when children practice table manners and learn appropriate meal time behavior
- Decreases food waste as children learn to take the amount of food they want
- Improves meal time behavior
- Reinforces basic concept skills from the classroom such as naming shapes, colors, flavors, and textures

HOW TO SERVE MEALS FAMILY STYLE IN HEAD START

Serving family-style meals is more than having food on the table for children to serve themselves. To make the mealtime environment pleasant and positive, Head Start staff can:

- **Involve children:** Ask children to help wash food or set the table; bring food to the table; pour, pass, and serve food; and clean up after a meal. Some children may not be ready for some of these tasks or may need help. Start with easier tasks such as setting the table or passing bowls. Support children's skill development by adding new and more challenging tasks when children are ready. Having more than one adult at a table with younger children or with children with special health care needs can help make sure all children get a chance to participate.

- **Model good mealtime behaviors:** Sit at the table with children. Modeling also includes demonstrating food safety (washing hands before meals), good table manners, using utensils, and trying new foods.
- **Allow children to choose whether to eat, and how much to eat:** To establish healthy eating habits that will last a lifetime, children need to feel in control of their eating. Provide healthy foods and encourage children to try new ones. Let children decide whether to eat, what to eat, and how much to eat.
- **Use the right equipment:** Use child size serving bowls, plates, and utensils. Tables and chairs should be the right size for children to sit comfortably with their feet on the floor. It is important children eating together be at the same eye level with each other.
- **Make mealtime interesting:** Use mealtimes as teaching opportunities by serving foods with a variety of shapes, colors, smells, tastes, and textures. Engage children by using pictures of foods or asking questions about foods' shape, color, smell, taste, or texture to build language skills.

Food will never be used for reward or punishment. For example, we cannot say if, "you don't try everything on your plate, you can't go outside".

1900 Kanawha Boulevard, East, Building 6 • Charleston, WV 25305
Steven L. Paine, Ed.D., State Superintendent of Schools
wvde.state.wv.us

Children with Disabilities and Special Dietary Needs

Schools participating in a federal school meal program (National School Lunch Program, School Breakfast Program, Fresh Fruit and Vegetable Program, Special Milk Program, and Afterschool Snack Program) are required to make reasonable accommodations for children who are unable to eat the school meals because of a disability that restricts the diet.

1. Licensed Medical Authority's Statement for Children with Disabilities

U.S. Department of Agriculture (USDA) regulations at 7 CFR Part 15b require substitutions or modifications in school meals for children **whose disabilities** restrict their diets. School food authorities must provide modifications for children on a **case-by-case basis** when requests are supported by a written statement from a state licensed medical authority.

The third page of this document (**"Medical Plan of Care for School Food Service")** may be used to obtain the required information from the licensed medical authority. For this purpose, a *state licensed medical authority* in West Virginia includes a:

- Physician, (MD or DO)
- Physician assistant,
- Certified registered nurse practitioner, or
- Dentist.

The written medical statement must include:

- An explanation of how the child's physical or mental impairment restricts the child's diet;
- An explanation of what must be done to accommodate the child; and
- The food or foods to be omitted and recommended alternatives, if appropriate.

2. Other Dietary Needs

School food service staff may make food substitutions for individual children who do not have a medical statement on file based on county policy. Such determinations are made on a case-by-case basis and all accommodations must be made according to USDA's meal pattern requirements. Schools are encouraged to have documentation on file when making menu modifications within the meal pattern.

3. Rehabilitation Act of 1973 and the Americans with Disabilities Act

Under Section 504 of the *Rehabilitation Act of 1973*, the *Americans with Disabilities Act (ADA) of 1990* and the *ADA Amendments Act of 2008,* a person with a disability means any person who has a physical or mental impairment that substantially limits one or more major life activities or major bodily functions, has a record of such an impairment, or is regarded as having such an impairment. A physical or mental impairment does not need to be life threatening in order to constitute a disability. If it limits a major life activity, it is considered a disability.

***MAY ONLY BE DISMISSED BY RECOGNIZED STATE MEDICAL AUTHORITY

HEAD START Medical Plan of Care for School Food Service for Berkeley, Jefferson, and Morgan County Schools

DO NOT WRITE IN THIS AREA
1875244720

This form must be completed at the start of each school year and each time student's diagnosis or change of treatment is indicated during the school year. Annual completion of this form by the student's medical authority ensures that current nutritional needs are being met at school.

Steps to Complete Diet Order Form

1. Parent/Guardian, complete Part A. Sign and date form (required for processing).
2. Medical Authority, complete Part B. Print name, sign and date form; stamp form with medical office stamp (required for processing).
3. Please submit to Head Start classroom or school nurse.
4. **Incomplete form will be returned to parent/guardian.**

PART A To be completed by Parent / Guardian

STUDENT INFORMATION

Student ID Number | Last, First, MI | Date of Birth | Current School | Grade

PARENT / GUARDIAN INFORMATION

First, Last | Daytime Phone Number | Mailing Address, City, State, Zip

E-mail Address (We will use this to send acknowledgement and details of your child's menu plan. PRINT NEATLY)

Describe concerns you have about your student's nutritional needs and ability to safely participate in meal time at school:

DIET ORDER FOR SCHOOL YEAR

20☐☐ - 20☐☐ ☐ **Initial Diet Order** ☐ **Revision to Diet Order**

Which meals provided by the School Cafeteria will the student eat? ☐ Breakfast ☐ Lunch ☐ Snack

☐ My child has a special diet and will NOT eat food from cafeteria.

Does the student have an identified disability (IEP or 504 Plan)? ☐ IEP ☐ 504 ☐ No

By signing here I give Child Nutrition & Wellness permission to speak with the Licensed Medical Doctor (MD) or recognized Medical Authority signing the Diet Order Form to discuss the student's dietary needs described in Part B of this form.

Parent / Guardian Signature (required for processing) X | Date

PART B To be completed by Licensed Healthcare Provider

STUDENT DIAGNOSIS OR CONDITION

Students with life threatening food allergies must have Epi-pen and emergency action plan in place at school.

☐ Food Intolerance ☐ Food Allergy ☐ *Life Threatening Food Allergy - Check appropriate box: ☐ Ingestion ☐ Contact ☐ Inhalation

☐ Disability (Specify) ______ Describe major life activities affected ______

☐ Other (Specify) ______

How does this allergy affect your child: ☐ * Anaphylactic reaction ☐ Rash only ☐ Swelling ☐ Other - Describe reaction: ______

*** (Epi-pen/other medication to be supplied by parent/guardian per doctor order)**

FOOD TEXTURE MODIFICATION (If needed)

Liquids (Check ONE):
☐ Thin (Regular liquids)
☐ Nectar thick
☐ Honey Thick
☐ Pudding Thick

Solids (Check ONE):
☐ Pureed
☐ Ground
☐ Chopped

OTHER ACCOMMODATIONS

☐ Calorie Recommendation: ______
☐ Low Added Sugar: ______
☐ Sodium Restriction: ______
☐ Carbohydrate Counting: ______
☐ High Fat: ______
☐ Nutritional Supplement: ______
☐ Adaptive Equipment: ______
☐ Enteral Feeding: ______
☐ Other: ______

FOOD(S) THAT SHOULD BE AVOIDED (Check all that apply)

LACTOSE INTOLERANCE ☐ No ☐ Yes ☐ Substitute lactose free milk

DAIRY ALLERGY
☐ Fluid Milk. Substitute with ☐ Soy milk ☐ Other______
☐ Cheese and recipes with cheese listed as an ingredient
☐ Ice Cream
☐ Yogurt
☐ Recipes with any dairy listed as an ingredient

EGG
☐ Whole eggs such as scrambled eggs or hard cooked eggs
☐ Recipes with any egg listed as an ingredient
☐ Egg whites

WHEAT / GLUTEN
☐ Recipes with any wheat listed as an ingredient

FISH OR SHELLFISH
☐ Fish ☐ Shellfish

TREE NUTS
☐ Food products identified as manufactured in a plant that also handles tree nuts

PEANUTS
☐ Peanuts

CORN
☐ Whole corn such as corn kernels, tortilla chips, corn muffin, corn meal
☐ Recipes with corn / corn products listed as an ingredient

SOY
☐ Soy Lecithin
☐ Soy Protein (concentrate, hydrolyzed, isolate)
☐ Recipes with any soy listed as an ingredient

SESAME
☐ Recipes with sesame / sesame seeds or oils listed as an ingredient

OTHER ☐ Specify if it is a cooked ingredient or when consumed fresh

LICENSED HEALTHCARE PROVIDER INFORMATION *Form will be returned to parent / guardian and NO accommodations will be made if this section is not complete.*

Medical Office Stamp (Required for processing)

Office Phone Number if not in the stamp | Medical Authority Signature X | Date

Fax Number | Medical Authority Printed Name

"This institution is an equal opportunity provider."

Major life activities include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also includes the operation of a major bodily function, including but not limited to: functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

4. Individuals with Disabilities Education Act

A child with a disability under Part B of the *Individuals with Disabilities Education Act* (IDEA) is described as a child evaluated in accordance with IDEA as having one or more of the recognized thirteen disability categories and who, by reason thereof, needs special education and related services. The Individualized Education Program (IEP) is a written statement for a child with a disability that is developed, reviewed, and revised in accordance with the IDEA and its implementing regulations. When nutrition services are required under a child's IEP, school officials need to ensure that school food service staff is involved early in decisions regarding special meals. If an IEP or 504 plan includes the same information that is required on a medical statement (see section 1, above), then it is not necessary to get a separate medical statement.

School Nutrition Program Contact

For more information about requesting accommodations to school meals and the meal service for students with disabilities, please contact:

Child Nutrition Office
Local School System

USDA Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. Mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410;

2. Fax: (202) 690-7442; or

3. Email: program.intake@usda.gov.

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Procedures for Celebration of Birthdays and Other Special Events

Birthdays and other special celebrations may not include snacks or treats. The child's parent or guardian is welcome to participate. Below are listed suggestions for celebrating the event; however, please feel free to share other ideas with your child's teacher or home visitor.

A. Suggestions for non-edible party contributions:

1. Cups, soil, and seeds to plant in celebration of a child's special day.
2. Bubbles (a small bottle for each child).
3. A special game.
4. Special paper hats to be decorated by the children.
5. Class painting on canvas.
6. Birthday books - every child would design a page for the birthday child and connect together with chenille stems for the birthday child to take home.
7. Glitter glue pens to decorate a frame for birthday child – class picture in frame.
8. Set up carnival games (ring toss, throw balls into cups or cans).
9. Make a collage of children's handprints.
10. Decorate a board for the Birthday "Star".
11. Stickers, pencils for each child in the class.
12. Special jobs for Birthday child (book selector, music selector).

*** Food allergies and sensitivities are common in young children. Please do not send in food or drink for special celebrations.**

Performance Standard	Program Operations Health	Head Start Policies and Procedures Eastern Panhandle Instructional Cooperative EPIC Serving the educational needs of the entire community
Subpart	§ 1302.47 Safety Practices	
Effective Date	07/2021	
Revised Date	06/2021	
Reviewed Date	06/2021	
Responsibility	Teaching Staff, Bus Drivers, Family Advocates, CD Managers, Specialists, Director	

Subject: Active Supervision

Policy: EPIC Head Start will ensure that no child shall be left alone or unsupervised while under their care.

Procedure: Active supervision is a set of strategies for supervising infants, toddlers, and preschool children in the following areas: grantee, delegate, and partner classrooms; field trips and socializations; family childcare homes; and on playgrounds and school buses. Active supervision includes the following six strategies:

1. Environment: Set up the environment to supervise children effectively.
   a. Develop and post a daily classroom schedule for children, staff, and volunteers to follow keeping the day predictable.
   b. Set up classroom furniture and outdoor equipment to allow effective monitoring and supervision of children.
   c. Display toys and materials are on low shelves.
   d. Ensure that arrangement of furniture does not block adult view of children.
   e. Keep small spaces clutter free and set up big spaces so that children have clear play spaces for observation.
   f. Post visual cues and reminders at the door to the classroom, such as pictures of stop signs, bells on the door, etc. as needed.
   g. Keep First Aid, Safety Binder and Emergency contact information readily available and easily accessible in case of emergency evacuation.
2. Position: Position yourself to see, hear, and always reach children quickly, indoors, and outdoors.
   a. Discuss and communicate a supervision plan with all staff present throughout the day.
   b. Always maintain adult-to-child ratios, with two paid staff members actively supervising children in ALL locations.
   c. Frequently move around during Choice Time, interacting and providing ongoing supervision.
   d. Stay close to children who may need additional support to react quickly, if necessary.
   e. Continue supervision when children leave the group for ANY reason, including using the restroom, going to the office, or receiving Specialized Services.
   f. Supervise in zoned areas. For example, one staff monitors block center and the dramatic play center, while another staff is in the art center, but also monitors the computer/writing centers. On the playground, one staff is at the swings, while another is near the climber and monitors the bikes.
   g. Position yourself to easily scan the entire room and NEVER with your back to a group of children or the door.
3. Scan and Count: Scan the environment and count the children with ***name to face recognition*** frequently and always during transitions when moving from one location to another.
   a. Communicate with each other so all Staff knows where each child is and what each one is doing. This is especially important in play areas and on the playground when children are constantly moving.
   b. Frequently scan and count children. Always know the number of children present.
   c. Be aware of any doors and notice when they are open or shut and who is entering and exiting.
   d. Investigate immediately if there is any reason to believe a child has exited the classroom.
4. Listen: Listen closely to children and the environment to identify signs of potential danger immediately. Listen to and talk with team members, especially when a staff person or a child must leave the area so that all staff knows where other staff are located.
   a. Always be aware of what is happening, monitor classroom activities and the use of materials, intervene when necessary.
   b. Provide supervision to facilitate children's activities and play, making sure all are involved.
   c. Children are always within sight and sound. If a child is actively using the restroom, it is acceptable to use sound only for privacy.
5. Anticipate Behavior: Anticipate children's behavior and provide additional support as needed, especially at the start of the school year and during transitions. Children who wander off or lag are more likely to be left unsupervised.
   a. Use each child's individual interests and skills to predict what he/she will do.
   b. Create challenges that children are ready for and support them in becoming engaged and successful.
   c. Recognize and respond immediately when children might wander, get upset, ask for help or take a dangerous risk.
   d. Utilize Pyramid Model and Conscious Discipline strategies as much as possible.
6. Engage and Redirect: Offer different levels of assistance according to each individual child's needs.
   a. Wait to get involved until children are unable to solve problems on their own.

b. Offer two acceptable choices to children when redirecting.
c. Help children problem solve and work together to find a solution.
d. Utilize Pyramid Model and Conscious Discipline strategies as much as possible.

Incidents involving a child being left unsupervised must be reported to the CD Manager and CD Specialist immediately.

Monitoring & Reporting:

1. **Dissemination of Policies & Procedures** will be made available to all employees through the agency's website. EPIC Head Start will educate and train applicable Staff regarding the policy and any conduct that could constitute a violation of the policy.
2. **Training** will be provided to staff annually during pre-service; new staff receive training during orientation. Implementation of training is monitored during classroom observations conducted by Managers and Specialists; retraining is provided on an as needed basis.
3. CD Managers and/or CD Specialist will conduct the ***Manager Monitor Log*** to monitor the implementation of policies and procedures, including reviewing the following (completed by the teaching staff): Daily Roster.

Essex Panhandle Instructional Cooperative

EPIC

Daily Roster

Site/Classroom ______________________ Staff ________________________________ Date _____/_____/_____

✓ if present and X if not present. Note time for each Transition Out and In.

Child's Name (First and Last)	Arrival	Transition Out ______	Transition In ______	Transition Out ______	Transition In ______	Transition Out ______	Transition In ______
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
Total Children Present							
Total Children Not Present							
Staff Initials							

**Place this roster on a clipboard and complete daily prior to transitioning out and transitioning in the classroom, always keeping it with the class.*

General Health & Safety Information

Fire extinguisher use

All EPIC full-time and part-time staff will be trained how to safely use their building/classroom fire extinguisher equipment. EPIC's Public Safety staff will train all Head Start/Pre-K employees after hiring. Staff will receive hands on training, using the building's fire extinguisher.

Sanitizing Toys/Infection Procedures

Staff members will wash their hands before starting work and when contaminated with body fluids, before preparing, handling, or serving food or assisting children with setting the table, after toileting, handling diapers or assisting a child in the bathroom, before and after eating meals, after handling pets or animals, prior to giving medication, after outdoor play, after handling garbage, and after removing gloves used for any purpose.

Universal Precautions training and explanations will be given to all staff at the beginning of program year and upon hiring of new staff.

Classroom toys are to be sanitized on a weekly basis. Each classroom has a schedule to wash and air dry all toys, blocks, and manipulatives. There are many communicable health viruses and infections that can be passed on through hand-and-mouth contact.

Universal Precautions

Use appropriate barrier precautions to prevent skin and mucous membrane exposure when contact with blood or body fluids is anticipated.

Wear gloves when touching blood and body fluids, mucous membranes, or non-intact skin of all patients, when handling items or surfaces soiled with blood or body fluids, and when performing venipuncture and other vascular access procedures.

Change gloves after contact with each patient. Wash hands immediately after glove removal.

Wear masks and protective eyewear/face shields during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose, and eyes.

Wear gloves during procedures likely to generate splashes of blood or other body fluids.

Take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices; do not recap, bend, or break needles by hand. Place used disposable syringes, needles, or other sharp items in puncture-resistant containers for disposal.

Prevention of Injury

EPIC Early Head Start/Head Start staff work closely together to prevent injuries both indoors and outdoors.

Staff are to check classrooms and playground areas daily for any potential hazards prior to children arriving at center. Staff may never be alone with children and each classroom must always have two adults at all times. A safety checklist is utilized by staff and training provided to them in all areas of injury prevention.

Miscellaneous Safety Procedures with Children

Traffic Safety
Children will be protected from traffic and other hazards by the supervising adult.

Bus children
Children must be walked to the **DOOR** of the bus each day by their parent or adult guardian.

Parents must see that children get **ON AND OFF** the bus safely. Bus Aides will not get off the bus except in special cases.

Departure Time
Children will begin boarding the bus 5 minutes prior to the departure of the bus. For example, if a class ends at 2:15, children will board the bus at 2:10.

Children transported by parents
Children must be brought **INTO THE CLASSROOM AND SIGNED IN** each morning by the parent or adult guardian. Once received by staff, the children become the responsibility of Head Start/Pre-K. Siblings can not be left outside unattended.

Parents or designated person over 18 years old must pick up children **FROM THEIR ROOMS** at the end of the day. Parents must submit in writing on the emergency release form the name(s) of persons designated.

Children will be signed out at the end of the class.

Walking Safety Procedures
When groups of children are walking, an adult will be present at the beginning and the end of the line.

Major streets will be crossed only at stop signs or traffic lights.

Brushing Teeth (Due to virus this may be adapted)
In order to promote good oral hygiene, proper tooth brushing skills with a fluoride toothpaste will be taught to each Early Head Start/Head Start/Pre-K child. Each child will have his/her own toothbrush and be instructed and supervised in brushing after meals.

Toothbrushes will be stored in a manner that meets licensing standards. Toothbrushes are replaced, and new brushes are given throughout the school year.

Policy on Sick Children & Outdoor Play
Licensing regulations require one hour of outdoor play for extended day programs, weather permitting. If a parent feels a child is too ill to participate in classroom activities including outdoor play, please keep your child at home.

Eastern Panhandle Instructional Cooperative

EPIC

Automated External Defibrillator (AED) Inspection

School Year ____________ Site/Classroom ____________ Staff ____________

AED Location ____________ AED Model ____________ AED Serial # ____________

Month	**Is the AED case accessible and highly visible?** *There should be nothing that obstructs or obscures the AED from quickly finding and accessing it for use.*	**Does the AED case alarm properly if applicable?** *Check that the case sounds the alarm if opened, and if provided, sends a signal to a monitoring location.*	**Is the AED intact and free of damage?** *Inspect the overall condition of the AED. Pay particular attention to connector sockets. AED should be clean.*	**Is the ✓ showing in the window?** *A green ✓ indicates the AED passed its last self-test. A red X indicates the AED has identified an issue that needs corrected. Most commonly low battery or out of date pads.*	**Are the AED pads and a spare set present, in good condition, and unexpired?**	**Are 2 pairs of exam gloves, 1 barrier face piece, scissors, and razor present?**	**Perform SELF CHECK.** *Push and hold the on/off button for up to 30 seconds. The unit will perform a self-check and verbally respond " UNIT OK" if no issued were identified.*	Date AED Inspected	Inspector Initials	Follow Up Need/Complete	Comments
Aug	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No			☐Need ☐ N/A ☐Complete	
Sep	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No			☐Need ☐ N/A ☐Complete	
Oct	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No			☐Need ☐ N/A ☐Complete	
Nov	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No			☐Need ☐ N/A ☐Complete	
Dec	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No			☐Need ☐ N/A ☐Complete	
Jan	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No			☐Need ☐ N/A ☐Complete	
Feb	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No			☐Need ☐ N/A ☐Complete	
Mar	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No			☐Need ☐ N/A ☐Complete	
Apr	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No			☐Need ☐ N/A ☐Complete	
May	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No	☐Yes ☐ N/A ☐No			☐Need ☐ N/A ☐Complete	

Performance Standard	Program Operations Health	Head Start & Early Head Start Policies and Procedures
Subpart	1302.47 Safety Practices	Eastern Panhandle Instructional Cooperative
Effective Date	7/2022	EPIC
Revised Date	6/2022	Serving the educational needs of the entire community
Reviewed Date	6/2022	
Responsibility	Education Staff, Child Development Managers, Child Development Specialists	

Subject: Child Safety

Policy: Direct Services and Support Staff will maintain a safe environment for children and staff. Managers will ensure that safety procedures are clearly explained and implemented consistently by all those employed by EPIC Head Start.

Procedure: All staff follow appropriate practices to keep children safe during all activities.

1. **Head Start Daily Roster** is used to monitor the number of students present.
   a. Teaching Staff will complete daily when entering and exiting classroom and keep on a clipboard accessible throughout the day.
   b. Turn in to CD Manager at the end of the year.
2. **Red First Aid Emergency Backpack**
   a. Kept in a visible location and out of the reach of the children in the classroom.
   b. First Aid backpack will be taken to the playground or any trip away from classroom site.
   c. Complete First Aid Checklist twice a month, beginning and middle of month, and will be filed in classroom safety binder.
3. **Outdoor Environment Checklist** is used daily to maintain a safe outdoor environment.
   a. Teaching Staff should complete prior to children's arrival and post near door closest to playground.
   b. Turn in to CD Manager at the end of the year.
4. **Emergency and Disaster Plan**
   a. Plan must be posted at each exit door in your classroom and center.
   b. Managers will provide updated form to be posted by teaching staff prior to beginning of school year.
5. **Emergency Response Drills**
   a. Must be completed twice a year including bomb threats, severe weather, and unwanted intruders.
   b. Managers and Teaching staff will complete response drills and update form with completed drills.
   c. Turn in to CD manager at end of school year.
6. **Fire Drills**
   a. Complete twice a month by managers and/or teaching staff and Update form with completed drills. Must be highly visible.
   b. Turn in to CD manager at end of school year.
7. **Classroom Cleaning Checklist** should be completed to keep the children safe.
   a. Teaching Staff should disinfect all areas and items weekly except for those noted daily on the form.
   b. Turn in at the end of the month with status.
8. **Accident/Incident Report (BRIM)**
   a. Completed by teaching staff immediately after incident occurs.
   b. Fill out form in its entirety and scan to ~~Director, Child Development Specialist,~~ Child Development Manager, and Human Resources (Shannon Johnson) prior to the end of the day. Health/Safety Specialist
   c. Parent must be notified at the time of incident and a copy of accident/incident report must be sent home.
9. **Hazard Mapping (Behavioral/Incident/Accident)**
   a. Completed by teaching staff as incidents occur and turn in at the end of the month with status.

Monitoring & Reporting:

1. **Dissemination of Policies & Procedures** will be made available to all employees through the agency's website. EPIC Head Start will educate and train applicable Staff regarding the policy and any conduct that could constitute a violation of the policy.
2. **Training** will be provided to staff annually during pre-service; new staff receive training during orientation. Implementation of training is is monitored during classroom observations conducted by Managers and Specialists; retraining is provided on an as needed basis.
3. CD Managers and/or CD Specialist will conduct the ***Manager Monitor Log*** to monitor the implementation of policies and procedures.

EMERGENCY AND DISASTER PLAN

Name of Facility: Phone:
Address:
Name of Owner of Building: Phone:
Children Services Supervisor: Phone:
Principal: Phone:

To be followed in the event of: ***Medical Emergency***
(Medical Emergency, Fire, Storm, Flood Bomb Threat, Power Failure, Chemical Spill, Kidnapping)

NOTE: WV Childcare Licensing Requires a plan for each of the above listed emergencies.

Assignments during an emergency

Name of Staff	**Title**	**Assignment**
	Teacher	Direct Evaluation/Procedures
	Teacher	Person Count/Attendance
	Asst. Teacher	First Aid/Emergency Supplies
	Asst. Teacher	Telephone Emergency #'s
	Bus Driver	Transportation

Location of First Aid Kit	
Location of Child Emergency Contact Info.	
Location of Attendance Records	

Emergency Names and Numbers

Fire	911	Police	911
Ambulance	911	Poison Control	1-800-222-1222
Doctor – on call at the hospital		Fire Marshal	1-800-233-3473
Other		Other- WV Road Conditions	304-558-2889

Exit Location (Post floor plan at each exit)

1.	2.
3.	4.

Temporary Relocation Site Within School

Location-	Highlighted Area	Telephone # - NA

Temporary Relocation Site Outside of School

Name	Address	Telephone Number

Utility Shut off Locations (See Floor Plan)

Electricity-	Water-
Gas- N/A	Other-N/A

Attach Floor Plan and Specific Disaster and Emergency Plan. Post at All Exits.

West Virginia Department of
Health and Human Resources

Emergency Plan
Child Care Center and Family Child Care Facility

Child Care Program Information				
Name of Child Care Service/Name of Location if Different				
Physical Address				
	Street address			
		WV		
	City	State	Zip Code	Telephone Number

Primary Emergency Contact at Child Care Program			
Name		Position	
Telephone Number		Alternate Telephone Number	
Email Address			

Staff Assignments During an Emergency		
Assignment	**Name of Staff**	**Title**
Direct Evacuation Manager		
Alternative Direct Evacuation Manager		
Person Count		
First Aid		
Telephone Emergency Numbers		

Transportation		
Other: ___________		
Other: ___________		

Emergency Telephone Numbers		
Name/Company	**Contact Person's Name**	**Telephone Number**
Fire		**911**
Police		**911**
Ambulance		**911**
Poison Control		
Health Consultant		
Gas Company		
Electric Company		
Water Company		
Electrician		
Plumber		
Child Protective Services		
Licensing Specialist/ Child Care Regulatory Specialist		

Relocation Site #1 (See Page 6 for Details)		
Relocation Site #2 (See Page 7 for Details)		
Red Cross		
Physician(s)		
Dentist(s)		
Hospital(s)		
Other: ___________		
Other: ___________		

Types of Disasters Most Likely to Occur In or Around the Program Area	
Disaster Type	**Describe how each disaster might affect the child care program**
Fire	
Flood	
Wildfire	

Severe Winter Weather	
Hazardous Material Spill	*(Listen for Emergency System on evacuation or shelter in place instruction)*
Hostage/Active Shooter	*(Listen for Law Enforcement instruction)*
Other:	
Other:	

Exit Locations		
Post a floor plan showing exit path at each room exit. Attach a copy(ies) to this plan.	Exit path copies attached?	Circle one: Yes No

Utility Shut-off locations			
Name of Utility	**Location**	**Name of Utility**	**Location**
Electricity		Gas	
Water		Other:	

Disaster Plan Coordination **Name and Phone Number** **If the program regularly picks up children from other locations (schools, church programs etc.,) list phone numbers and contact names at the pick up location.**	
Local Emergency Management Officials	

Businesses	
Schools	
Churches	
Child Care Resource and Referral Agency	
Others:	

Communications	
Describe how program staff will be trained on disaster plan procedures.	
Describe how parents will be notified of the emergency or relocation. Include plans for reunifying parents and children. (A copy of page 6 of this plan must be provided to parents annually)	

Describe how the program will coordinate with local emergency management officials.	
Describe disaster plan procedures to address the needs of individual children, including children with special needs, infants, etc.	

Completion Date and Annual Review	
Date the Emergency plan was completed	
Date the emergency plan will be reviewed and updated	

Continuity of Operations - Procedures for Maintaining Essential Functions	
Describe how will you ensure essential functions can be maintained so children are safe and healthy during an emergency:	

Toileting/Diapering	
Feeding	
Sleeping	
Engagement (age-appropriate play materials, books, toys, etc. so that children can be engaged in play during an emergency).	

Relocation Site#1 for Disaster or Emergencies

Location to which you and the children will evacuate nearby – Include simple map of route as well as directions.

Name of facility				
Facility Address				
	Street address			
		WV		
	City	State	Zip Code	Telephone Number
Directions to facility				

Relocation Site #2 for Disaster or Emergencies

Location to which you and the children will evacuate out of the immediate area – Include simple map of route as well as directions.
Relocation Site #2 needs to be a further distance away than Site #1.

Name of facility				
Facility Address				
	Street address			
		WV		
	City	State	Zip Code	Telephone Number
Directions to facility				

In the event the facility must be evacuated because of an emergency in the immediate are the children and staff will be transported by ______________________ to: ______________________

If necessary, children will be transported to this health care facility:				
Facility Address				
	Street address			
		WV		
	City	State	Zip Code	Telephone Number
Directions to facility				

EPIC Early Head Start/Head Start/Pre-K
Emergency Response Drills

Site: ______________________________ School Year: _______________

Person(s) completing drills: ____

Person/Date Staff **Trained** on completing drills: __________________________________

**1st set of drills to be completed by September 20th.

**2nd set of drills to be completed by February 15th.

Bomb Threat Drills:

Date/Time: __________________________ Date/Time: _______________________

Severe Weather Drills:

Date/Time: __________________________ Date/Time: _______________________

Unwanted Intruder:

Date/Time: __________________________ Date/Time: _______________________

Bus Evacuation Drills:

Date/Time (of 1st)____________________ (due by September 2)

Date/Time (of 2nd) ____________________ (due by January 13)

Date/Time (of 3rd)____________________ (due by April 6)

Date/Time (of 4th) ____________________ (due by June 16 for **EHS only**)

Bus off-site evacuation due by November 17 - ________________________________
Date/Time Completed

Comments/Concerns:

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First Aid Kit Checklist

School Year ____________________ Site/Classroom ___________________________ Staff ______________________________________

✓ if item is in the First Aid Kit and X if item needs to be replaced.

Month	Review 2x/month (Sep-May)	Band-Aids	Tape	Non-Mercury Thermometer	Gauze	Scissors	Tweezers	Gloves	First Aid Guide	Poison Control Number	Pencil / Paper	Sealed Water Bottle	Date Reviewed	Staff Initials	Follow Up Need/Complete	Comments
Aug	1														☐Need ☐ N/A ☐Complete	
Sep	1														☐Need ☐ N/A ☐Complete	
	2														☐Need ☐ N/A ☐Complete	
Oct	1														☐Need ☐ N/A ☐Complete	
	2														☐Need ☐ N/A ☐Complete	
Nov	1														☐Need ☐ N/A ☐Complete	
	2														☐Need ☐ N/A ☐Complete	
Dec	1														☐Need ☐ N/A ☐Complete	
	2														☐Need ☐ N/A ☐Complete	
Jan	1														☐Need ☐ N/A ☐Complete	
	2														☐Need ☐ N/A ☐Complete	
Feb	1														☐Need ☐ N/A ☐Complete	
	2														☐Need ☐ N/A ☐Complete	
Mar	1														☐Need ☐ N/A ☐Complete	
	2														☐Need ☐ N/A ☐Complete	
Apr	1														☐Need ☐ N/A ☐Complete	
	2														☐Need ☐ N/A ☐Complete	
May	1														☐Need ☐ N/A ☐Complete	
	2														☐Need ☐ N/A ☐Complete	

Early Head Start/Head Start/Pre-K
School Fire Drill Safety Report

School Year ________________ **County** ______________________________

____
School **City/State/Zip Code**

This school fire drills report is published by the West Virginia State Fire Marshal's Division as an aide to school principals and teachers in conducting fire drills. It is mandatory that at least eight drills be conducted during the school year. All doors and exits are to be kept unlocked and unfastened during school hours. Drills are to be scheduled at random and not develop a consistent pattern.
This report is sent to schools whose principals and teachers may be properly instructed in the work of conducting drills. Orderly and well executed fire drills may be the means of saving lives.

Date of Drills	Time of Day	Number of Students	Evacuation Time	Blocked Exits	Signature of Administrator

POST in a conspicuous place in school building where it can be seen by teachers, students and patrons at all times.

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Hazard Mapping
(Incident/Accident/Behavioral)

Month/Year ____________________ Site/Classroom __________________________Staff ____

Complete this mapping based on your BRIM reports.

When did it occur? (Date and Time)	Who was Involved?	Where did it occur? (Specific Location)	What happened? What was the cause?	What was the severity?	Who witnessed?	How could it have been prevented?

EPIC Early Head Start/ Head Start/ Pre-K
Internal Investigation Procedure

To establish an internal concern and investigation process for the EPIC EHS/ HS/ PK program.

I. **Who may file concerns?**
Anyone can file a concern at any time.

II. **Why could a report be made?**
Examples of reportable actions are inappropriate interactions with children or families; violation of policies; questionable supervision of children; children being left alone; inappropriate statements or treatment of staff, etc.

III. **Investigation of Complaints.**

A. All concerns will be filed with the Director using the Internal Concern Form.

B. Once the Internal Concern Form has been submitted, there will be no further communication in regard to the matter unless with or to the Director.

C. In the case of a conflict of interest, the Director will immediately refer the matter to another member of the administrative team.

D. The Director (or his / her replacement) shall have (10) working days from the date on which the concern was filed to complete a thorough investigation.
   1. If the concern involves an allegation of child abuse or neglect, the matter will be reported to the West Virginia Department of Health and Human Resources. Such concerns may therefore require more than (10) days for investigation and completion.
   2. If the concern overlaps with a Serious Occurrence, the appropriate paperwork will be filed with the appropriate childcare licensing official.
   3. If the concern involves actions from one staff towards another, the EPIC Administrator and Human Resources will be notified.

E. Upon completion of the investigation, the individual submitting the concern will be notified of the results of the investigation. (No confidential information obtained during the investigation will be shared with any party)
   i. Each concern will be determined to be substantiated or unsubstantiated.

* There will be no negative actions imposed on the individual who submits a Concern Form.

*Reference:

- Internal Concern Form

EPIC Early Head Start / Head Start / Pre-Kindergarten
Internal Concern Form

Date:

Staff Member in Question:

Location of Incident:

Date of Incident:

Witnesses to Incident:

Nature of the Concern:

Name of individual submitting concern:

Phone: email:

EPIC Early Head Start/Head Start/Pre-K
Monthly Safety/Requirements Checklist

The county Family and Community Partnership staff will inspect each site monthly. Items found to be out of compliance will be addressed by that county's manager(s) and appropriate actions taken.
A copy of the monthly checklist and actions will be due by the 10th of each month, **beginning in October**. Copies will be given to the Director and Health Specialist (HS only) and the county Manager. The original will be kept in the Facilities Binder at each site. * If two or more classrooms are at a site, complete only one checklist for site noting specific classroom that has concern or needs repairs.

Members completing Inspection: ______________________________
Location: ______________________ Date Inspection Completed: ______________________
(month/day/year)

Staff	
☐ Yes ☐ No	Are all adults in the classrooms following ALL safety procedures including release of a child to authorized persons only?
☐ Yes ☐ No	Do staff members report and follow-up on safety problems?
☐ Yes ☐ No	Are licensure work and safety procedures in place and are staff adequately trained on procedures?
☐ Yes ☐ No	Do staff consistently adhere to staff/child ratios regardless of environment?
☐ Yes ☐ No	Are slip, trip and fall hazards quickly identified and corrected?
☐ Yes ☐ No	Do employees use proper lifting techniques when lifting either children or objects?
☐ Yes ☐ No	Are staff notifying parents (phone call **and** contact or accident form) when a child is sick or injured?
Comments:	
Postings	
☐ Yes ☐ No	Are evacuation routes, emergency phone numbers, mandated reporters list and first aid procedures current and posted in each classroom?
☐ Yes ☐ No	Hand-washing procedures (above or around each sink) and diapering procedures are posted in required areas in English and Spanish.
☐ Yes ☐ No	Is the WV DHHR Child Care license posted conspicuously? **(if applicable)**
☐ Yes ☐ No	Are health and fire marshal reports posted and current? **(if applicable)** *Health expiration date: * Fire Marshal expiration date:
☐ Yes ☐ No	Covered allergy sheet is posted and complete.
☐ Yes ☐ No	Are the most current Policy Council minutes, status reports and newsletter posted?
Comments:	
Housekeeping	
☐ Yes ☐ No	Are classrooms & common areas kept clutter free and drawers/cabinets closed when not in use?
☐ Yes ☐ No	Is trash disposed of properly (no overflowing garbage cans) and spills cleaned up promptly by staff members?
☐ Yes ☐ No	Is the center clean, free of dirt, odor and scraps of materials?
☐ Yes ☐ No	Are restrooms and child toileting areas kept clean and sanitized daily?

☐Yes ☐ No	Do trashcans, used for dumping food/food containers, have lids?
☐Yes ☐ No	Is the **sanitizing checklist** being completed weekly?
Comments:	
Hazardous Materials	
☐Yes ☐ No	Are janitor closets or other chemical storage areas inaccessible to children, orderly and locked?
☐Yes ☐ No	Is the chemical inventory adequate yet not excessive and are all items in the inventory being used?
☐Yes ☐ No	Are all hazardous materials kept in their original container or stored in a properly labeled secondary container?
☐Yes ☐ No	Do all containers of non-hazardous materials have their contents written on them in permanent ink (i.e. soap and water or water)?
☐Yes ☐ No	Is the facilities Binder current with MSDS sheets, pest inspection and copy of safety checklist? * **Please note that in school buildings, our classrooms will only have MSDS sheets and safety checklist.**
Comments:	
Storage Safety	
☐Yes ☐ No	Are all items stacked and stored properly- heavy items on bottom shelves and lighter on top?
☐Yes ☐ No	Are ALL storage areas neat and clutter free? Are aisles clear from trip and fall hazards?
☐Yes ☐ No	Are items accessible without unnecessary shifting of materials/equipment?
☐Yes ☐ No	Is medication properly stored and labeled and inaccessible to children?
☐Yes ☐ No	Are First Aid checklists completed and initialed twice a month & items current?
Comments:	
Equipment	
☐Yes ☐ No	Is all shelving stable and secured, if necessary?
☐Yes ☐ No	Is all equipment maintained and cleaned regularly?
☐Yes ☐ No	Do staff know how to use the equipment necessary to perform their duties?
Comments:	
Kitchens * complete only if NOT in school building	
☐Yes ☐ No	Is there grease build-up and excessive water on the floor?
☐Yes ☐ No	Are there adequate mats on the floor to prevent slips and falls?
☐Yes ☐ No	Do all garbage cans have lids?
☐Yes ☐ No	Is electrical equipment unplugged when not in use?
☐Yes ☐ No	Are knives stored separately?
Comments:	

Electrical	
☐Yes ☐ No	Do all electrical outlets where children have access, have plug protectors?
☐Yes ☐ No	Extension cords are used for temporary purposes only.
☐Yes ☐ No	Are outlets and switches free of cracks, tight against wall, with no exposed wires?
☐Yes ☐ No	Are electrical cords in good condition-free of cracks and exposed wires?
☐Yes ☐ No	Are all electrical panels clearly marked with 3 ft. of unobstructed clearance?
Comments:	

Floors	
☐Yes ☐ No	Are floors free of holes and loose/torn carpet or tiles?
☐Yes ☐ No	Are changes in floor level clearly marked? (Note: this is usually done with yellow paint unless site is a regular stairwell)
Comments:	

Emergency and Fire Protection	
☐Yes ☐ No	Are smoke detectors properly located and tested regularly?
☐Yes ☐ No	Are fire extinguishers readily available and inspected by Fire Safety annually?
☐Yes ☐ No	Are fire extinguishers checked and initialed monthly by staff to ensure they are full?
☐Yes ☐ No	Have staff members been trained on the use of fire extinguishers?
☐Yes ☐ No	Are exits well marked with appropriate exit sign lighting **and has emergency lighting been checked and found to be in good working order?**
☐Yes ☐ No	Are fire drills conducted twice a month and clearly documented?
☐Yes ☐ No	Are alternative drills, such as lockdowns, earthquakes and shelter-in-place conducted as required and documented on red sheet?
☐ Yes ☐ No	Are First Aid kits properly located, are all required contents current and available and has checklist been completed in accordance with policy?
☐Yes ☐ No	Have staff members received training on how to safely perform emergency drills?
Comments:	

Outdoors	
☐Yes ☐ No	Are the grounds around the classroom(s) free of holes, protruding roots, high grass, muddy ground or pools of water that create a slip, trip or fall hazard?
☐Yes ☐ No	Are outdoor premises checked daily for cleanliness, kept free of undesirable and hazardous materials and documented on **playground safety checklist**?
☐Yes ☐ No	Are the playground equipment and outdoor toys in good repair and in safe condition?
☐Yes ☐ No	Are there any areas of cracked/uneven concrete?
☐Yes ☐ No	Do children, when outside, have access to unsupervised or unsafe areas (unlocked and child accessible gates facing parking lots of the road, bodies of water, etc)
Comments:	

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Outdoor Environment Checklist

Month/Year ______________________________ Site/Classroom ______________________________

Staff responsible will check each item listed and ensure the criteria are met. If repairs are needed, these must be reported to the site supervisor in writing, after checklist completed. Any serious hazards must be reviewed to determine if the children should be allowed on the grounds. Signing this means each item has been inspected. ***This checklist must be completed before children are allowed in the area.***

Children are to go outside unless there is a weather advisory, or the site supervisor so directs due to security or other concerns.	**Date Hazard Reported**	**Comments**
1. Check that lighting is working and areas are properly lit		
2. Check that gate(s) is properly secured and in good condition. The gate latches appropriately, can be easily secured and there are no gaps wider that 3.5". Report any holes under the fencing or any wires, rust or chipping paint.		
3. Check play structures to ensure that they are safe and complete. There should be no gaps to catch clothing, no bolts or nails protruding, no fasteners missing, and nothing broken. Report any cracks, holes, or rust. Check under the equipment and in any area the children may go.		
4. Outdoor premises are checked for cleanliness, trip hazards, and kept free of undesirable and hazardous conditions. Check that area and equipment are free from trash, sharp or dangerous materials, poisonous plants, or other hazardous objects or materials. Is the bicycle path free from rocks or mulch that would cause the bikes to overturn? Clean up any hazards that are found.		
5. Take out riding toys and check that they are safe to use and in good condition. Place safety cones to mark area.		
6. Take out other equipment, i.e.: balls, blocks, hoops, balance beams chalk, sand and water toys, etc. Be sure there is sufficient variety and there are enough items for the largest group that will be outside. Check that all equipment is in good condition and will not cause injury when properly used.		
7. Check that surfacing materials are in place and that they are 9" deep. If they have been displaced at the bottom of equipment, be sure to replace it before children play on the equipment. 6ft. "use zone" has appropriate surfacing.		
8. Make sure there is drinking water available outside for the children.		
9. Check for any other hazardous conditions. Report any suspicious people or conditions that might be a danger to the children.		

Date	Staff Initials	Date	Staff Initials	Date	Staff Initials	Date	Staff Initials

Eastern Panhandle Instructional Cooperative
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Visitor/Volunteer Tracking

School Year ____________________ Site ______________________________

If you are under the age of 18, please have your parent/guardian sign you in and out

Date	Classroom	Child Name	Visitor Name	Time In	Time Out	Purpose of Visit	*Photo Consent
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐

** By checking the Photo Consent box, you are permitting photos taken to be used for promoting the program (i.e., used in Newsletters, Websites, etc.)*

Eastern Panhandle Instructional Cooperative

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Special Services Tracking

School Year ________________________ Site/Classroom ____

**Place this Cover and form on a clipboard and hang near the door. All Special Services Staff must complete for tracking purposes.*

EPIC

Special Services Tracking

School Year ____________________ Site/Classroom ______________________________

Date	Child Name	Staff Name	Start Time	End Time	Purpose of Visit	Serviced In or Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out
					☐ PSSN ☐ Speech ☐ MH ☐ Other ________	☐ In ☐ Out

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Classroom Cleaning Checklist

Month/Year ______________ Site/Classroom ______________ Staff ______________

*✓ items completed each day and initial at end of month

Clean and Sanitize or Disinfect Daily	Week 1 M	T	W	T	F	Week 2 M	T	W	T	F	Week 3 M	T	W	T	F	Week 4 M	T	W	T	F	Week 5 M	T	W	T	F	Staff Initials
Organize/Return toys/materials/equip.																										
Organize/Return items in cubbies																										
Tabletop /chairs before/after use, using 3 step process (frame/legs when soiled)																										
Sweep floors after each meal/at the end of the day/ Spot clean spills, as needed																										
Mouthed toys																										
Door/Cabinet handles, light switches, toilet/sink handles and other high touch areas																										
Computers/iPad (mouse, keyboard, screen, table)																										
Water table after choice times																										
Top/Outside of trashcans, as needed																										
Paint easel, cups, brushes, walls, mat																										

*Enter date items completed each week and initial at end of month.

Clean and Sanitize or Disinfect Weekly	Week 1	Week 2	Week 3	Week 4	Week 5	Staff Initials
Cubbies, Walls, Shelves, etc.						
Launder cloth toys, clothes, stuffed items						
Lauder Cot sheets, blankets, towels, etc.						
Trashcan, dustpan, step stool						
Block Center items						
Dramatic Play/Cooking Center items						
Toys/Games Center items						
Art Center items						
Library Center items						
Discovery Center items						
Music/Movement Center items						
Animal feeders, tanks/bowls, cages, etc.						

Serious Occurrence Form

Child Care Center Regulation Definition of a Serious Occurrence:
Serious Occurrence – An event that either harms or could potentially harm a child or compromises the operation of the center.
It may include:
a. A child who dies while in care;
b. A child who is injured while in care to the extent that the child requires medical care beyond immediate first aid;
c. A diagnosed reportable communicable disease that is introduced in the center;
d. A medication error that occurs;
e. A legal action involving or affecting the operation of the center;
f. A serious violation of a licensing requirement, such as physical punishment or failure to supervise; or
g. A report given to Child Protective Services of suspected abuse or neglect of a child at the center.

Child Care Center Regulations on Reporting a Serious Occurrence:
19.12 Reporting a Serious Occurrence. A center shall:
19.12.a. Immediately inform the parent or parent's authorized designee when a child is involved in a serious occurrence;
19.12.b. Verbally report the occurrence within 24 hours or by the next work day to the Secretary, and before the end of the day, ensure that the staff member in Charge prepares and signs a serious occurrence report; and
19.12.c. Complete a report of each serious occurrence ensuring that the report is signed by the staff member completing it and by the child's parent.

Center ______________________________ Date of Serious Occurrence _______________

What type of occurrence is being reported:

Name of child(ren) involved in serious occurrence:

Precise location of where serious occurrence happened: ___________________________________
____

Name(s) of parent(s) notified	Time Notified

Staff person(s) involved with or witnessing serious occurrence:

Use the Accident/Incident Report form to explain in detail the serious occurrence. Include dates, times, actions and immediate responses. (Attach to Serious Occurrence Form)

Accident/Incident report completed? (circle one) Yes No

Date and Time Licensing Authority notified ____

Name of Licensing Authority notified ______________________________

Method of Notification: ______________________________

	Signature	Date
Staff Person:		
Staff Person:		
Director:		
Parent:		
Other:		

ratio set out in this rule.

3.25. Immediate Area. -- Within reach, easily accessible and in the same room.

3.26. Infant. -- A child between the age of six weeks and the age of ambulation and walking, usually through 12 months.

3.27. Level I Field Trip. -- An excursion or outing to a destination that is 30 minutes or less from the center or from the site where program activities regularly occur.

3.28. Level I Water Activity. -- Any activity occurring in or near water 18 inches deep or less.

3.29. Level II Field Trip. -- An excursion or outing to a destination that is more than 30 minutes from the center or from the site where program activities regularly occur.

3.30. Level II Water Activity. -- Any activity occurring in or near water with a depth of more than 18 inches.

3.31. License. -- A written certificate issued by the Secretary authorizing a person, corporation, partnership, voluntary association, municipality, county, or any agency thereof, to operate a child care center in accordance with the terms and conditions of the license and this rule.

3.32. Licensed Capacity. -- The maximum number of children permitted in a center.

3.33. Licensed Health Care Provider. -- For the purpose of this rule, an individual who holds a license to practice in West Virginia as a physician, Doctor of Medicine or (MD), Doctor of Osteopathy (DO) or, physician's assistant (PA), chiropractor or nurse practitioner.

3.34. Licensee. -- The holder of a license or certificate of approval obtained from the Secretary to operate a child care center in West Virginia.

3.35. Medical Plan of Care. -- A document that provides specific health care information, including any medications, procedures, precautions or adaptations to diet or environment that may be needed to care for a child with chronic medical conditions or special health care needs. Medical plans of care also describe signs and symptoms of impending illness and outline the response needed to those signs and symptoms.

3.36. Medication Error. -- An error caused by either:

3.36.a. Failure to administer a dose of medication; or

3.36.b. The administration of a medication:

3.36.b.1. To the incorrect child;

3.36.b.2. In the incorrect dosage;

3.36.b.3. At the incorrect time, other than within 30 minutes before or after the scheduled

time;

3.36.b.4. In the incorrect form;

3.36.b.5. By the incorrect method or route; or

3.36.b.6. That is incorrect itself.

3.37. Moderate to Vigorous Physical Activity. -- Levels of activity that are conducted at varying intensities. Moderate physical activity is faster than a slow walk, but still allows children to talk easily. It increases the heart rate and breathing rate. Vigorous physical activity is rhythmic, repetitive physical movement that uses large muscle groups, causing children to breathe rapidly and only enabling them to speak in short phrases. Typically children's heart rates are substantially increased and they are likely to be sweating. Toddlers and preschoolers generally accumulate vigorous physical activity over the course of the day in very short bursts, usually 15 to 30 seconds.

3.38. Multifunction school activity bus. -- Any vehicle operated by the center that can carry eleven or more passengers meeting the federal motor safety standards applicable to school buses with some exclusions regarding traffic control devices.

3.39. Night Time Care. -- Care provided to the child who stays during nighttime hours or overnight, which may include the time usually designated as sleep time.

3.40. Out-of-school Time Program. -- A program that offers activities to children before and after school, on school holidays, when school is closed because of an emergency, and on school calendar days set aside for teacher activities.

3.41. Parent. -- The biological or adoptive parent or parents of a child, a person or persons, or the Department, who has legal custody of a child, or the lawful guardian of a child.

3.42. Person-in-Charge. -- The qualified staff member with responsibility for the daily operation of the center at any specific time.

3.43. Plan of Correction. -- A written agreement between the Department and a center, approved prior to implementation, that outlines the steps the center shall take to correct deficiencies identified by the Secretary through an inspection or the investigation of a complaint.

3.44. Practicum Contact Hour. -- A period of supervised experience recognized for credit toward a credential by an educational institution or similar organization.

3.45. Pre-service Training. Training completed by all child care staff and applicable volunteers as required by the S1086 Child Care and Development Block Grant (CCDBG) Act of 2014, Section I. Health and Safety Requirements (I-XII).

3.46. Professional Development. -- A continuum of learning and support opportunities designed to prepare individuals for work with and on behalf of young children and their families, as well as opportunities that provide ongoing experiences to enhance this work. Professional development programs encompass both education and training programs.

3.47. Qualified Staff. -- A staff member who has a high school diploma or GED and meets the requirements under this rule for the position of director, assistant director, lead teacher, teacher, assistant teacher, or teaching assistant.

3.48. Registered Apprenticeship Certificate for Child Development Specialist. -- A nationally recognized credential awarded by the United States Department of Labor for the successful completion of a combination of classroom and on-the-job training.

3.49. Related Field. -- As approved by the Secretary, an area of study that includes credit hours associated with the early child care and education field, including elementary education, social work, recreation and leisure studies, nursing, counseling, psychology, and administration related to the care and education of the child from birth through 12 years of age.

3.50. Relevant Work Experience. -- Work that is directly with or on behalf of children from birth through 12 years of age, and their families in areas of supervision, leadership or management; program coordination, development or regulation; training, instruction or technical assistance; or evaluation or research. Private or family child care is considered relevant work experience only if the care was regulated care and can be verified.

3.51. Responsible Person. -- A parent, center staff member, or other person designated by the parent in written information to drop off or pick up the child.

3.52. Sanitize. -- Destroy pathogens on food contact surfaces, such as utensils, cups and glasses, through the use of processes involving chemicals or heat that do not pose a threat to food safety.

3.53. Secretary. -- The Secretary of the Department of Health and Human Resources or his or her designee.

3.54. School -Age Child. -- A person who is between five and 13 years of age and is eligible to attend school or is enrolled in grades K-12.

3.55. School-Age Program. -- Services provided by a center for the care and supervision for school-age children. These programs include summer recreation camps, day camps and out-of-school time programs.

3.56. Screen Media. -- Forms of communication or entertainment viewed on a screen such as televisions, computer monitors, digital gaming equipment, etc.

3.57. Self-disclosure Application and Consent form -- A signed declaration of criminal convictions, indictments, and court ordered supervision, and authorization to allow a criminal history background check.

3.58. Serious Occurrence. -- An event that either harms or could potentially harm a child or compromises the operation of the center. It may include:

3.58.a. A child who dies while in care;

3.58.b. A child who is injured while in care to the extent that the child requires medical care beyond immediate first aid;

3.58.c. A diagnosed reportable communicable disease that is introduced in the center;

3.58.d. A medication error that occurs;

3.58.e. A legal action involving or affecting the operation of the center;

3.58.f. A serious violation of a licensing requirement, such as use of physical punishment or failure to supervise; or

3.58.g. A report given to Child Protective Services of suspected abuse or neglect of a child at the center.

3.59. Special Activities. -- Potentially dangerous organized recreation that require special technical skills, safety equipment, safety regulations, or involve fire or heat-producing equipment. These include, but are not limited to, Level II water activities, archery, gymnastics, karate, horseback riding, bicycling, rock climbing, spelunking, hiking and cookouts.

3.60. Staff Member. -- Any center personnel, including substitutes and student interns, whether or not he or she receives compensation.

3.61. Staff-to-Child Ratio. -- A relationship which describes the number of children that one qualified staff member or substitute is permitted to supervise. The number varies according to the ages and developmental levels of the children and the types of activities in which they are participating.

3.62. Substitute. -- An individual who is present at the center to maintain the staff-to-child ratio when a qualified staff member is absent.

3.63. Summer Recreation Camp. -- A school age program that operates during the summer months, whose program orientation is primarily recreational, and of which 80 percent of the program occurs outdoors.

3.64. Support Staff. -- Staff who carry out duties not regularly involving the supervision of children.

3.65. Teen Aide. -- An individual who is between 13 and 18 years of age who works with or without compensation under the direct supervision of a qualified staff member who has a minimum of the qualifications of an assistant director or lead teacher.

3.66. Time-Out. -- A positive behavioral support strategy to help children change their undesired behavior and help teach a desired replacement behavior. The time-out period is the length of time when the child is removed from regular activities as a consequence for specific behavior.

3.67. Toddler -- A child between ambulation/walking to 24 months of age.

3.68. Training. -- Instruction provided that is designed to impart knowledge or skills.