

Fire Extinguisher Use

All EPIC staff, full-time and part-time, will be trained how to safely use their building/classroom fire extinguisher equipment. WV Public Service Training will conduct the hands-on training. Training will be held at the beginning of the year for all staff and additional times will be set up for new hires during the program year.

Universal Precautions

Staff members will utilize washing hands, wearing gloves and any other necessary personal protective equipment like mask or eye protection to prevent any exposure to possible blood borne pathogens.

Staff members will wash their hands before starting work and when contaminated with body fluids, before preparing, handling or serving food/setting the table, after using the restroom or assisting children in the restroom/changing diapers, before and after eating, after handling pets/animals, before giving medication, after outdoor play, after handling garbage and after removing gloves.

Wear gloves when touching blood and bodily fluids, mucous membranes, non-intact skin, preparing, handling or serving food, assisting children in the restroom. Gloves must be changed between contact with different persons and hands washed before putting on new gloves.

Sanitizing

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 communicable health viruses and infections that can be passed on through hand-to-mouth contact. Staff should wear gloves when sanitizing to reduce potential exposure.

Prevention of Injury

EPIC Early Head Start/Head Start Staff will 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 the center. Staff may never be alone with children and each classroom must have two adults at all times. A safety checklist is utilized by staff and training provided to them in all areas of injury prevention.

Health Procedures

All children must have a dental exam for enrollment and one dated within the program year. For example, if a child submits papers for an exam in May (previous program year) for enrollment purposes, then we will require a new one submitted for the six-month cleaning done in November. A physical exam not more than a year old must be submitted for enrollment or have been completed within 30 days after enrollment. Immunizations must be completed prior to the first day of class. A lead and hematocrit screening will be completed at the first home visit using the Head Start screening form. Each child will be screened for speech, hearing, vision, social/emotional 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 Specialist 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 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.

Obtaining Initial Health Events

1. Ten (10) days after enrollment if no physical or dental has been received, the Family Advocate will send a Health Follow-Up letter to remind the parents/guardians it is due and call parent/guardian to let them know the paper is in the child's folder.
2. Fifteen (15) days after enrollment if no physical or dental has been received, the Family Advocate will make a phone call to the family to inquire if an appointment has been made.
 - a. If an appointment has been made the Family Advocate will make note of the date on the documentation of the phone call and then call the medical office to confirm the appointment.
 - b. If an appointment has not been made, the Family Advocate will inquire if any barriers exist they can assist with and note these on the call documentation.
3. Twenty (20) days after enrollment and no physical or dental has been received, the Family Advocate will make a home visit to address any barriers.
4. Twenty-Two (22) days after enrollment the Family Advocate will make a referral to the Health & Safety Specialist if no appointment has been made and include all contact documentation made with the family.
5. Twenty-Five (25) days after enrollment if no physical or dental has been received or no appointment made, the Family Advocate will make a phone call and an unscheduled home visit to address barriers and assist in making the appointment and have them fill out a permission slip with WVU Dental Program and/or Shenandoah Health if needed.

Expiring Health Events

If a physical from the physician is dated August through December of the previous year, we will follow the following procedures to receive an updated physical for the file.

1. Thirty (30) days prior to the expiring physical or dental examination, Family Advocate will send a Health Follow-Up letter reminder to the parent/guardian and call them to let them know the letter is in the child's folder.
2. Twenty (20) days prior to the expiring physical, the Family Advocate will make a phone call to the family to discuss the expiring event and assist with scheduling an appointment.
3. Fifteen (15) days prior to the expiring physical or dental, if there has been little communication by the family and no appointment made, the Family Advocate will make a home visit to assist with scheduling the appointment.
4. Five (5) days prior to the expiration, if no appointment or physical has been received a referral should be made to the Health & Safety Specialist and include all contact documentation.

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 a child's file.**

Unresolved follow up of health issues noted on the physical will be documented on a referral form and given to the Health & Safety Specialist. Concerns should be addressed with the Health & Safety Specialist and during child's staffing times and as need to assure the provision of services in a timely manner.

Child's Dental Form

Dental forms are to be followed up on 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/dates with Health & Safety 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 child. Height/weight due dates are on the staff calendar. The Family Advocate should send a referral to the Health & Safety Specialist when a child is either below the 5th percentile or above the 95th percentile for height/weight. Some children are small or large for their age. The Health & Safety Specialist will discuss the family history with the Family Advocate including parents and siblings. Concerns need to be documented and shared with the Health & Safety Specialist. Staff may need to contact the physician for information and help. The WIC program can also be a referral source.

Immunizations

Please refer to the most recent CDC recommended immunization schedule. Head Start is required to have an immunization record or a plan to get immunizations caught up for each child prior to the first day of class. Staff will work with the family on updating their child's immunization record, however we do need documentation that immunizations have been given. If a family cannot locate their child's immunization record, the Family Advocate will work with the family in helping them to locate where the last immunizations were given. In the rare case no immunization records can be located, the child may need to begin a new series of shots.

Nutrition Assessment

A nutrition assessment form will be completed by the teaching or family service staff during an initial home visit. The form must be filled out completely. Getting all questions answered gives staff the knowledge to any food allergies, special diets, or food related insecurities the child may have. Any issues must be shared with teachers, family services, manager and Health & Safety Specialist. If any child does have a food allergy or intolerance, the special diet form must be completed by their healthcare provider to accommodate the child's nutritional needs.

Hematocrit/Hemoglobin

The WV EPSDT requires this test to be completed at 12 and 24 months of age. Typically, results or risk is indicated on the child's physical. All Head Start children will have an assessment completed during the initial home visit by either the teaching or family service staff. If the assessment is high risk, the family will be notified to contact their healthcare provider for follow up services and a referral made to the Health & Safety Specialist. On going follow up will be done by the Family Advocate to ensure the child has been seen and all documentation from the healthcare provider filed.

Lead

The WV EPSDT requires a blood test at 12 and 24 months of age. The routine test is not performed at 36 and 48 months but Head Start can use previous scores. All Head Start children will have a lead assessment form completed during the initial home visit by either the teaching or family service staff. If any question on the form is answered with a 'yes' then the family will be notified to contact their healthcare provider for follow up services and a referral will be made to the Health & Safety Specialist. On going follow up will be done with the Family Advocate to ensure the child has been seen and all documentation from the healthcare provider filed.



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.

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*):

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

Prenatal Exposure to Drugs:

- Don't know Non-prescription Drugs, specify _____
 Alcohol Prescription Drugs
 Caffeine Other, specify _____
 Cigarettes/Tobacco

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: _____

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.



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			<input type="checkbox"/> Pass <input type="checkbox"/> Rescreen <input type="checkbox"/> Refer			<input type="checkbox"/> Pass <input type="checkbox"/> Rescreen <input type="checkbox"/> Refer			
Hearing			<input type="checkbox"/> Pass <input type="checkbox"/> Rescreen <input type="checkbox"/> Refer			<input type="checkbox"/> Pass <input type="checkbox"/> Rescreen <input type="checkbox"/> Refer			
Speech			<input type="checkbox"/> Pass <input type="checkbox"/> Rescreen <input type="checkbox"/> Refer			<input type="checkbox"/> Pass <input type="checkbox"/> Rescreen <input type="checkbox"/> Refer			
Developmental		<input type="checkbox"/> ANL/WNL <input type="checkbox"/> BNL	<input type="checkbox"/> Pass <input type="checkbox"/> Rescreen <input type="checkbox"/> Observation Dt _____ <input type="checkbox"/> Refer			<input type="checkbox"/> ANL/WNL <input type="checkbox"/> BNL	<input type="checkbox"/> Pass <input type="checkbox"/> Rescreen <input type="checkbox"/> Observation Dt _____ <input type="checkbox"/> Refer		
Self Help / Social Emotional		SH <input type="checkbox"/> AA <input type="checkbox"/> A <input type="checkbox"/> BA SE <input type="checkbox"/> AA <input type="checkbox"/> A <input type="checkbox"/> BA	<input type="checkbox"/> Pass <input type="checkbox"/> Rescreen <input type="checkbox"/> Refer			SH <input type="checkbox"/> AA <input type="checkbox"/> A <input type="checkbox"/> BA SE <input type="checkbox"/> AA <input type="checkbox"/> A <input type="checkbox"/> BA	<input type="checkbox"/> Pass <input type="checkbox"/> Rescreen <input type="checkbox"/> Refer		

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

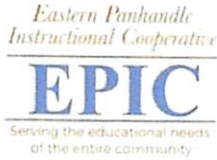
Parent/Guardian Signature _____

Staff Signature _____

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

Parent/Guardian Signature _____

Staff Signature _____



Head Start & Pre-K
Lead Risk Assessment

Child's Name: _____ Date of Birth: _____

How long has child lived at current address? _____

Date of Assessment: _____

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? Yes ____ No ____

If yes: Where _____ When _____ Blood Test Score _____

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 Assessment Completed _____ Age: 3yrs 4yrs Result: 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

Head Start Staff Signature

Child's Name: _____

Date of Birth: _____ Age: _____

Parent/Guardian: _____

Child Nutrition Assessment

1. Check all that your child takes:

- Medicine _____
- Vitamins/Minerals _____
- Herbal teas/herbal products _____
- Home remedies _____
- None

2. Check all that your child uses to eat or drink:

- baby bottle sippy cup his/her fingers
- regular cup spoon or fork other _____

3. Does your child skip meals or have a limited amount of food at meals because there is not enough money to buy food?

- Yes No

4. Do you have a working stove, refrigerator, and sink?

- Yes No

5. Check how often your child eats these foods:

Meat, poultry, fish, beans, or eggs	<input type="checkbox"/> Daily	<input type="checkbox"/> Some Days	<input type="checkbox"/> Never
Milk, yogurt, cheese	<input type="checkbox"/> Daily	<input type="checkbox"/> Some Days	<input type="checkbox"/> Never
Fruits	<input type="checkbox"/> Daily	<input type="checkbox"/> Some Days	<input type="checkbox"/> Never
Vegetables	<input type="checkbox"/> Daily	<input type="checkbox"/> Some Days	<input type="checkbox"/> Never
Grains – cereal, bread rice, pasta, tortillas	<input type="checkbox"/> Daily	<input type="checkbox"/> Some Days	<input type="checkbox"/> Never
Cookies, cakes, pies, candy	<input type="checkbox"/> Daily	<input type="checkbox"/> Some Days	<input type="checkbox"/> Never
Fried foods, French fries, sausage, hot dogs, bacon	<input type="checkbox"/> Daily	<input type="checkbox"/> Some Days	<input type="checkbox"/> Never

6. Check all that your child drinks:

- whole milk 2% milk reduced fat milk Soy milk
- 1% reduced fat milk fat free milk water fruit drink
- 100% fruit juice soda Gatorade tea
- Other: _____

7. Check all that your child eats:

- hard candies seeds dirt
- gummy candies raisins clay
- chewing gum dried fruit chalk
- chips whole grapes ashes
- pretzels hot dogs laundry starch
- nuts uncooked meat cornstarch
- spoonful of peanut butter uncooked fish baking soda
- large amounts of ice uncooked eggs crayons

8. Does your child eat fast food meals more than 2 times a week? Yes No

10. How do you know when your child is hungry?

How do you know when your child is full?

10. Does your child go for:

Regular health check-ups? Yes No

Regular dental check-ups? Yes No

11. Check all your child has had in the last month:

- diarrhea constipation vomiting nausea
- difficulty chewing or swallowing unable to feed self
- dental problems
- special diet: _____
- health or medical problem: _____
- food allergy or intolerance: _____
- none

12. What is your child's usual daily activity?

- very active (plays actively 2 or more hours per day)
- active some of the time (about 1-2 hours per day)
- not active

13. How many hours a day does your child watch TV, play at the computer, or play video games? _____ hours per day

14. Do you have questions or concerns about your child's health, diet, feeding or growth? Yes No

If yes, please describe _____

15. Please offer any suggestions on what Head Start can do to better serve you and your family

EPIC Head Start/Pre-K Individualized Health Plan

Medication will be administered by Head Start staff ONLY when this form has been completed and signed by the Health Care Provider and parent/guardian.

Today's Date: _____ Review no later than: _____

Child's Name: _____ Birthdate: _____

Phone number: _____

Diagnosed Medical Condition Being Treated: _____

Symptoms Staff Should Look For: _____

Regularly Scheduled Medications

Medication	Frequency/Time (When)	Dosage (How Much)	Route (How)	Duration of Treatment (Start date/end date)	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:		

Comments/Specific Instructions:

Primary Health Care Provider Signature: _____ Date: _____

Printed Health Care Provider Name, Address and Phone Number:

I authorize EPIC Head Start/Pre-K program personnel to administer the medication named above to my child in the manner as stated by the Health Care Provider. 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: _____

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**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 is 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.

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
 - < Read the label three times
 - < 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 devices for medications
 - < **Do Not Use Kitchen Utensils.** These do not provide accurate measurements
 - < 1 milliliter = 1cc
 - < 5 milliliters 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. **DOCUMENTATION**
 - < 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

RECORD OF EMERGENCY MEDICATION ADMINISTRATION

Child's Name _____ Parent/Guardian Name _____
Phone (home) _____ Phone (work) _____

Date _____

Time of occurrence _____ Time 911 was called _____ Time 911 arrived _____

Time Parent/Guardian Called _____

Symptoms _____

Medication/s administered _____ Dose _____

Route: injection inhaled other: _____

If injection, site medication was administered: _____

Side Effects

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

Staff Signature _____ Date _____

Child's Medical Conditions: _____

Child's Allergies: _____

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?

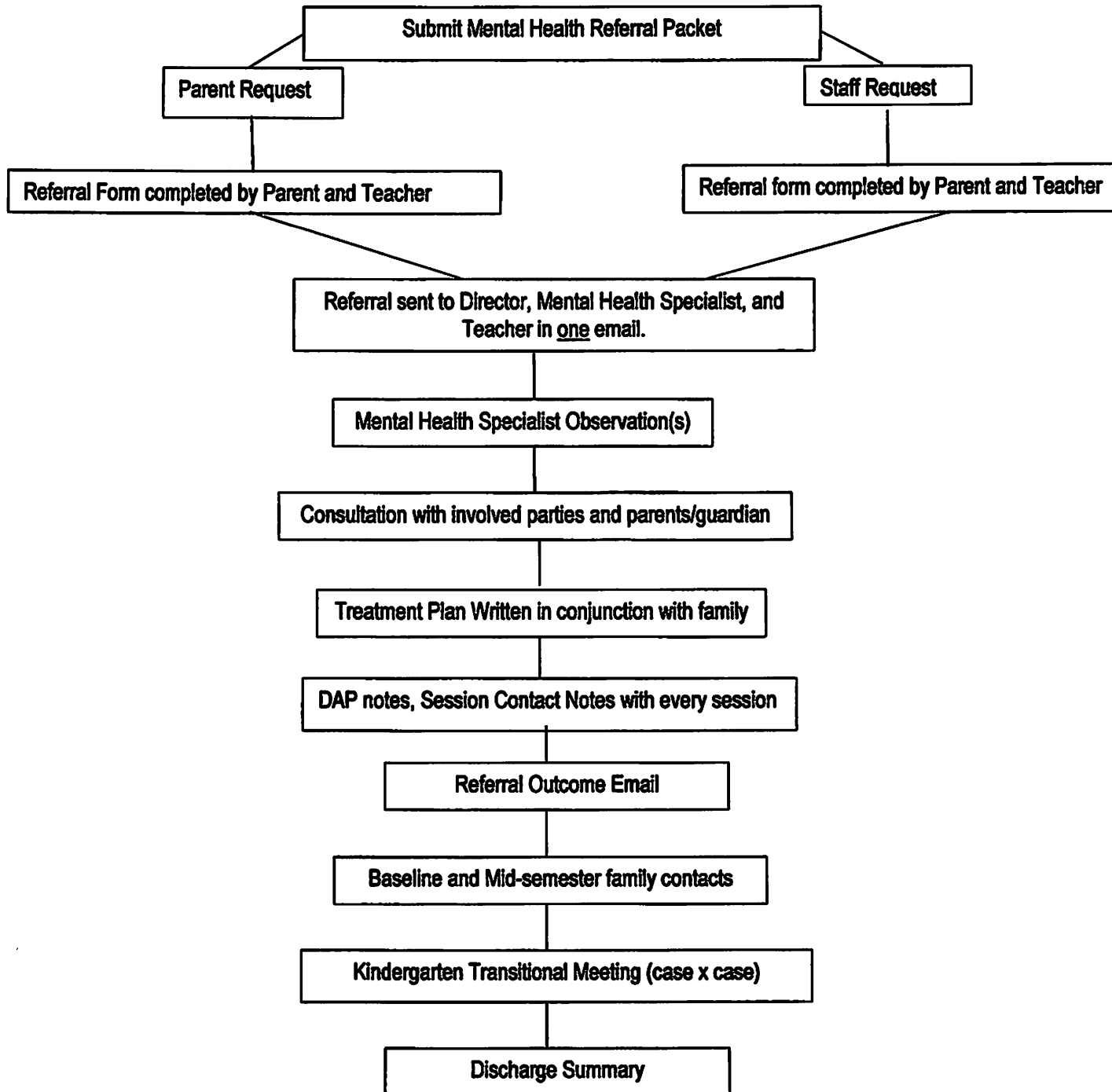
The following guidelines are provided to help you determine if your student is ready to return to school after an illness.

- Fever free for the past 24 hours without the use of fever-reducing medications such as Tylenol. A fever is defined as a temperature $\geq 100.4^{\circ}$.
- 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 manager. They will be happy to assist you in deciding what is best for your child.

Reviewed and endorsed by Berkeley County Health Department

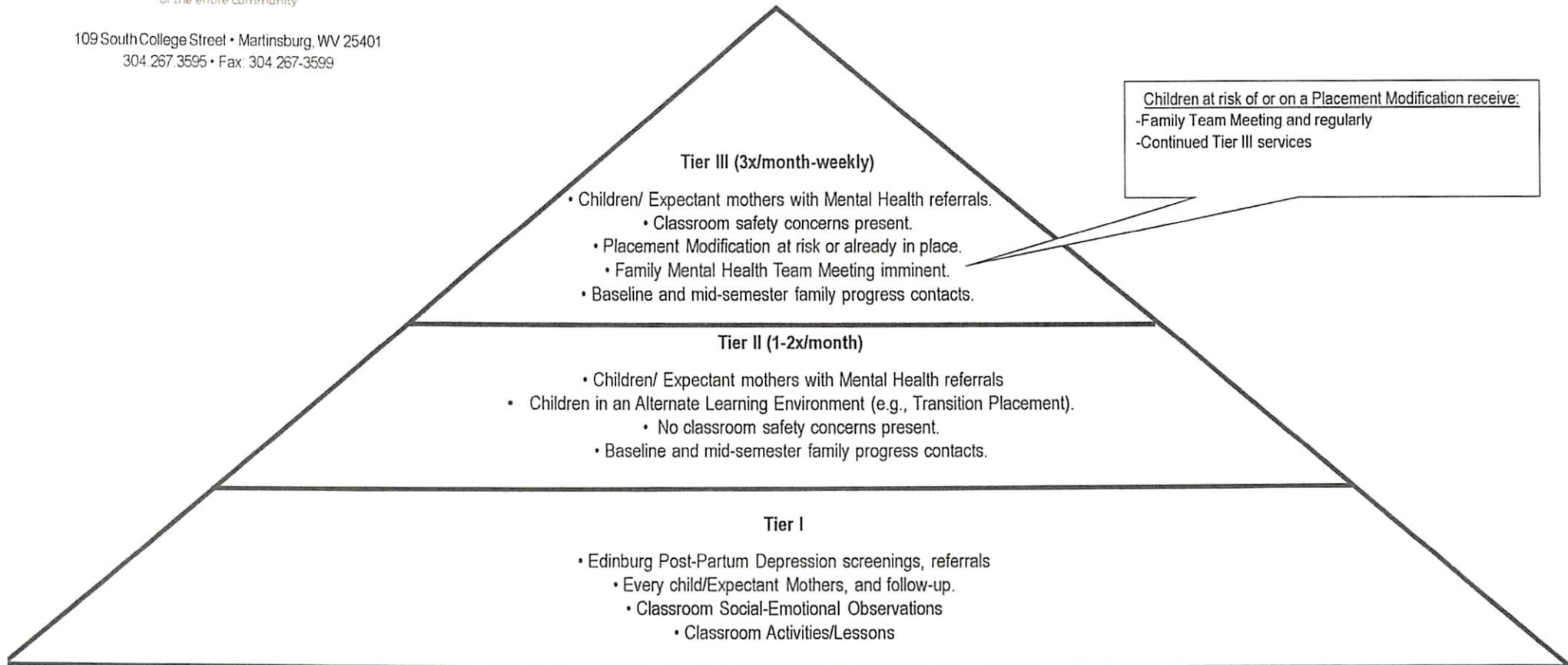
The Mental Health Observation Map



The Mental Health Tiers of Service

2023-2024

The following tier levels implemented by the Mental Health Specialist determine Service frequency to EPIC Early Head Start/ Head Start/ Pre-K children, expectant mothers and families.



Mental Health Process Policy and Procedures 2023-2024

*The Mental Health process is strengths-based, respectful, reciprocal, and family-focused from initiation of a referral to discharge. Mental Health Referrals can be completed by either/or Parent or Teacher-Request. Unless an exception is provided by the Mental Health Specialist, Mental Health referrals submitted by Teacher-Request will not be made the first 3 weeks of the school year to allow children time to adjust to the classroom environment. Mental Health Referrals based on Parent-Request can be made at any time.

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. Thus, complete Steps 1-4 of the Mental Health Referral Process.

AFTER SUBMISSION OF A MENTAL HEALTH REFERRAL

1. After a complete Mental Health Referral Packet is submitted:
 - a. The Mental Health Specialist completes an Initial Observation-Functional Behavior Assessment *within 15 business days* 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.
 - b. Parent/guardian contact is then made to:
 - i. Inform of the outcome of the observation,
 - ii. Conduct further assessment,
 - iii. Determine treatment goals/plan,
 - iv. Refer to a community mental health agency, or both (internal/external service referral),
 - v. Inform of Tiered Level Assignment

- vi. Planned session days to optimize school attendance, and expectations.
- vii. A Mental Health Introductory Packet is provided to the parent/guardian.
- c. A copy of the Treatment Plan will be provided to the teacher for parent/guardian signatures. Then, the signed Treatment Plan will be emailed to the Mental Health Specialist.
 - i. Tier Level Assignment and Treatment Plan goals will be reviewed and updated as needed.
- d. Consistent contact with the family will be maintained to ensure their active participation and involvement in the process.

INTERNAL SERVICE PROVISION

1. Individual/group classroom-based social-emotional skill building/support sessions, unless otherwise specified, are completed by the Mental Health Specialist on designated days, as determined by the Tier of Service.
2. After a session is completed, the Parent/Guardian will receive a Session Contact Note.
3. Classroom Activity/Lessons may be requested by Teaching Staff.
4. If a session is unable to be completed as expected, a DAP note documenting the reason for the missed session is completed.

FAMILY TEAM MEETINGS

1. Family Team Meetings are completed as necessary per the *Severe Behavior Intervention Policy*, or as requested.
2. Members of the Family Team Meetings include, but not limited to: Parent/Guardian, Family Members, Teacher, Assistant Teacher, Family Advocate, Manager, Specialists, or Director.
3. Additional members are welcome to attend. A signed Release of Information received one business day prior to the meeting must be completed due to the confidential nature being discussed.
4. A Family Team Meeting Summary Form is completed after the meeting.

PLACEMENT MODIFICATIONS

1. Per the *Severe Behavior Intervention Policy*, 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*.
2. After a child's schedule is modified, Placement Modification Review Meetings will occur to review progress at a minimum of every two weeks, behaviors, and plan accordingly to continue to ensure classroom health and safety. Attendees of the Placement Modification Review Meetings include Teaching Staff, Manager, Family Advocate, Mental Health Specialist, Director, or additional staff. A Mental Health Placement Modification Review Meeting Form is completed at the end of the meeting and provided to the Teaching Staff.
3. Mental Health Behavior Tracking Forms are submitted in the excel format at the end of every school day to the Mental Health Specialist.

CONCLUSION OF SERVICES

1. A Mental Health Discharge Summary will be written by the Mental Health Specialist upon termination of services (e.g., at the end of the school year), when children receive direct services from the Mental Health Specialist.
2. A Mental Health Kindergarten Transition Packet is provided to the parent/guardian.
3. 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.
4. If it is determined that the concern is NOT mental health related (e.g., Brigance Social-Emotional/Self-Help screening referral) the Manager may:
 - a. Develop a Child / Family Support Plan with input from all the individuals involved
 - b. Submitting the completed Child / Family Support Plan to the Child Development Specialist.

ADDITIONAL SUPPORT/RESOURCES

1. For strategies/tips on managing behavior, explore the electronic folders located on OneDrive titled:
 - "Mental Health Resource Bank"
 - "Preschool Mental Health-Head Start Research Articles"

MENTAL HEALTH RECORDS

1. Release of Mental Health Records are not permitted in any circumstance and cannot 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.
2. All Mental Health Records are uploaded in a highly secure and protected manner to GoEngage, an electronic data management system. Hard copies are located in the file.
3. Mental Health records/Protected Health Information include:
 - a. Mental Health Referral Packet
 - b. Mental Health Initial Observation-Functional Behavior Assessment Form
 - c. Mental Health DAP notes
 - d. Mental Health Treatment Plan
 - e. Mental Health Placement Modification Form
 - f. Mental Health Family Team Meeting Summary Form
 - g. Mental Health Placement Modification Review Meeting Summary Form
 - h. Mental Health Behavior Tracking Forms
 - i. Mental Health Teacher Behavior Report Form
 - j. Mental Health Discharge Summary
 - k. Mental Health Contact Notes

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**Mental Health Referral Packet
2023-2024**

Mental Health Referral Information Form

Date: _____

Program: EHS HS PK County: Jefferson Berkeley Morgan Site: _____

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

If child, name of parent/guardian _____

Teacher/Assistant: _____ Family Advocate/Home Visitor: _____

Kindergarten eligible: Yes No Receiving School: _____

IEP: Yes, Specify Type(s): _____ No Referral in Progress

DLL: Yes, Specify Language(s): _____ No

Address: _____

Phone Number(s): _____

Email address: _____

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

1. Primary reason 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): _____

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

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

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):

Required attachments:

- Brigance Developmental/Self-help
- Classroom schedule

If applicable, attach:

- 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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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

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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

**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?

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

What happened after?

- | | | |
|--|--|--|
| <input type="checkbox"/> Given social attention | <input type="checkbox"/> Time away | <input type="checkbox"/> Ignored by classmates |
| <input type="checkbox"/> Given an object/activity/food | <input type="checkbox"/> Removed from Classroom | <input type="checkbox"/> Redirected |
| <input type="checkbox"/> Given assistance/help | <input type="checkbox"/> Removed from an activity/area | <input type="checkbox"/> Other (specify) _____ |

Purpose of Behavior:

To Get or Obtain:

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Activity | <input type="checkbox"/> Attention |
| <input type="checkbox"/> Object | <input type="checkbox"/> Food |
| <input type="checkbox"/> Person | <input type="checkbox"/> Place |
| <input type="checkbox"/> Other (specify) _____ | |

To Get Out Of, Avoid, or Delay:

- | | | |
|-----------------------------------|------------------------------------|--|
| <input type="checkbox"/> Activity | <input type="checkbox"/> Attention | <input type="checkbox"/> Demand / Request |
| <input type="checkbox"/> Object | <input type="checkbox"/> Food | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Person | <input type="checkbox"/> Place | |

Replacement Behavior:

- | | |
|---|--|
| <input type="checkbox"/> TPOT | <input type="checkbox"/> Go to Safe Place |
| <input type="checkbox"/> Use Kind Words | <input type="checkbox"/> Use breathing exercises |
| <input type="checkbox"/> Use Walking Feet | <input type="checkbox"/> One to one guidance |
| <input type="checkbox"/> Use Gentle Hands | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Use choices | |

Comments: _____

Recommendations: _____

Staff Signature: _____ Date: _____

Observations

CONFIDENTIAL

Family Team Meeting Summary Form 2023-2024

Child's Name: _____ (DOB: _____)

Date: _____

Attendees (location, relationship to child): _____

Child Strengths: _____

Family Strengths: _____

Reason for Meeting: _____

Family History: _____

Prior Behavioral/Mental Health Intervention: _____

Prior Educational Placement History: _____

Medical History/ Physical Development: _____

Social-Emotional Development:

A. Self Help Skills: _____

B. Peer Interaction: _____

C. Response to Adults: _____

D. Behavioral Concerns: _____

Weekly Behavior Communication Preferences to the Family: Paper Teacher Communication App Phone Call

Team Recommendations: _____

Date of Next Meeting: _____

**DAP Note
2023-2024**

Name/Classroom (i.e., for Activity/Lesson): _____ Date: _____

Services: Individual Child/Adult
 Parent/Guardian
 Family
 Group

Location: Home
 Classroom
 Center
 Other: _____

Tier: N/A
 I
 II
 III

Placement Modification: Yes No

Missed Visit: Yes

Reason: Child ill Child asleep Child absent MH Specialist absent/schedule Other: _____

Classroom/Site: _____

Observer (if applicable): _____

Teacher/HV: _____

Family Advocate: _____

Session Goal: _____

Description: _____

Assessment: _____

Plan: _____

Mental Health Specialist Signature: _____

**Treatment Plan
2023-2024**

Date: _____ Program: EHS HS PK County: Jefferson Berkeley Morgan Site: _____

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

If child, name of parent/guardian _____

Teacher/Assistant: _____ Family Advocate/Home Visitor: _____ Tier: I II III PM: Yes No

1.) Goal #1.

Child will: (do this, when):

_____ will meet with Erin Impellizzeri, LICSW weekly for classroom-based individual/group services.

Parent will: (do this, when):

_____ will practice PBIS Framework and comply with Head Start program rules.

Staff will:(do this, when)

Head Start staff will communicate with _____ regularly regarding _____ needs and presenting concerns.

Therapist will:(do this, when)

Erin Impellizzeri, LICSW will complete weekly sessions with _____ and communicate with _____ per Tier III protocol.

2.) Goal #2

Child will: (do this, when):

_____ will meet with Erin Impellizzeri, LICSW weekly for classroom-based individual/group services.

Parent will: (do this, when):

_____ will practice PBIS Framework and comply with Head Start program rules.

Staff will:(do this, when)

Head Start staff will communicate with _____ regularly regarding _____ needs and presenting concerns.

Therapist will:(do this, when)

Erin Impellizzeri, LICSW will complete weekly sessions with _____ and communicate with _____ per Tier III protocol.

Parent/Guardian Signature

Date

**DISCHARGE SUMMARY
2023-2024**

Child / Adult name: _____ Date: _____

Beginning Tier: I II III Ending Tier: I II III

Placement Modification: Yes No

If Yes, original modification/schedule: _____

Final modification/schedule: _____

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)

Mental Health Specialist Signature _____ Date _____



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.



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Classroom Social-Emotional Observation Form 2023-2024

Classroom _____ Teacher/Assistant Teacher _____ Date _____

	Observed		Feedback/Suggestions
	Yes	No	
RELATIONSHIP BUILDING			
<ul style="list-style-type: none"> • Greets children by name 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). 			
<ul style="list-style-type: none"> • Classroom staff are responsive to individual children and the group as a whole. 			
ACTIVE SUPERVISION			
<ul style="list-style-type: none"> • Aware of situations that require adult guidance and respond in a timely manner. 			
<ul style="list-style-type: none"> • Engages in active, ongoing supervision of children throughout activities (e.g. playground, choice-time, classroom). 			
<ul style="list-style-type: none"> • Establish and enforce clear rules, practice these expectations and frequently reinforce appropriate behavior. 			
TRANSITIONS			
<ul style="list-style-type: none"> • Transitions from one activity to the next are smooth and appropriate prompts are provided if necessary. 			
<ul style="list-style-type: none"> • Children <u>do not</u> wait idle between activities or for a turn. 			
<ul style="list-style-type: none"> • Large groups do not exceed 15 minutes (all children must be engaged). If not, staff adapt and adjust accordingly. 			
BEHAVIOR MANAGEMENT			
<ul style="list-style-type: none"> • Staff demonstrate an understanding that challenging behaviors are conveying some type of message 			
<ul style="list-style-type: none"> • Equal acceptance of all children observed. 			

<ul style="list-style-type: none"> Implementation of strategies for dealing with disruptive/unsafe/trauma-responsive behaviors. 			
<ul style="list-style-type: none"> Utilization of the PBIS solution kit. 			
VISUALS			
<ul style="list-style-type: none"> There is evidence of a clear schedule/routine for children at children's eye level with pictures. 			
<ul style="list-style-type: none"> Classroom Job Chart visible with pictures and being utilized. 			
<ul style="list-style-type: none"> Classroom Rules visible at children's eye level with pictures. 			
<ul style="list-style-type: none"> Family pictures visible at children's eye level for all students. 			
<ul style="list-style-type: none"> Children have names displayed in multiple locations. 			
<ul style="list-style-type: none"> Children's art work displayed throughout classroom. 			
<ul style="list-style-type: none"> Safe Spot contains comfortable seating and multiple regulation tools in an open, well-visible location. 			
CLIMATE			
<ul style="list-style-type: none"> The classroom climate is positive, warm, and responsive. 			
<ul style="list-style-type: none"> Children appear happy and emotional needs are met. 			
<ul style="list-style-type: none"> Children's interactions are respectful to one another, verbally and non-verbally. 			
COMMUNITY			
<ul style="list-style-type: none"> The classroom is a community. 			
<ul style="list-style-type: none"> Staff create opportunities for decision making, problem solving and working together. 			
<ul style="list-style-type: none"> The children assist with family style dining, if observed. 			

Notes: _____



Classroom Activity/Lesson Request Form 2023-2024

Date of Request: _____ County: Jefferson Berkeley Morgan Site: _____

Teacher/Assistant Teacher: _____

1. Primary Reason(s) for Classroom Activity/Lesson Request:

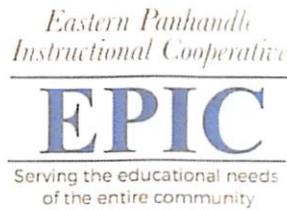
2. What Are You Seeing Multiple Children in the Classroom Having Difficulty With?

3. What Topics Would be Helpful for the Majority of the Children in the Classroom?

- Identifying Feelings Labeling Feelings Understanding Feelings Using Our Words Sharing Taking Turns
- Problem Solving Mindfulness Relaxation Team Work Taking Care of Our Things Empathy Community
- Confidence Looking Ahead Forming Friendships Saying Goodbye Classroom Safety Delayed Gratification
- Other(s):

4. When Would You Like the Activity/Lesson to Start?

5. What is the Best Time during the School Day for this Activity/Lesson to Occur?



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Severe Behavior Intervention Policy and Procedures 2023-2024

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 provide reasonable modifications to reduce or eliminate serious safety concerns in the classroom, using research-based early childhood best practices. In extraordinary circumstances, when a child's behavior creates a serious safety concern to him/herself, others, and/or seriously disrupts the classroom environment after more than one occurrence, the *Severe Behavior Intervention Procedure* will be implemented upon approval of the Mental Health Specialist and/or Child Development/Health and Safety Specialist.

Serious safety concerns are defined as more than one occurrence of the following:

- Violence or aggression 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. See Threat Policy.
- 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 serious safety concerns to their Manager.
2. 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.
3. If severe and extreme health and safety behaviors are being observed in the classroom, and unable to be de-escalated, the Mental Health Specialist must be contacted.
4. At the end of the school 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.
5. A Family 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.
6. The plan will be documented on the *Family Team Meeting 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 and is implemented on a case-by-case basis:
 - Change in Classroom Assignment

- **Modified (shortened) schedule, with a plan to gradually increase the schedule pending observable positive behavior.**
 - **Temporary Alternative Learning Environment**
 - **Referral to Local Education Agency**
7. **Family Team Meetings will occur to review progress, regularly, as needed, which include the parent/guardian, Teaching Staff, Manager, and Mental Health Specialist. Additional members may attend Family Team Meetings, as requested by the parent/guardian, with 24 hours notice to the Mental Health Specialist and signed Release of Information, due to the confidential information discussed. Further changes or recommendations to an existing schedule may be made. Parent/Guardian communication preferences will be obtained at this meeting. Prior to a schedule increase, an additional Mental Health Observation will be completed.**
 8. **The Mental Health Specialist will continue to provide services and parent communication based on the tier service level requirements.**

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Teacher Behavior Report Form

2023-2024

Child's name: _____ Date: _____

Strength: _____

Challenge: _____

Strength: _____

Child's name: _____ Date: _____

Strength: _____

Challenge: _____

Strength: _____

Child's name: _____ Date: _____

Strength: _____

Challenge: _____

Strength: _____

Child's name: _____ Date: _____

Strength: _____

Challenge: _____

Strength: _____

Child's name: _____ Date: _____

Strength: _____

Challenge: _____

Strength: _____

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



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Placement Modification Approval Form 2023-2024

Date: _____

Child's Name: _____ (DOB: _____)

Parent/Guardian Name: _____ Family Advocate: _____

Site/Classroom: _____ Teacher: _____ Assistant Teacher: _____

Please select and describe in detail which of the following have occurred:

- Mental Health Referral: _____
- Mental Health Observation-Functional Behavior Assessment: _____
- Family Team Meeting: _____
- Follow Through on Suggestions Given by Manager, Mental Health Specialist, Child Development Specialist:

Please select details of the plan:

- Change in Classroom Assignment: _____
- Modified Schedule: _____

Temporary Alternative Learning Environment: _____

Referral to Local Education Agency : _____

Approved By:

Mental Health Specialist Signature

Date

Child Development or Health & Safety Specialist Signature

Date

Parent/Guardian Signature

Date



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

Alternate Placement Lesson Plan Procedure

A program must ensure Alternate Placement Staff, Head Start Transition Interventionist and Head Start Assistant Transition Interventionist, implement developmentally appropriate suggestions, activities, lesson plans, and indoor and outdoor learning experiences that provide adequate opportunities for choice, play, exploration, and experimentation among a variety of learning, sensory, and motor experiences.

Alternate Placement Lesson Plan:

1. Head Start Transition Interventionist and Head Start Assistant Transition Interventionist will include the following items on each lesson plan:
 - A conjoint parent-child initiated social-emotional activity
 - The title of the book being read
 - Learning Objective #1 – SMART Goal, coinciding with classroom lesson plan
 - Learning Objective #2 – SMART Goal, coinciding with classroom lesson plan
 - A plan/objective for the parents to do during the week to support learning/behavior objective
 - Information shared on various topics
 - Materials left in the home
 - Parent comments
 - Safety
2. Lesson plans will coincide with classroom lesson plan in which the child was original placed, based on teaming with the teaching staff.
3. Lesson plans will be signed and dated by parents/guardians at the completion of each home visit.
4. Lesson planning will be individualized based on observations during home visits and classroom transition visits, goals set with parents/guardians and information based on any documented disability/IFSP/IEP in place.
5. Time in and time out of the home visit must be documented accurately.
6. Home visit number will be noted and indicative of the number of home visits that a specific family has received to date.
7. Head Start Transition Interventionist and Head Start Assistant Transition Interventionist will assist families in reviewing and commenting on the lesson plan.
8. Parents will complete the parent comment section and sign the plan.

Head Start Alternate Placement Lesson Plan

Child's Name: _____ Parent's Name: _____ Lead Transition Interventionist: _____ Assistant Transition Interventionist: _____ Date: _____ Home Visit # _____	Transition Classroom visit plans:
Previous Lesson Reviewed: <input type="checkbox"/> Independent Activity:	
IFSP/IEP Parent Education (if applicable):	Book: Interventionist Read <input type="checkbox"/> Parent Read <input type="checkbox"/>
School Readiness Goal: Approaches to Learning <input type="checkbox"/> Social and Emotional Development <input type="checkbox"/> Language and Literacy <input type="checkbox"/> Perceptual, Motor and Physical Development <input type="checkbox"/> Cognition <input type="checkbox"/> Interventionist Led <input type="checkbox"/> Parent Led <input type="checkbox"/>	School Readiness Goal: Approaches to Learning <input type="checkbox"/> Social and Emotional Development <input type="checkbox"/> Language and Literacy <input type="checkbox"/> Perceptual, Motor and Physical Development <input type="checkbox"/> Cognition <input type="checkbox"/> Interventionist Led <input type="checkbox"/> Parent Led <input type="checkbox"/>
Weekly activities to support school readiness goal:	Parent Comments: What did your child work on today? What skill would you like to see him / her working on next week?
Weekly Family Support Activities: (to include PBIS)	

Home Materials Used: _____ Materials/ Book(s) left in home: _____

Parent Signature _____

Time In: _____ Time Out: _____

*Eastern Panhandle
Instructional Cooperative*

EPIC

Serving the educational needs
of the entire community

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Placement Modification Review Meeting Summary Form 2023-2024

Date of Meeting: _____

Child's Name: _____ (DOB: _____)

Meeting Attendees (location, relationship to child):

Current Schedule:

Summary:

Documentation Review: _____

Classroom Update: _____

Parent/Guardian Update: _____

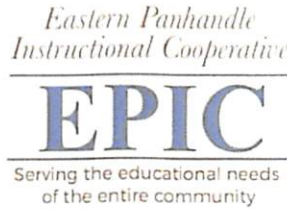
Mental Health Update: _____

Meeting Outcome:

Select one: Schedule increase (specify): _____ No change _____ Schedule decrease (specify): _____

Recommendations/Plan:

Date of Next Meeting: _____



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Family Team Meeting Summary Form 2023-2024

Child's Name: _____ (DOB: _____)

Date: _____

Attendees (location, relationship to child): _____

Child Strengths: _____

Family Strengths: _____.

Reason for Meeting: _____

Family History: _____

Prior Behavioral/Mental Health Intervention: _____.

Prior Educational Placement History: _____.

Medical History/ Physical Development: _____

Social-Emotional Development:

A. Self Help Skills: _____

B. Peer Interaction: _____

C. Response to Adults: _____

D. Behavioral Concerns: _____

Weekly Behavior Communication Preferences to the Family: Paper Teacher Communication App Phone Call

Team Recommendations: _____

Date of Next Meeting: _____

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".

WHAT TO PACK FOR LUNCH

Choose one protein

Ham	Chicken	Tuna
Turkey	Pepperoni Slices	Hard-boiled Eggs
Hummus	Beans	

Choose at least one vegetable (can include dip like ranch)

Carrots	Celery	Cucumbers
Bell Peppers	Olives	Edamame
Broccoli	Cauliflower	

Choose at least one fruit

Apple/Applesauce	Banana	Melon
Grapes	Oranges	Peaches
Berries	Pineapple	

Choose one dairy

Cheese Cubes/String Cheese	Yogurt	Milk
Cottage Cheese		

Choose one whole grain

Cereal	Crackers	Pretzels
Pasta Salad	Rice Cakes	Bagel
Muffin	Tortilla	Pita Bread

Foods not to send to school: If sent, these items will be placed in the child's backpack and returned home

Potato Chips/Doritos	Cookies	Candy	Snack Cakes	Soda
Yoo-Hoo	Hawaiian Punch	Cupcakes	Restaurant Food	



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

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

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: _____ Nutritional Supplement: _____
 Low Added Sugar: _____ Adaptive Equipment: _____
 Sodium Restriction: _____ Enteral Feeding: _____
 Carbohydrate Counting: _____ Other: _____
 High Fat: _____

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

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

Celebration Procedures Birthdays and other Special Events

Birthdays and other special celebrations may not include snacks or treats due to food allergies. 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.

Suggestions for non-edible party contributions:

- Cups, soil and seeds to plant
- Bubbles (small bottle for each child)
- A special game
- Paper hats the children can decorate
- Canvases for each child to paint
- Birthday books- every child can design a page for the birthday child and connect together with a chenille stem for the child to take home.
- Glitter glue pens to decorate a frame
- Make a collage of each classmate's handprints
- Set up carnival games like ring toss
- Decorate a board for the birthday "star"
- Stickers or pencils for each child in class
- Special jobs for the birthday child (pick the book or music)

*Please note that staff will only pass out party invitations if there is one for each child in the class.

Performance Standard	Program Operations Health	<p style="text-align: center;">Head Start Policies and Procedures</p> <p style="text-align: center;"><i>Eastern Panhandle</i> <i>Instructional Cooperative</i></p> <p style="text-align: center;">EPIC</p> <p style="text-align: center;"><small>Serving the educational needs of the entire community</small></p>
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**.

Performance Standard	Program Operations Health	Head Start & Early Head Start Policies and Procedures <i>Eastern Panhandle Instructional Cooperative</i> EPIC <i>Serving the educational needs of the entire community</i>
Subpart	1302.47 Safety Practices	
Effective Date	7/2022	
Revised Date	6/2022	
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.
 - 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.

<p>Monitoring & Reporting:</p> <ol style="list-style-type: none"> 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 <u>Manager Monitor Log</u> to monitor the implementation of policies and procedures.
--

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.*

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 <input checked="" type="checkbox"/> showing in the window? A green <input checked="" type="checkbox"/> 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 issues were identified.	Date AED Inspected	Inspector Initials	Follow Up Need/Complete	Comments
Aug	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No			<input type="checkbox"/> Need <input type="checkbox"/> N/A <input type="checkbox"/> Complete	
Sep	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No			<input type="checkbox"/> Need <input type="checkbox"/> N/A <input type="checkbox"/> Complete	
Oct	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No			<input type="checkbox"/> Need <input type="checkbox"/> N/A <input type="checkbox"/> Complete	
Nov	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No			<input type="checkbox"/> Need <input type="checkbox"/> N/A <input type="checkbox"/> Complete	
Dec	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No			<input type="checkbox"/> Need <input type="checkbox"/> N/A <input type="checkbox"/> Complete	
Jan	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No			<input type="checkbox"/> Need <input type="checkbox"/> N/A <input type="checkbox"/> Complete	
Feb	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No			<input type="checkbox"/> Need <input type="checkbox"/> N/A <input type="checkbox"/> Complete	
Mar	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No			<input type="checkbox"/> Need <input type="checkbox"/> N/A <input type="checkbox"/> Complete	
Apr	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No			<input type="checkbox"/> Need <input type="checkbox"/> N/A <input type="checkbox"/> Complete	
May	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No			<input type="checkbox"/> Need <input type="checkbox"/> N/A <input type="checkbox"/> Complete	

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	<i>(Listen for Emergency System on evacuation or shelter in place instruction)</i>
Hostage/Active Shooter	<i>(Listen for Law Enforcement instruction)</i>
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)	

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

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	
<p>Describe how will you ensure essential functions can be maintained so children are safe and healthy during an emergency:</p>	

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

Date/Time (of 3rd) _____ Date/Time (of 4th) _____
(due by April 15) (due by June 16 for EHS only)

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

Comments/Concerns:

**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.

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

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

Electrical	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do all electrical outlets where children have access, have plug protectors?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Extension cords are used for temporary purposes only.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are outlets and switches free of cracks, tight against wall, with no exposed wires?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are electrical cords in good condition-free of cracks and exposed wires?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are all electrical panels clearly marked with 3 ft. of unobstructed clearance?
Comments:	
Floors	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are floors free of holes and loose/torn carpet or tiles?
<input type="checkbox"/> Yes <input type="checkbox"/> 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	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are smoke detectors properly located and tested regularly?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are fire extinguishers readily available and inspected by Fire Safety annually?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are fire extinguishers checked and initialed monthly by staff to ensure they are full?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have staff members been trained on the use of fire extinguishers?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are exits well marked with appropriate exit sign lighting and has emergency lighting been checked and found to be in good working order?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are fire drills conducted twice a month and clearly documented?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are alternative drills, such as lockdowns, earthquakes and shelter-in-place conducted as required and documented on red sheet?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are First Aid kits properly located, are all required contents current and available and has checklist been completed in accordance with policy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have staff members received training on how to safely perform emergency drills?
Comments:	
Outdoors	
<input type="checkbox"/> Yes <input type="checkbox"/> 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?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are outdoor premises checked daily for cleanliness, kept free of undesirable and hazardous materials and documented on playground safety checklist?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are the playground equipment and outdoor toys in good repair and in safe condition?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are there any areas of cracked/uneven concrete?
<input type="checkbox"/> Yes <input type="checkbox"/> 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:	



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 than 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

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
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
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							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>

* 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.)

Special Services Tracking

School Year _____ Site/Classroom _____

Date	Child Name	Staff Name	Start Time	End Time	Purpose of Visit	Serviced In/Or Out
					<input type="checkbox"/> PSSN <input type="checkbox"/> Speech <input type="checkbox"/> MH <input type="checkbox"/> Other _____	<input type="checkbox"/> In <input type="checkbox"/> Out
					<input type="checkbox"/> PSSN <input type="checkbox"/> Speech <input type="checkbox"/> MH <input type="checkbox"/> Other _____	<input type="checkbox"/> In <input type="checkbox"/> Out
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Month/Year _____ Site/Classroom _____ Staff _____

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

	Week 1					Week 2					Week 3					Week 4					Week 5					Staff Initials							
	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F								
Clean and Sanitize or Disinfect Daily																																	
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						
Launder 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;

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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.