# PROGRAM OPERATIONS

## PERFORMANCE STANDARD 1302

SUBPART A – ELIGIBILITY, RECRUITMENT, SELECTION, ENROLLMENT & ATTENDANCE

SUBPART B – PROGRAM STRUCTURE

SUBPART C - EDUCATION & CHILD DEVELOPMENT PROGRAM SERVICES

SUBPART D – HEALTH PROGRAM SERVICES

SUBPART E – FAMILY AND COMMUNITY ENGAGEMENT PROGRAM SERVICES

SUBPART F – ADDITIONAL SERVICES FOR CHILDREN WITH DISABILITIES

SUBPART G – TRANSITION SERVICES

SUBPART H – SERVICES TO ENROLLED PREGNANT WOMEN

SUBPART I – HUMAN RESOURCES MANAGEMENT

SUBPART J – PROGRAM MANAGEMENT AND QUALITY IMPROVEMENT

| | |
|---|---|
| **Performance Standard** | Program Operations |
| **Subpart** | § 1302.47 (b)(4)(i) Safety Practices; Safety Training |
| **Effective Date** | |
| **Revised Date** | |
| **Reviewed Date** | |
| **Responsibility** | Teaching Staff, Family Advocates, Managers, Specialists and Director |

**Head Start Policies and Procedures**

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**Subject:** Safety Training and Monitoring

**Policy:** All staff with regular child contact have initial orientation training within 3 months of hire and ongoing training in all state, local, tribal, federal, and program-developed health, safety, and child care requirements to ensure the safety of children in their care.

**Procedure:**

The table below outlines the trainings all staff will be provided and the frequency in which it will be done and who will facilitate.

| Trainings | Frequency of training | Who facilitates |
|---|---|---|
| Universal Precautions | Annually | Health & Safety Specialist |
| Active Supervision | Annually | Health & Safety Specialist |
| Child Abuse & Neglect | Annually | Online Training |
| Communicable Disease Prevention | Annually | Health & Safety Specialist |
| CPR/FA | Every 2 years | Public Service Training |
| Fire Extinguisher | Annually | Public Service Training |
| Workplace Safety | Annually | Public Service Training |
| Medication Administration | Annually | WV Early Childhood Training Connections & Resources |
| Fire Drills | Twice monthly | Classroom staff |
| Unwanted Intruder | Twice a year | Classroom staff |
| Severe Weather | Twice a year | Classroom staff |
| Bomb Threat | Twice a year | Classroom staff |
| Bus Evacuations | 3 times a year HS<br>4 times a year EHS | Bus staff |

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# 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 wo 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/guarding 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.

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# 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 2 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 a 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. West Virginia does not recognize religious exemptions and will only provide food substitutions to menu items for medically documented food allergies or intolerances.

Hematocrit/Hemoglobin

The WV EPSDT requires this test to be completed at 12 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. Ongoing follow up will be done by the Family Advocate to ensure the child has been seen and all documentation from the healthcare provider filed.

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# 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.

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## Health Follow Up

Child's Name _____ Parent/Guardian Name _____
Site/Classroom _____ Family Advocate _____

Date _____/_____/_____

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

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

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

_____ Physical examination, expired/will expire _____

_____ Dental examination, expired/will expire _____

_____ Immunizations _____

_____ HCT/HGB _____

_____ Lead blood score: _____

_____ Heights/Weights follow up

_____ Vision screening follow up

_____ Hearing screening follow up

_____ Other _____

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

# WEST VIRGINIA EPSDT/HEALTHCHECK PROGRAM PERIODICITY SCHEDULE

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

**KEY:** ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ⟵ ● ⟶ = range during which a service may be provided

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

(1) If a child comes under the care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.

(2) Newborns should have an evaluation after birth, and breast feeding should be encouraged (instruction and support should be offered).

(3) Newborns should have an evaluation within 3-5 days after birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/122/2/426.full).

(4) Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).

(5) Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (http://pediatrics.aappublications.org/content/140/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.

(6) A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 5 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/127/1/e222.full).

(7) Newborn hearing screening should be completed according to WV state law (https://www.legiscan.com/WV/text/HB4359/id/1555927). Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).

(8) Screen with audiometry including 6000 and 8000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00049-3/fulltext).

(9) Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://pediatrics.aappublications.org/content/143/1/e20182259).

(10) Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://pediatrics.aappublications.org/content/145/1/e20193449).

(11) Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://pediatrics.aappublications.org/content/145/1/e20193447).

(12) This assessment should be family centered and include an assessment of child social emotional health, caregiver depression, over all stressors and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).

(13) Patient Health Questionnaire (PHQ) 2 recommended questions on the Preventive Health Screening forms. If positive, perform PHQ 9 (https://www.uhsacreenews.com/images/sites/pt/files/pt1906/ph18/201612/PHQ-9_English.pdf) or other tool available in the GLAD-PC toolkit and at https://downloads.aappublications.org/AAPPDF/Mental_Health_Tools_for_Pediatrics.pdf.

(14) If positive for tobacco, alcohol and/or drug use, complete recommended screening tool CRAFFT available at (https://crafft.org.pt4free.pdf) or Substance Abuse and Mental Health Services Administration (SAMHSA) -Screening, Brief Intervention, and Referral to Treatment (SBIRT) (https://www.samhsa.gov/sbirt).

(15a Newborn metabolic screening should be completed according to State law (http://apps.legislature.wv.gov/WVCODE/ChapterEntire.cfm?chap=16&art=2&section=3&level=2&year=2007&sessiontype=RS&btnSubmit=Go+%C2%BB), Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (https://www.hrsa.gov/advisorycommittees/heritabledisorders/rusp/index.html), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws regulations (https://www.law.cornell.edu/wex/newborn_screening_statutes), establish the criteria for and coverage of newborn screening procedures and programs.

(15b Cadaver initial screening was completed, verify results, and follow up as appropriate. See "Hyperbilirubinemia in newborn infant ≥35 Weeks' Gestation: An Update with Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).

(17) Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from hospital. Refer to the Bureau for Public Health policy at (http://www.wvdhhr.org/bph/oscscript/CCHD_OPERATIONAL_POLICY_UPDATE_7%2012.pdf).

(18) Every visit should be an opportunity to update and complete a child's immunizations. See Immunization Schedules for Providers (http://cdc.gov/vaccines/schedules/hcp/index.html).

(19) Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the *AAP Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).

(20) Hemoglobin or Hematocrit screen to be completed at 12 months.

(21) For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (http://pediatrics.aappublications.org/content/138/1/e20161493) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (https://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).

(22) All children should be screened for lead at 1 year and again at 2 years of age and children 36 months to 72 months of age who have not been screened previously. (https://www.cdc.gov/nceh/lead/publications/recommendations/translations/translations.htm).

(23) Tuberculosis testing per recommendations of the *AAP Committee on Infectious Diseases*, published in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.

(24) See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).

(25) Screening for dyslipidemia (lasting lipoprotein profile) should occur once between 9 and 11 years of age and once between 17 and 21 years of age to be consistent with guidelines of the National Heart, Lung, and Blood Institute.

(26) Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases*.

(27) Adolescents should be screened for HIV according to the US Preventive Services Task Force (USPSTF) recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-infection-screening) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.

(28) All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/datastatistics/index.htm#1992a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.

(29) Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/OralHealth/Pages/OralHealthPractice-Tools.aspx) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).

(30) Perform a risk assessment (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/OralHealth/Pages/OralHealthPractice-Tools.aspx). See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).

(31) See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/dental-caries-in-children-from-birth-through-age-5-years-screening), Once teeth are present, fluoride varnish may be applied to all children every 3 to 6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/5/995).

(32) If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/5/995).

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

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

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

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

**Sexually Transmitted Infections (STI) Risk Factors**
- Multiple or anonymous sex partners
- Sex in conjunction with illicit drug use
- Sex with partners who have sex with multiple or anonymous partners and/or use illicit drugs
- Those in adult correctional facilities

**Human Immunodeficiency Virus (HIV) Risk Factors**
- Males who have sex with males
- Active injective drug users
- Unprotected vaginal or anal sex
- Sexual partners who are HIV infected
- Exchange sex for drugs or money
- Acquired or tested for STIs

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

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

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

# BIRTH HISTORY – CHILD

Child's Name: _____ D.O.B ___/___/____

Completed by: Name: _____

Date Completed: ___/___/____

## PRENATAL HISTORY

Child Adopted ☐ Yes ☐ No
Foster Child ☐ Yes ☐ No

Time mother first received prenatal care:

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

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

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

Prenatal Exposure to Drugs:

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

Neonatal Abstinence Syndrome (NAS) Yes ☐ No ☐

## 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: _____

_____

Comments: _____

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# Health and Screening Timelines

| Screening | Initial Screening Date | 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 March | | Immediately for concerns | Health Follow Up | 30 days from 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 from referral and then as needed |
| Vision | 45 Days | | Immediately | Health Screening Referral | 30 days from referral and then as needed |
| Hearing | 45 Days | 30 Days | Immediately | Health Screening Referral | 30 days from referral and then as needed |
| Speech | 45 Days | 30 Days | Immediately | LEA sends notification | 30 days from referral and then as needed |
| Developmental | 45 Days | 30 Days | Immediately | CD Manager will follow individual County LEA process in place | 30 days from referral and then as needed |
| Self Help / Social Emotional | 45 Days | 30 Days | Immediately | Self Help/Social Emotional Referral | 30 days from referral and then as needed |
| Nutritional | 30 Days | | Immediately for concerns | Health Follow Up | 30 days from referral and then as needed |
| Lead | 30 Days | | Immediately for high risk | Health Follow Up | 30 days from referral and then as needed |
| HCT/HGB | 30 Days | | Immediately for high risk | Health Follow Up | 30 days from 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 the data tracking system and in the child's file.

# Screening Summary

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

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

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

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 _____

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EPIC Early Head Start/Head Start/Pre-K
POLICES AND PROCEDURES

LEAD POLICY

PURPOSE: Lead poisoning can cause serious health and developmental problems in young children. Eliminating the source of lead and treating the child can improve the health and developmental outcomes.

POLICY: All children are considered at risk and must be screened for lead poisoning. Centers for Medicare and Medicaid Services (CMS) and WV EPSDT require that all children receive a screening blood lead test at 12 months AND 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. All children within 45 days of enrollment into the program will be assessed for lead health risk utilizing the lead risk assessment.

REQUIREMENTS:

a. The requirements for an **Early Head Start** enrolled child are:
    1. For a child enrolled before the age of 12 months, the program must obtain documentation that a blood lead test was done when the child reaches the ages of 12 months and 24 months
    2. If there is no documentation that a blood lead test was performed at 12 months for a child enrolled between 12 and 24 months of age, a blood lead test must be performed as soon as possible.
    3. For a child enrolled t age 24 months or older, the program is required to obtain documentation that a blood lead test was performed at 24 months of age or soon thereafter.
b. The requirements for a **Head Start** enrolled child is:
    1. The program must obtain documentation that a blood lead test was performed at 24 months. If a blood lead test was not performed at 24 months, the program must obtain documentation that it was performed soon thereafter.

PROCEDURES:

a. At the initial home visit, the staff will inform parents/guardians of the program's health requirements, determine if the participating child is up-to-date on the recommended schedule, and complete the lead risk assessment via interview style.
    1. Completed risk assessments will be placed in the individual file and documents in the program data base.
        i. All children with a high-risk score on the assessment will have information on lead and lead prevention given to their parent/guardian and a referral to their primary care physician.
b. Staff will work with the primary care providers to obtain results of lead blood testing per the WV EPSDT.
    1. Results will be documented on the Lead Testing Form in the individual file and in the program data base.
c. If a parent does not have a copy of the participating child's last well child visit, a release of information (ROI) will be signed to obtain a copy of the record and will include a request for the results of the last blood lead test performed
        i. For the blood lead test, parents can choose to either sign the ROI for that information or have the Health & Safety Specialist perform the test.
    2. If a copy of the physical and/or blood lead testing results have not been received within two weeks after sending the ROI, a second request will be sent.
    3. Two weeks after the second request has been sent if the program has not received a response, the blood lead testing will be performed by the Health & Safety Specialist with parental consent.
        i. A blood level of 0 to 3.4 will be considered within normal limits and no further testing is required.
        ii. A blood level of 3.5 and above will be considered elevated. The parent will be given information on lead and lead prevention and referred to their primary care physician.
d. No child will be excluded from the program because of incomplete blood lead test results.

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Head Start & Pre-K
Lead Risk Assessment

Date of Assessment: _____

Child's Name: _____ Date of Birth: _____ Age: 3yrs 4yrs

How long has child lived at current address? _____

Lead Risk Assessment Questionnaire: - Circle YES or NO for each question

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
- Had a brother, sister, housemate, or playmate been 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 at or after 24 months of age? Yes ____ No ____**

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 file.)

**Assessment Result: High Low Referral to PCP needed: Yes No Date of referral: _____**

**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

SB/2023

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Child's Name: _____

Date of Birth: _____ Age:_____

# Child Nutrition Assessment

**GENERAL:**

How many times a day does your child eat? _____
How many hours a day (on average) does your child sleep? _____
At what age (months) did your child start eating solid food? _____
At what age (months) did your child start drinking from a cup? _____
At what age (months) did your child start feeding himself/herself? _____
How physically active is your child? _____

Comments:

Concerns:

**Current Dietary Habits**

Favorite Foods: _____

Least Favorite Foods: _____

Child takes vitamin/mineral supplements? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Vitamin/mineral supplements contain iron? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Vitamin/mineral supplements contain fluoride? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Vitamin/mineral supplements were prescribed? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Child is on a special diet? ☐ Yes ☐ No ☐ Unknown ☐ N/A Specify: _____

Child's appetite has changed in the past month? ☐ Yes ☐ No ☐ Unknown ☐ N/A Specify: _____

Child takes bottle? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Child eats or chew things that are not food? ☐ Yes ☐ No ☐ Unknown ☐ N/A Specify: _____

Child has trouble chewing and/or swallowing? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Child often has diarrhea? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Child often has constipation? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Concerns about what the child eats? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Child needs medical treatment? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Received medical treatment? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Child drinks tap water? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Child drinks bottled water? ☐ Yes ☐ No ☐ Unknown ☐ N/A

**Current Food Group Eating Frequency (# of times per week)**

A. Milk, cheese, yogurt: _____
B. Meat, poultry, fish, eggs, dried beans/peas, peanut butter: _____
C. Rice, grits, bread, cereal, tortillas: _____
D. Greens, carrots, broccoli, squash, pumpkin, sweet potatoes: _____
E. Oranges, grapefruit, tomatoes (fruit/juice): _____
F. Other fruits and vegetables: _____
G. Oil, butter, margarine, lard: _____
H. Cakes, cookies, sodas, fruit drinks, candies: _____
I. Fast food: _____

Parent Signature: _____ Date: _____

# EPIC Head Start Health Support Plan

Child's Name: _____ Date of Birth: _____

Classroom: _____ Teacher: _____

This health support plan has been created in collaboration with the parent/guardian, Family Advocate and Health & Safety Specialist in order to provide support for existing medical conditions as outlined in the Individualized Health Plan completed by the child's Health Care Provider.

Date of Plan: _____

Plan Maintained by: _____

Medical Information:

Plan:

The plan has been reviewed and approved by:

_____
Parent/Guardian Signature

_____
Family Advocate Signature

_____
Health & Safety Specialist

# 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: _____

Child's Name: _____ Birthdate: _____

Phone number: _____

**Diagnosed Medical Condition Being Treated:** _____

*If anaphylaxis, list what child is allergic to: _____

**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: _____

# EPIC HEAD START/ PRE-K
# MEDICATION ADMINISTRATION POLICY

PURPOSE:

This policy defines 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 extra responsibility 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 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 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 Head Start/Pre-K requires a written order from the health care provider for all over the counter medications except for sunscreen, lip balm, diaper cream and toilet wipes.

3. Instructions for the dose, frequency, method to be used, and duration of administration must be provided to the staff in writing by a signed note from the health care provider and the 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.

5. Medications and medication supplies must be stored in a clean, secure, and locked box in a cool, dry place 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 the Medication Log.

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 or, if not collected within one week of pick-up notice, will be properly disposed. All returned/disposed medications will be documented on the Medication Return Log.

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 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

** Additional training must be given to prepare staff in WV child care centers to provide specific, specialized care, not covered in this **basic** medication administration training course. This specialized training must be based upon the specific child's health care plan and be provided by parent/guardian or medical personnel familiar with the child's needs and the required procedure. Such training must not require medical/nursing judgment and must be consistent with WV Day Care Center Licensing Regulations (WV 78 CSR 1).

# 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 devises for medications
   - < **Do Not Use Kitchen Utensils.** These do not provide accurate measurements
     - < 1milliter = 1cc
     - < 5 milliters or 5 cc = 1 teaspoon

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

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

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

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

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

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

# MEDICATION LOG

CHILD'S NAME:_____ CHILD'S CLASSROOM/TEACHER: _____

MEDICATION: _____

ALWAYS review the written parent/guardian medication instructions and Health Care Provider's medical order prior to EVERY administration. Instructions should be attached to this sheet.

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

| Date Initially Received by Staff | Date Given | Time Given | Dose Given | Route Given | Time last dose was given by guardian | Comments/Reactions | **Controlled Substances** | | | | Staff Signature |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | # Received | # Given | # Remain | Staff/Parent Signature | |
| | | | | | | | | | | | |
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## 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 HEAD START / PRE-K
# MEDICATION RETURN LOG

Chile Name _____ Classroom _____

**All medication will be given to the parent upon expiration or if child is no longer in need. If the parent does not pick up the medication within 7 days of being notified, Staff will follow procedures for disposing of medication.**

| Date Parents Notified to Pick-Up Medication | Date and Time Picked Up | Did Not Pick Up | Medication | Amount Picked Up/Disposed | Staff Disposal Date | Staff Signature | Parent/Staff Signature |
|---|---|---|---|---|---|---|---|
| 6/30/2023 | 7/3/2023 12:30 pm | | Tylenol | 15 mL | | Staff Sign | Parent Sign |
| 6/30/2023 | | ✓ | Tylenol | 15 mL | 7/10/2023 | Staff Sign | Staff Sign |
| | | | | | | | |
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|---|---|---|
| **Performance Standard** | Program Operations | **Head Start Policies and Procedures**<br>*Eastern Panhandle Instructional Cooperative*<br>**EPIC**<br>Serving the educational needs of the entire community |
| **Subpart** | § 1302.47 Safety Practices | |
| **Effective Date** | | |
| **Revised Date** | | |
| **Reviewed Date** | | |
| **Responsibility** | Teaching Staff, Family Advocates, Managers, Specialists | |

**Subject:** Sunscreen

**Policy:** EPIC Head Start will maintain a safe environment for all children and staff by utilizing sun protection when children will be outside for program activities for a duration longer than 30 minutes.

**Procedure:**

Should a parent/guardian approach staff and inquire about reapplying sunscreen to their child for outside play during the school day the following procedures will be followed.

1. The parent/guardian must supply the sunscreen to the classroom. Broad Spectrum sunscreen with an SPF of 30 or higher is recommended.
2. The parent/guardian must also give written permission for the sunscreen to be applied and the note will be filed in the child's file under the medication section.
3. Once the sunscreen is given to the classroom staff, the container will be labeled with the child's name and date received.
4. The sunscreen will be stored out of reach of the children in the classroom
5. Staff will wear gloves when applying sunscreen to the child.
6. Sunscreen will be applied to all exposed areas of skin, arms, legs, neck, etc.
7. Sunscreen will be applied 30 minutes prior to child going outside.
8. Sunscreen applications do not need to be recorded on medication logs.
9. Any unused sunscreen will be returned to the parent/guardian at the end of the year.

Eastern Panhandle Instructional Cooperative
EPIC
Serving the educational needs of the entire community

EPIC Early Head Start/Head Start/Pre-K
POLICES AND PROCEDURES

# COMMUNICABLE DISEASE POLICY

PURPOSE: Reducing the days of illness or absence helps children continue with optimal growth and development. Head Start and Early Head Staff will lower the risk of spreading communicable diseases in our classrooms and offices by utilizing preventative health practices and appropriate procedures, including training, supplies and practicing universal precautions.

POLICY: The program will be responsible and follow the generally accepted practices related to public health issues. This policy applies to all persons – children, staff and volunteers. Head Start and Early Head Start Staff are not qualified to make a diagnosis and all suspected cases of any illness should be verified by a health care professional. A Communicable Disease chart for reference has been included to help understand the practices to be followed for each diagnosed communicable disease.

PROCEDURES:

EPIC Early Head Start/Head Start cannot admit an ill child if one or more of the following exists:

(1) The illness prevents the child from participating comfortably in activities including outdoor play;

(2) The illness results in a greater need for care than staff can provide without compromising the health, safety, and supervision of the other children;

(3) The child has one of the following:

(A) Oral temperature of 100.4 degrees or greater, accompanied by behavior changes or other signs or symptoms of illness;

- Take child's temperature when any of the following signs are present: Nausea, vomiting, flushed cheeks, diarrhea, excessive coughing, or fatigue

(B) Symptoms and signs of possible severe illness such as lethargy, abnormal breathing, uncontrolled diarrhea, two or more vomiting episodes in 24 hours, rash with fever, mouth sores with drooling, behavior changes, or other signs that the child may be severely ill; or

(4) A health-care professional has diagnosed the child with a communicable disease, and the child does not have medical documentation to indicate that the child is no longer contagious.

When a suspected communicable disease is noted for a child during the school day, staff will follow the steps outlined.

- Place a phone call to the parent/guardian to alert them of the symptoms the child is experiencing, inform them the child needs to be picked up and encourage them to have the child seen by a health care professional.
  - DO NOT tell the parent that the child has a specific illness. We are not qualified to diagnosis.
- Provide a safe and nurturing area for the child to rest and relax until their parent/guardian can pick them up. Try to make this space in a quiet and less busy area of the room.
  - Once the child is picked up, sanitize the area the child was resting in including any furniture or items they were in contact with.
- If the child is a bus rider, contact the bus driver so they are aware a child was sick and sent home so they may disinfect the bus.
- Notify the County Manager and the Health & Safety Specialist
- At the end of the day, clean and sanitize all toys and surfaces

Once we receive confirmation of a communicable disease from a health care provider:

- An exposure letter should be sent to all parents to educate them to the illness and symptoms to watch for.
- Notify the County Manager and Health & Safety Specialist to confirmation of disease

A child can return to the classroom:

- When a release from the health care provider is provided given they have seen one or
- The child has been fever free for 24 hours without the use of fever reducing medications
- The child has been vomiting free for 24 hours
- The child has been diarrhea free for 24 hours
- The child's cough is not interfering with their daily activities including sleep

# EPIC HEAD START/EARLY HEAD START
# COMMUNICABLE DISEASE REFERENCE CHART

| Disease | Incubation Period | Transmission | Common Symptoms | Recommendations |
|---|---|---|---|---|
| Chickenpox (Varicella) | 10–21 days, usually 14–16 days. | By direct contact with vesicular fluid or by airborne spread from respiratory tract secretions. Infectious from 1 to 2 days before rash onset until all lesions have dried/crusted over and no new lesions appear within a 24-hour period (average is 4–7 days). | Sudden onset with slight fever, other systemic symptoms and itchy eruptions which become vesicular (small blisters) within a few hours. Lesions commonly occur in successive crops, with several stages of maturity present at the same time. Communicable for as long as 5 days (usually 1–2 days) before eruption of vesicles and until all lesions are crusted (usually 5 days). Communicability may be prolonged in people with weakened immune systems. | Exclude from school until released by health care provider |
| Conjunctivitis (Pink Eye) | Usually 1–3 days, but variable depending on the causative agent. May be bacterial, viral, allergic, or chemical/irritant. | By contact with discharge from the conjunctivae or contaminated articles, if the cause is bacterial or viral. Allergic and chemical causes are not contagious. | Pink or red eye with swelling of the eyelids and eye discharge. Eyelids may be matted shut after sleep. May involve one or both eyes. | Exclude from school while symptomatic or until cleared to return by a healthcare provider. Important to wash hands thoroughly after contact with eye drainage. Also, do not share any articles that have come into contact with the eyes |
| COVID-19 (Coronavirus disease 2019 caused by SARS-CoV-2 virus) | Usually 2–14 days. | COVID-19 spreads when an infected person breathes out droplets and very small particles that contain the virus. These droplets and particles can be breathed in by other people or land on their eyes, noses, or mouth. In some circumstances, they may contaminate surfaces they touch. Infected people are believed to be infectious 2 days prior to symptom onset through 10 days after symptom onset, with viral loads being higher earlier in the course of infection. | Children may be asymptomatic. Children who develop symptoms may have a wide variety of symptoms of variable severity:<br>• Fever and/or chills<br>• Cough<br>• Shortness of breath<br>• Headache<br>• Runny nose<br>• Fatigue<br>• Sore throat<br>• Muscle aches/body aches<br>• New loss of taste or smell<br>• Nasal congestion<br>• Nausea and vomiting<br>• Diarrhea | Exclude from school for 5 days. Children may return to school on day 6 as long as there has not been a fever, vomiting, or diarrhea for 24 hours and no fever reducing medication have been used. Upon return on day 6 a mask must be worn until day 10. If a mask cannot be worn then the child would be excluded for 10 days.<br><br>*Day 0 is the day symptoms started or if asymptomatic, the day of the positive test. |

# EPIC HEAD START/EARLY HEAD START
# COMMUNICABLE DISEASE REFERENCE CHART

| Disease | Incubation Period | Transmission | Common Symptoms | Recommendations |
|---|---|---|---|---|
| Diarrheal Diseases (Campylobacteriosis, *E. coli*, Giardiasis, Salmonellosis, Shigellosis, etc.) | Campylobacteriosis: Usually 2–5 days but can be longer (1-10 days).<br>*E. coli* : Varies from 1 to 10 days, usually 3 to 4 days.<br>Giardiasis: Usually 1 to 3 weeks.<br>Salmonellosis: Usually, 6– 72 hours, but periods of a week or more have been reported.<br>Shigellosis: Varies from 1 to 7 days, typically 1–3 days. | Primarily by the fecal-oral route through direct contact or by ingestion of contaminated (or improperly cooked) food or water. | Ranges from sudden onset of fever, abdominal pain, diarrhea, nausea, and sometimes vomiting in salmonellosis, to cramps and bloody stools in severe cases of shigellosis and *E. coli*. In giardiasis, persons may be asymptomatic or have decreased appetite and weight loss.<br>The most common symptoms are diarrhea, abdominal pain, malaise, and fever. Stools can contain visible or occult blood. Dangerous dehydration may occur in younger children. | Exclude from school until diarrhea has ceased for 24 hours. |
| Fifth Disease (slap cheek) | Between 4–14 days but can be as long as 21 days. | By contact with respiratory tract secretions or exposure to blood or blood products.<br>Once the characteristic rash appears, the child is considered no longer contagious. | Distinctive rash characterized by a vivid reddening of the skin, especially of the face, which fades and recurs; classically, described as a "slapped cheek appearance." The rash can fluctuate in intensity and can recur with environmental changes, such as temperature and exposure to sunlight, for weeks to months. Mild symptoms of fever, body aches, and headache may occur 7–10 days before rash. | Exclusion not indicated beyond policies about fever. |
| Hand Foot and Mouth | The usual period from initial infection to the time symptoms appear (incubation period) is 3 to 6 days. | By Person-to-person contact, Droplets made when a person who is sick with HFMD sneezes, coughs, or talks, Contact with contaminated surfaces and objects. | Usually include fever, mouth sores, and skin rash. The rash is commonly found on the hands and feet and blistered appearance<br><br>Hand, foot, and mouth disease is common in infants and children younger than 5 years old. Most children have mild symptoms for 7 to 10 days. | Exclude following fever protocol. Children may not attend school with open blisters that can spread the infection. |

# EPIC HEAD START/EARLY HEAD START
# COMMUNICABLE DISEASE REFERENCE CHART

| Disease | Incubation Period | Transmission | Common Symptoms | Recommendations |
|---|---|---|---|---|
| Influenza | Usually 1–4 days, with an average of 2 days. | Person-to-person by respiratory droplets created by coughing or sneezing or indirect contact with surfaces, where it can remain or up to 24 hours, with transfer from hands to mucosal surfaces of the face.<br>Persons may be infectious 24 hours before onset of symptoms. Viral shedding in nasal secretions usually peaks during the first 3 days of illness and ceases within 7 days but can be prolonged (10 days or longer) in young children and immunodeficient patients. | Sudden onset of fever, often accompanied by nonproductive cough, chills or rigors, diffuse myalgia, headache, and malaise. Subsequently, respiratory tract symptoms, including sore throat, nasal congestion, rhinitis, and cough, become more prominent. Less commonly, abdominal pain, nausea, vomiting, and diarrhea are associated with influenza illness. In some children, influenza can appear as an upper respiratory tract illness or as a febrile illness with few respiratory tract symptoms. | Exclude from school until at least 24 hours following resolution of fever without the use of fever- reducing medication(s).<br><br>Annual seasonal influenza vaccination for staff and children ≥ 6 months of age is strongly encouraged to prevent cases of influenza or lessen severity of illness. |
| Measles (Rubeola, Red Measles) | Generally, 8–12 days from exposure to onset of symptoms. (Range of 7 to 21 days, average of 14 days between appearance of rash among case and contacts) | Direct contact with infectious droplets or by airborne spread through inhalation of infectious droplets when a person with measles coughs, sneezes, etc.<br>Persons infected with wild-type measles virus are contagious from 4 days before the rash onset through 4 days after appearance of the rash. | cold-like symptoms, such as a runny nose, sneezing, and a cough, sore, red eyes that may be sensitive to light, watery eyes, swollen eyes, a high fever, which may reach around 104°F, small greyish-white spots in the mouth, aches and pains, loss of appetite, tiredness, irritability and a general lack of energy<br><br>The measles rash appears around 2 to 4 days after the initial symptoms and normally fades after about a week. The rash is made up of small red-brown, flat or slightly raised spots that may join together into larger blotchy patches usually first appears on the head or neck, before spreading outwards to the rest of the body, is slightly itchy for some people | Exclude from school until released by health care provider |
| Norovirus | From 12–48 hours | Primarily by the fecal-oral route through direct contact or ingestion of contaminated food or water, or by touching contaminated surfaces. Transmission is also possible through direct contact with the vomit, exposure to contaminated surfaces and aerosolized vomitus of an infected person. | Sudden onset of vomiting and/or diarrhea, abdominal cramps, and nausea. Symptoms typically last from 24 to 72 hours but prolonged illness can occur. Systemic manifestations, including fever, myalgia, malaise, anorexia, and headache, may accompany gastrointestinal tract symptoms. | Exclude from school until 48 hours after symptoms resolve.<br>Environmental cleaning is a very important component of the response to a norovirus outbreak. A high-concentration bleach solution can be used—this solution must remain on the surface for enough time to kill norovirus. Surface must be rinsed with water to remove bleach residue. |

# EPIC HEAD START/EARLY HEAD START
# COMMUNICABLE DISEASE REFERENCE CHART

| Disease | Incubation Period | Transmission | Common Symptoms | Recommendations |
|---|---|---|---|---|
| Pediculosis (Head Lice) | Eggs hatch in about 1 week (range 6–9 days), and reach maturity to an adult about 7 days later. | By direct head-to-head contact with hair of an infected person.<br>Transmission can occur by the personal belongings of an infected person, but this is uncommon.<br>Head lice occurs most commonly in children attending child care, preschool, and elementary school, and is not a sign of poor hygiene. | Severe itching and scratching. Eggs of head lice (nits) attach to hairs as small, round, gray lumps. | Notify parents; inform that child has lice and should be treated. Children should not be excluded or sent home early from school. Children can return to school once proper treatment has been completed. |
| Pertussis (Whooping Cough) | From 5–21 days, usually 7–10 days.<br>All suspected or confirmed cases of pertussis are rapidly reportable to the local health department | By direct contact with large respiratory droplets (coughing, sneezing) of an infected person by the airborne route. | The initial stage begins with mild upper respiratory symptoms of a common cold and increasingly irritating cough. Usually followed within 1 to 2 weeks with the characterized violent cough with high pitched whoop and vomiting. "Classic" pertussis has a duration of about 6–10 weeks. | Exclude from school until released by health care provider |
| Ringworm of the Body<br>(Tinea Corporis) | Incubation period believed to be 1 to 3 weeks but can be shorter, as reported cases have occurred at 3 days of age. | By contact with lesions of infected persons, animals, soil or fomites (e.g., brushes, combs, hats, towels). | Circular, red to brown, lesion that can involve face, trunk, or limbs. The classic eruption displays a scaly, vesicular, or pustular border with central clearing. Itching is common. | Exclusion not indicated as long as lesions are covered or child is receiving treatment. |
| Scabies | Persons without previous exposure: 4 to 6 weeks. Previously infested and sensitized: 1–4 days after re-exposure. | By direct skin-to-skin contact, usually prolonged exposure. Infection from dogs or other animals is uncommon. Casual skin contact unlikely to result in transmission. | Begins as itchy raised areas around finger webs, wrists, elbows, armpits, belt-line, thighs, naval, abdomen, buttocks and/or genitalia. In older children and adults, in areas such as the scalp, face, neck, palms, and soles. | Exclude from school until after the first course of appropriate treatment has been completed. Children identified during the school day should not be sent home early from school because scabies has a low contagion within classrooms. |
| Streptococcal Diseases<br>(Including Impetigo, Scarlet Fever, and Streptococcal pharyngitis) | Some common Group A Streptococcal infections include (1) impetigo, (2) streptococcal pharyngitis ("strep" throat) and (3) Scarlet fever.<br>Typical incubation periods are as follows:<br>Impetigo: 7–10 days<br>Streptococcal pharyngitis: 2–5 days<br>Scarlet fever: generally occurs in conjunction with streptococcal pharyngitis | In impetigo, usually acquired by direct contact with skin lesions or their discharge from an infected person.<br>Strep pharyngitis/Scarlet fever: By direct contact with infected persons and carriers or by contact with their respiratory droplets. | Impetigo: Multiple skin lesions usually of exposed area but may involve any area. Lesions vary in size and shape, and begin as blisters, which rapidly mature into brown crusts on a reddened base.<br>Scarlet Fever: Fever, sore throat, tonsillitis or pharyngitis. Sandpaper-like rash appears most often on neck, chest, and skin folds of arms, elbows, groin, and inner aspect of thighs.<br>"Strep" throat: Sudden onset of fever, sore throat, tonsillitis or pharyngitis, and enlarged lymph nodes. Symptoms may be absent in some cases. | Exclude from school until at least 24 hours after antibiotic treatment has been started AND fever freee without the use of fever-reducing medications (e.g. acetaminophen or ibuprofen). |

*Eastern Panhandle*
*Instructional Cooperative*

**EPIC**

Serving the educational needs
of the entire community

# When to Keep Your Child at Home or Cancel a Home Visit

Often we have parents that question when they should keep their child home from school. A child that is ill will not preform well in school and can spread the germs to other children and staff. Below you will find some guidelines that can help you make the decision to keep your child home or cancel a home visit.

Our wellness policy states that you should not send your child to school if he/she is experiencing the following:

- Fever (100.4 degrees or higher)
- Vomiting in the past 24 hours
- Diarrhea in the past 24 hours
- Chills
- Sore throat
- Strep Throat
- Pink Eye
- Bad cold with a very runny nose and/or bad cough, especially if it has kept your child awake at night.

You know your child best and if they are not acting as they usually would such as low activity and low appetite, without any of the above symptoms, it could be an indication that they are coming down with an illness.

# When is it Safe to Return to School

A child can return to school once they have been fever free for 24 hours without the use of fever reducing medication (Tylenol, Motrin) and vomiting and diarrhea free for 24 hours. If a child has Strep Throat, they may return once they have been on antibiotics for 24 hours. With pink eye, as long as the child is not rubbing/scratching at his/her eyes, they can return to the classroom.

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

Family style dining in early childhood education is when children and staff sit together at a table for a meal and used for intentional teaching. It helps children make healthy food choices by seeing positive attitudes from teachers and peers. It also can improve motor skills and self-confidence, expand social skills, reinforce table manners.

Staff will encourage the children to try new foods, but children do not have to try any foods they do not want to eat.

The following procedures will be followed in all EPIC Early Head Start/Head Start Classrooms:

1. Staff and children must wash their hands; staff will wear gloves when helping with meal service.

2. Child helpers will do the following:

    a. Pass out plates, utensils, napkins, and milk at each place setting.

3. Staff can choose two options for serving the food depending on developmental abilities of the children:
    a. Teachers serve the children and place all meal items on their plates
    b. Children can pass the food to each other and serve themselves

**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.

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

DO NOT WRITE IN THIS AREA
1875244720

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

## Steps to Complete Diet Order Form

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

## PART A. To be completed by Parent / Guardian

**STUDENT INFORMATION**

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

**PARENT / GUARDIAN INFORMATION**

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

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

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

**DIET ORDER FOR SCHOOL YEAR** 20 ☐☐ - 20 ☐☐ ☐ Initial Diet Order ☐ Revision to Diet Order

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

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

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

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

**Parent / Guardian Signature (required for processing)** X _____ Date _____

## PART B. To be completed by Licensed Healthcare Provider

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

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

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

☐ Other (Specify) _____

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

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

**FOOD TEXTURE MODIFICATION (If needed)**

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

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

**OTHER ACCOMMODATIONS**
- ☐ Calorie Recommendation: _____
- ☐ Low Added Sugar: _____
- ☐ Sodium Restriction: _____
- ☐ Carbohydrate Counting: _____
- ☐ High Fat: _____
- ☐ Nutritional Supplement: _____
- ☐ Adaptive Equipment: _____
- ☐ Enteral Feeding: _____
- ☐ Other: _____

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

**LACTOSE INTOLERANCE** ☐ No ☐ Yes ☐ Substitute lactose free milk

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

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

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

**FISH OR SHELLFISH**
- ☐ Fish ☐ Shellfish

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

**PEANUTS**
- ☐ Peanuts

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

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

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

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

_____

_____

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

| Medical Office Stamp (Required for processing) | Office Phone Number if not in the stamp | Medical Authority Signature | Date |
|---|---|---|---|
| | | X | |
| | Fax Number | Medical Authority Printed Name | |

"This institution is an equal opportunity provider."

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

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

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

Child Nutrition Office
Local School System

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

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

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

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

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

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

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

Eastern Panhandle Instructional Cooperative
EPIC
Serving the educational needs of the entire community

# Celebration Procedures

## Birthdays and other Special Events

Birthdays and other special celebrations may include **healthy** snacks or treats but due to food allergies please inform your teacher prior to the day what the snack item will be. Should a child in class have an allergy to the treat you want to bring, we will suggest an alternative item. We cannot allow any homemade healthy snack options, all food items must be prepackaged. The child's parent or guardian is welcome to participate in the celebration.

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 healthy snacks

- 100 calorie pretzels snack bags
- Goldfish crackers
- Fruit (apple slices, bananas, watermelon etc.)
- Carrots with ranch dip
- Celery (cut into to smaller sections to reduce string)
- Yogurt (freeze them too for a cool treat)
- 100% fruit gummy snacks

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
- Sent 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 | Head Start Policies and Procedures<br>Eastern Panhandle Instructional Cooperative<br>EPIC<br>Serving the educational needs of the entire community |
|---|---|---|
| Subpart | § 1302.47 Safety Practices | |
| Effective Date | 07/2021 | |
| Revised Date | 06/2021 | |
| Reviewed Date | 06/2021 | |
| Responsibility | Teaching Staff, Bus Drivers, Family Advocates, CD Managers, Specialists, Director | |

**Subject:** Active Supervision

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

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

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

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

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

**Monitoring & Reporting:**

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

| | |
|---|---|
| **Performance Standard** | Program Operations Health |
| **Subpart** | § 1302.47 Safety Practices |
| **Effective Date** | 07/2024 |
| **Revised Date** | 07/24 |
| **Reviewed Date** | 05/25 |
| **Responsibility** | Education Staff, Child Development Managers, Child Development Specialist |

**Head Start Policies and Procedures**

*Eastern Panhandle Instructional Cooperative*

**EPIC**

Serving the educational needs of the entire community

**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 will follow appropriate practices to keep children safe during all activities.

1. **Head Start Daily Roster is used to monitor the number of students that are 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 the CD manager at the end of each month with status.
2. **First Aid Emergency Backpack**
   a. Kept in a visible location and out of 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 the month, online data system.
3. **Outdoor Environment Checklist is used daily to maintain a safe outdoor environment**
   a. Teaching staff should complete prior to the children's arrival and post near door closet to the playground.
   b. Turn into to CD Manager at the end of each month with status.
4. **Emergency and Disaster Plan**
   a. Plan must be posted at each exit door in your classroom and center.
   b. Health and Safety Specialist will provide updated form to be posted by teaching staff prior to beginning of school year.
5. **Emergency Response Drills**
   a. Must complete 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.
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 manger 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 (Company coverage)**
   a. Completed by teaching staff immediately after incident occurs.
   b. Fill out form in its entirety and scan to Health and Safety Specialist, Child Development Manager, and Human Resources (Shannon Johnson) within 24 hours.
   c. Parent must be notified at the time of incident and a copy of accident/incident report must be sent home.
9. **Hazard Mapping (Behavior/Incident/Accident)**
   a. Completed by teaching staff as incidents occur and turn in at the end of the month with status.

**Monitoring & Reporting:**

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

# Head Start Daily Roster

**CODES**
**P** (Phone Call)
**F2F** (Face to Face)
**LM** (Left Message)
**NA** (No Answer)
**OT** (Other Contact)

Classroom/Site: _____ Date: _____

Staff: _____

☐ received head count from driver #_____ #_____ #_____

☐ verified head count initials _____ _____ _____
time _____ _____ _____

| Child's Name (First and Last Name) | Place an X if not present today | Time parent contacted by Staff / Initial | Present at | Present at | Present at | Present at | Present at | Present at |
|---|---|---|---|---|---|---|---|---|
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☐ provided head count to driver #_____ #_____ #_____

☐ driver verified head count

initials _____ _____ _____

4/25

Notes:

These sheets must be used each day you have children, and should be turned in to your Manager at the end of each week.

# EMERGENCY AND DISASTER PLAN

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

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

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

**Assignments during an emergency**

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

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

**Emergency Names and Numbers**

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

**Exit Location (Post floor plan at each exit)**

| | |
|---|---|
| 1. | 2. |
| 3. | 4. |

**Temporary Relocation Site Within School**

| Location- | Highlighted Area | Telephone # - NA |
|---|---|---|
| | | |

**Temporary Relocation Site Outside of School**

| Name | Address | Telephone Number |
|---|---|---|
| | | |
| | | |

**Utility Shut off Locations (See Floor Plan)**

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

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

West Virginia Department of
Health and Human Resources

# Emergency Plan

Child Care Center and Family Child Care Facility

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

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

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

| | | |
|---|---|---|
| Transportation | | |
| Other: _____ | | |
| Other: _____ | | |

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

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

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

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

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

**Utility Shut-off locations**

| Name of Utility | Location | Name of Utility | Location |
|---|---|---|---|
| Electricity | | Gas | |
| Water | | Other: | |

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

| | |
|---|---|
| Local Emergency Management Officials | |

| | |
|---|---|
| Businesses | |
| Schools | |
| Churches | |
| Child Care Resource and Referral Agency | |
| Others: | |

| **Communications** | |
|---|---|
| Describe how program staff will be trained on disaster plan procedures. | |
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| Describe how parents will be notified of the emergency or relocation. Include plans for reunifying parents and children.<br><br>(A copy of page 6 of this plan must be provided to parents annually) | |
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| Describe how the program will coordinate with local emergency management officials. | |
| Describe disaster plan procedures to address the needs of individual children, including children with special needs, infants, etc. | |

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

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

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

| **Relocation Site#1 for Disaster or Emergencies**<br>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**<br>Location to which you and the children will evacuate out of the immediate area – Include simple map of route as well as directions.<br>Relocation Site #2 needs to be a further distance away than Site #1. | | | | |
|---|---|---|---|---|
| Name of facility | | | | |
| Facility Address | | | | |
| | Street address | | | |
| | | WV | | |
| | City | State | Zip Code | Telephone Number |
| Directions to facility | | | | |

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

**If necessary, children will be transported to this health care facility:**

| | | | | |
|---|---|---|---|---|
| Facility Address | | | | |
| | Street address | | | |
| | | WV | | |
| | City | State | Zip Code | Telephone Number |
| Directions to facility | | | | |

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

Site: _____ School Year: _____

Person(s) completing drills: _____

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

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

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

**Bomb Threat Drills:**

Date/Time: _____ Date/Time: _____

**Severe Weather Drills:**

Date/Time: _____ Date/Time: _____

**Unwanted Intruder:**

Date/Time: _____ Date/Time: _____

**Bus Evacuation Drills:**

Date/Time (of 1st)_____ (due by August 25)

Date/Time (of 2nd) _____ (due by January 7)

Date/Time (of 3rd)_____ (due by April 8)

Date/Time (of 4th) _____ (due by June 23 for **EHS only**)

Bus off-site evacuation due by November 18 - _____ Date/Time Completed

**Comments/Concerns:**

| | |
|---|---|
| **Performance Standard** | Program Operations |
| **Subpart** | § 1302.47(b)(7)(ii) Safety Practices; Admin safety procedures |
| **Effective Date** | |
| **Revised Date** | |
| **Reviewed Date** | |
| **Responsibility** | All Staff |

**Head Start Policies and Procedures**

*Eastern Panhandle Instructional Cooperative*

EPIC

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**Subject:** Fire Drills

**Policy:** Twice a month all centers will conduct fire alarms mimicking a real emergency to ensure all staff and children have the proper knowledge of what to do and where to go should a real fire emergency occur within the center. These drills will be performed at various times of the day to include breakfast, lunch, nap, outside time, etc., so all staff and children will be adequately prepared for an evacuation no matter the part of the daily schedule they are in when the alarm sounds.

**Procedure:**

- Teaching staff can be told that a drill will happen at some point during the day but not an exact time.
    - Should a class have a child with sensory issues, then advance notice for that teacher can be given so they can be close to the child when the alarm sounds.
- When preforming a drill, the actual fire alarm must be used so all children and staff are aware of the sound
    - All staff should be trained at the beginning of the year on how to test the alarm system at their site
- Once the fire alarm sounds
    - All children will quickly and calmly line up
        - Children and staff will not be permitted to grab any belongings including coats
        - Children are to nap with shoes on
    - Staff will grab emergency binder and first aid bag
    - Before exiting the room, one staff member will check the bathrooms and closets to ensure all children are accounted for
- Evacuation
    - Staff will lead the children the designated location on the emergency plan quickly and calmly.
        - It is important to follow the plan so children are familiar with where they are to go.
    - Once at the evacuation site, staff will take attendance to ensure all children are accounted for.
- Re-Entry
    - Once the all clear is given by site manager, staff and children can return to their classroom.

# 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. 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 the Health & Safety Specialist at the end of the school year for record retention. 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 |
|---|---|---|---|---|---|
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**POST** in a conspicuous place in school building where it can be seen by teachers, students and patrons at all times.

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# Hazard Mapping
## (Incident/Accident/Behavioral)

Month/Year _____ Site/Classroom _____ Staff _____

**Complete this mapping based on your BRIM reports.*

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

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# Outdoor Environment Checklist

Month/Year _____ Site/Classroom _____

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

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

| Date | Staff Initials | Date | Staff Initials | Date | Staff Initials | Date | Staff Initials |
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|---|---|
| **Performance Standard** | Program Operations |
| **Subpart** | § 1302.47 (b)(1)(ii) Safety Practices; Facilities |
| **Effective Date** | |
| **Revised Date** | |
| **Reviewed Date** | |
| **Responsibility** | Teaching Staff, Family Advocates, Managers, Specialists and Director |

**Head Start Policies and Procedures**

*Eastern Panhandle Instructional Cooperative*

EPIC

Serving the educational needs of the entire community

**Subject:** Head Lice

**Policy:** EPIC Head Start will implement the following procedures should a child have live lice. These procedures are in place to maintain the health and safety of the children and staff and a clean, pest free facility. Children found to have live bugs will not be excluded from the classroom setting. Educational information will be provided to the family to assist in helping them understand lice and how to treat their home.

**Procedure:**

- Observation
  - If a child is excessively scratching or complaining of an itchy scalp, staff should perform a head check to see if lice is the cause of the itching/scratching.
- Confirmation
  - Bugs
    - If bugs are located on a child, staff should contact the parent/guardian to inform them of the discovery.
    - The child does not need to be picked up from school. They can finish out the school day.
    - During the phone call, staff should inquire if the family is in need of any lice treatment aides and if so, they should be sent home with the child
- Treatment

Parents will be provided a Head Lice Checklist outlining best practices to treat their child and home. Children must be properly treated to return to the classroom.

  - Shampoo
    - Medicated over the counter shampoos can be utilized.
      - Shampoos cannot be used more than once in a 7-day period
    - Should a child have reoccurring lice, prescription strength medicated shampoo may be needed through their primary care physician.
  - Robi Comb ®
    - Robi Combs ® are available to assist the family in the lice treatment process through the Health and Safety Specialist
  - Any blankets or pillows the child has at school will be sent home with the child to be properly washed.
  - The cot sheet the child has used will be cleaned before they return.

- Prevention
  - Head checks will be performed by staff on a weekly basis for all children in the classroom

# HEAD START LICE CHECKLIST

## IMMEDIATE

### FIRST THINGS FIRST

- ☐ TREAT CHILD WITH TREATMENT SHAMPOO
- ☐ WASH CLOTHING, BEDDING, AND TOWELS IN HOT WATER
- ☐ WASH STUFFED ANIMALS AND SOFT TOYS IN HOT WATER OR PLACE IN SEALED PLASTIC BAG FOR 10 DAYS
- ☐ VACUUM ROOMS AND UPHOLSTERY FURNITURE

## 7 DAY CHECK

### COMB AND CHECK FOR 7-10 DAYS

- ☐ DAY ONE
- ☐ DAY TWO
- ☐ DAY THREE
- ☐ DAY FOUR
- ☐ DAY FIVE
- ☐ DAY SIX
- ☐ DAY SEVEN
- ☐ DAY EIGHT
- ☐ DAY NINE
- ☐ DAY TEN

## PREVENTION

### PREVENT FOR THE FUTURE

- ☐ RETREAT 7-10 DAYS AFTER FIRST TREATMENT
- ☐ USE LICE PREVENTION SHAMPOO, CONDITIONER AND DETANGLING SPRAY
- ☐ NO SHARING PERSONAL ITEMS AND LIMIT HEAD-TO-HEAD CONTACT

| Performance Standard | Program Operations | Head Start Policies and Procedures<br>Eastern Panhandle Instructional Cooperative<br>EPIC<br>Serving the educational needs of the entire community |
|---|---|---|
| Subpart | § 1302.47 (b)(1)(ii) Safety Practices; Facilities | |
| Effective Date | | |
| Revised Date | | |
| Reviewed Date | | |
| Responsibility | Teaching Staff, Family Advocates, Managers, Specialists and Director | |

**Subject:** Bed Bug Prevention and Control

**Policy:** EPIC Head Start will implement the following procedures should a suspected bed bug be observed through bites on the skin or live bugs. These procedures are in place to maintain the health and safety of the children and staff and a clean, pest free facility. Children found to have bites or live bugs will not be excluded from the classroom setting. Educational information will be provided to the family to assist in helping them understand bed bugs and how to treat their home. Should an infestation occur in the home, additional resources will be provided to help the family gain control of the situation.

**Procedure:**

- Observation
  - Bites
    - If a child is scratching excessively, staff should perform a check of the child's legs, arms, hands, neck, face, back and abdomen and note if any bites are seen.
      - Bed bug bites are typically in a rough line or cluster.
      - Send a picture of bites to manager and Health & Safety Specialist for confirmation
  - Live Bugs
    - Should a live bug be seen on a child's belongings or in the classroom, the bug should be caught and sealed on clear tape to be inspected by the manager and Health Specialist to confirm identity of bug.
- Confirmation
  - Bites
    - Once the manager and Health & Safety Specialist have identified the bites as bed bugs, classroom staff should discreetly check the child's belongings for evidence of live bugs.
    - Family Advocate will contact the family to inform them of the bites found.
    - Classroom staff or FA will send program provided educational information to the family in how to look for and treat their home/belongings. Assistance will also be offered to assist the family.
  - Live Bugs
    - Once the manager and Health & Safety Specialist have confirmed the bug is a bed bug, classroom staff should discreetly check the child for bites and their clothing for more bugs along with any belongings they have brought from home.
      - Should more bugs be found, classroom staff should change the child into new clothing and check the rest of the children and their belongings to prevent any bugs from hitchhiking.
        - If live bugs are found on other children, the parent/guardians will be informed of the discovery.
      - The child's backpack and other belongings should be placed inside a plastic bag and sealed to prevent any others migrating to another child's belongings.
    - Family Advocate will contact the family to inform them of the bugs found.
    - Classroom staff or FA will send program provided educational information to the family and offer assistance.
    - Classroom staff will inspect the area of the classroom the child has been in to ensure no bugs are present in the environment.
- Monitoring
  - Bites
    - If bites have been noted, but not any live bugs on child or belongings, staff will have continuing communication with family to check the status of the home.
    - Spot checks every 3 to 4 days can be done on the child to ensure there are no new bites.
      - Should the child show sign of new bites between the monitoring days such as scratching, proceed as you would with a new observation and check the child.
  - Live Bugs
    - No child will be excluded from the classroom upon discovery of live bugs on their person and/or in their belongings.
    - If live bugs have been identified on the child or in the belongings, checks should be performed in the restroom discreetly each morning when the child arrives for 7 classroom days.

- A spare set of season appropriate clothes (including coat) should be available for the child should a bug be found.
- During the 7-day checking period, if another bug is found follow the procedures as indicated for confirmation for informing the family and bagging belongings.

- Treatment
  - Non-Head Start owned facilities
    - If live bugs are found in the classroom environment and not on a person, staff will contact manager and Health & Safety Specialist to inform of discovery and get confirmation of bed bug. The owner of the facility will be contacted and also informed of the discovery.
    - Owner will be responsible for contacting pest control company to complete an inspection
    - After inspection if evidence of infestation is found, treatment will be completed on facility and families will be notified regarding infestation and treatment. Program provided educational information will be given to families on how to look for and treat bed bugs in their homes.
    - After inspection if no evidence of infestation is found, continued monitoring will take place by staff.
  - Head Start owned facilities
    - If live bugs are found in the classroom environment and not on a person, staff will inform manager and Health & Safety Specialist of the discovery and get confirmation on bug.
    - Manager or Health & Safety Specialist will contact pest control company to complete an inspection of facility for infestation.
    - After inspection, if evidence of infestation is found, treatment will be completed on facility and families will be notified regarding infestation and treatment. Program provided educational information will be given to families on how to look for and treat bed bugs in their homes.
    - After inspection, if no evidence of infestation if found, continued monitoring will take place by staff.
- Prevention
  - If possible, do not store children's jackets, backpacks, and other items in close contact with each other.
  - Limit the items the children bring from home.
  - Reduce classroom clutter and remove all cardboard.
  - Inform Health & Safety Specialist of any crevices that need to be sealed.
  - Cleaning staff will vacuum all carpeted areas each evening. If bugs have been suspected, cleaning staff will dispose of vacuum contents outside into a plastic garbage bag and seal closed.

Dear Parent,

Today, a bed bug was found on your child or in your child's belongings. While this does not necessarily mean that the bed bug was brought to school by your child, it is important for the school community and your home that you inspect your home for signs of bed bugs.

Enclosed you will find information about bed bugs and an identification guide to help you with your inspection. Once you have inspected your home, please fill out the form below and return to the school by _____.

Sincerely,

Health & Safety Specialist

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I have been informed that a bed bug was found on my child (or their belongings) at school. I understand that bed bugs can be very difficult to control and in the best interest of my child and the school community, I have read and understand the educational materials provided to me regarding bed bugs. I have:

□ Carefully checked my family and home for signs of bed bug infestation myself.

□ Hired a pest management professional to check my family and home for signs of bed bug infestation. Name of pest control company:

_____

After completing a careful inspection, I certify that to the best of my knowledge:

□ I, or a pest management professional, found signs of bed bugs in my home and I will take the following actions to eliminate this infestation:

_____

_____

_____

_____

_____

□ I, or a pest management professional, did not find any signs of bed bugs in my home at this time. If I find evidence of bed bugs in the future, I will notify the school immediately and take action to address the infestation.

I understand that bed bugs can be spread to other homes if they are brought to school in backpacks, clothing, and other belongings. I understand that if bed bugs are repeatedly found on my child, then the school may take additional actions to protect the school community from bed bugs.

Signature: _____ Date: _____

Pest Management Professional's Signature: _____ Date: _____

EPA 730-F-16-001
June 2016

# Bed Bugs in Schools
## *Guidance for Parents*

*Bed bugs can hitchhike from different locations into homes and schools. Education and preparation are the formula for success in dealing with bed bugs. Here are things you can do as a parent to keep bed bugs out of your child's school and your home.*

### Prevent Bed Bugs from Coming Home

- Limit the items your child brings home from school.
- Inspect items as they arrive from school.
- Keep school items like backpacks, books, and jackets in a single area of the home that is separate from the sleeping areas. If the school has reported problems with bed bugs, isolate them in a sealed plastic container.

**A school is not an ideal place for bed bugs, but it can serve as a hub for their travel to other locations, including homes.**

### Keep Them Out of School

- Limit the items your child takes to school.
- Because backpacks and coats are the most common way for a bed bug to get a ride to school, put them in a dryer on high heat for 30 minutes weekly.
- Store freshly laundered clothing in sealed plastic bags or boxes until they are put on if you have problems with bed bugs in your home.

### If You Spot a Bed Bug

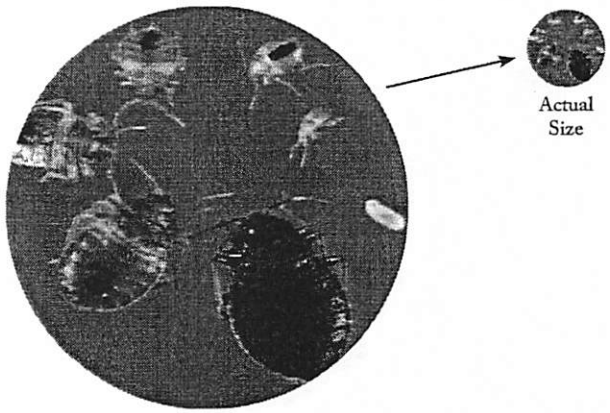
- Catch the suspected bed bug in a zip top bag or contain it under clear tape for identification.
- Many universities and pest management firms offer identification services.
- Arrange for an inspection by a pest management professional.
- Contact your school nurse so they can investigate within the school.

**Bed bugs are not a sign of unhealthy living conditions. We can unknowingly bring them home from infested areas in clothes, shoes, backpacks and other items.**

### If You Have Bed Bugs at Home

- Put clothing, backpacks, shoes, bedding, and similar objects in a dryer at high temperature for 30 minutes.
- Vacuum bed bugs from cracks and crevices in furniture, equipment, walls, and floors.
- Eliminate clutter to reduce hiding places.
- Use a protective cover that encases mattresses and box springs and eliminates bed bug hiding spots.
- Install bed bug interceptors (devices placed under the legs of furniture to catch bed bugs and keep them from climbing the legs).
- Talk with a professional pest control company about non-chemical methods like heat treatment of rooms, furniture and other large items.
- If needed, use pesticides made specifically for bed bugs carefully according the label directions or hire a pest management professional.

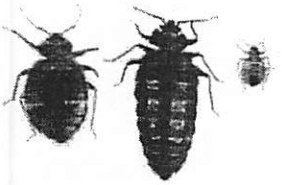
### Identification is Key!



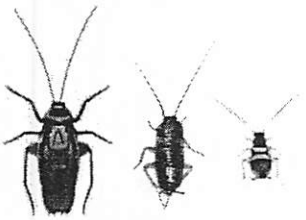

**Learn more at epa.gov/bedbugs**

NYC Health

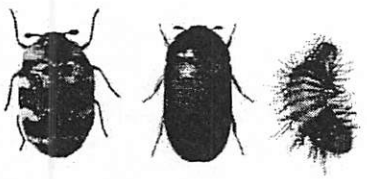
# Is it a Bed Bug, Cockroach or Carpet Beetle?



**Bed Bugs:** Reddish brown, flattened and oval in shape; about 1/5 inch long; short thick antennae; dark protruding eyes and wing-like structures on either side of the head; Immature bed bugs are similar to adult, about the size of a poppy seed and yellowish-white in color.



**Cockroaches**: dark brown to reddish mahogany, flattened, oval in shape; 1 1/5 - 2 inches long; long thin antennae; large eyes and membranous wings; abdomen with tail-like structures; Immature cockroaches are similar to adults, smaller in size and without wings



**Carpet Beetles:** Round, solid brown to blackish, or have irregular pattern of white, brown and orange scales; about 1/5 inch long; short club-shaped antennae; inconspicuous eyes, and a hard outer shell covering their membranous wings. Immature beetles are about the same length as adults and are covered with dense tufts of hair.

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## Visitor/Volunteer Tracking

School Year _____ Site _____

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

| Date | Classroom | Child Name | Visitor Name | Time In | Time Out | Purpose of Visit | *Photo Consent |
|---|---|---|---|---|---|---|---|
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*** 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.)***

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**Special Services Tracking**

School Year _____ Site/Classroom _____

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

# Special Services

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## Special Services Tracking

School Year _____ Site/Classroom _____

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

Eastern Panhandle Instructional Cooperative
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# Classroom Cleaning Checklist

Month/Year _____ Site/Classroom _____ Staff _____

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

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

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

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

| | |
|---|---|
| **Performance Standard** | Program Operations |
| **Subpart** | § 1302.47(c)(v) Safety Practices 1302.90 (c) Standards of Conduct |
| **Effective Date** | 7/1/2023 |
| **Revised Date** | |
| **Reviewed Date** | |
| **Responsibility** | Education Staff, Transportation Staff, Family Advocates, Managers, Specialists and Director |

**Head Start Policies and Procedures**

*Eastern Panhandle Instructional Cooperative*

**EPIC**

Serving the educational needs of the entire community

**Subject:** Threat Intervention Policy

**Policy:** EPIC Head Start/Early Head Start will implement threat intervention procedures when any child, parent or staff member displays threat-making behavior which is defined as any action by an individual, who in any manner, knowingly utters, conveys or causes any person to perceive a threat.

**Procedure:**

**Monitoring/Reporting** - All Staff are responsible for monitoring and reporting any threats by children, children's family members or staff to their immediate supervisor. The immediate supervisor will document the incident and send it to the threat assessment team.

**Assessment** – The team will meet when a report has been made to determine if it is a transient or substantive threat. The threat assessment team will consist of the Director, Mental Health Specialist, Health & Safety Specialist and the Manager.

- Transient Threat
  - Intended as a figure of speech
  - Feelings that dissipate in a short period when the threat maker thinks about the meaning of what he/she said
- Substantive Threat
  - Express a continuing intent to harm someone that extends beyond the immediate incident or argument when the threat was made

If a threat is found to be substantive, the team will identify if it is serious (assault) or severe (involving weapon). An incident report will be completed for all substantive threats.

**Written Plan** – The threat assessment team will write a plan to outline appropriate interventions the program will initiate. Interventions for children in the program may vary depending on the type of threat but could include:

- Meeting with parent/guardian of threat maker
- Mental health observation by Mental Health Specialist
- Referrals to community providers
- Accommodations in classroom to separate threat maker from person threatened
- Child may be placed on modified day or transition to home-based service

Interventions for staff may include:

- Administrative leave pending investigation
- Law enforcement
- Dismissal from position

Interventions for parents/guardians may include:

- No longer allowed on Head Start property
- Law enforcement

After the written plan is finalized, a meeting will occur with parents of child, or threat maker, and threat assessment team to ensure all are aware of the plan.

**On-Going Monitoring** – Any written plans will be reviewed every two weeks and any changes will be noted and discussed with all parties to ensure full understanding.

**Documentation** – all documentation related to a threat will be filed in a child's file if they or their parent/guardian is the threat maker. Any staff member that makes a threat will have their documentation filed in their personal file at the main EPIC office.

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# THREAT ASSESSMENT INCIDENT REPORT

To be completed by the Threat Assessment Team

| | |
|---|---|
| Name of Student: (print clearly) | |
| School: | Classroom: |
| Date of Birth: | Age: |

| | |
|---|---|
| Mother/Legal Guardian: | Father/Legal Guardian: |
| Telephone:<br>Home_____<br>Work_____ | Telephone:<br>Home_____<br>Work_____ |

**Brief Summary of the Threat and Incident**

| |
|---|
| When and where did the incident occur? |
| Describe the threat in detail: |
| Threat-maker's relationship to the target/school: |
| Name(s) of victims or potential victims: |
| What happened immediately prior to the incident and other triggers? |
| How did the incident end? |
| Threat-maker's plan and capacity to carry out plan: |
| Physical conduct that would substantiate intent to follow through on the threat: |
| Explain the threat-maker's access to weapons: |
| **Is the threat Transient, if YES stop here and complete applicable parts of second page.<br>If the threat is Substantive, please complete the entire form.** |
| Appearance of threat maker (physical and emotional): |
| Names of witnesses and others who were directly involved: |
| Describe consistency between witnesses and threat: |
| Threat-maker's stressful events (e.g., bullying, loss, self-harm, trauma, etc.) |
| Other relevant information (e.g., history of violence, diagnoses, mental health, etc.) |
| Threat-maker's support system (e.g., family, friends, therapists, positive adult relationships, etc.) |

## ACTION STEPS CHECKLIST

| |
|---|
| ☐ Witnesses interviewed: |
| ☐ Searched belongings/cubby (list anything found that is of concern): |
| ☐ Email teachers asking about any past concerns related to the threat-maker: |
| ☐ For any adult threat-maker's, confiscate electronic devices to prevent social media posting: |
| ☐ For any adult threat-maker's, searched publicly available social media (list anything found that is of concern): |
| ☐ Complete the Threat Assessment Screening Summary Worksheet (please attach to report) |
| ☐ Disciplinary action taken Y or N? If yes, describe actions taken: |
| ☐ Maintained direct supervision of threat-maker until parent picked up the individual: Y or N |
| ☐ Intended victim warned and/or parent/guardian notified:<br>By who _____; How _____; When _____ |
| ☐ Mental health assessment initiated? If yes, when: _____ ; who is conducting the assessment _____ |
| ☐ Safety plan to address concerns about safety to self or others: Y or N (please attach) |
| ☐ Behavior Intervention Plan to support behavior and further identification of needs: Y or N (please attach) |
| ☐ Alert staff and teachers on a need-to-know basis: Y or N |

**Report completed by:** _____

**Signature:** _____ **Date:** _____

**Signature:** _____ **Date:** _____

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# Threat Assessment: Threat Maker Interview Form

| Directions: This form should be completed by a member of the threat assessment team; not the child. Use these questions as a guide to interview the child/person making the threat. Other questions can be asked as appropriate. Use quotation marks to indicate child/person exact words when possible. | |
|---|---|
| Person completing the form: | Position: |
| Center/Classroom: | Date Form Completed: |
| Child/Person Interviewed: | |

1. What happened today when you were (place of incident)? (Record child/person's exact words for key statements if possible)

2. What exactly did you say? What exactly did you do?

3. What did you mean when you said or did that?

4. How do you think (person who was threatened) feels about what you said or did? (Probe to see if the child/person believes it frightened or intimidated the person.)

5. What was the reason you said or did that? (Probe to find out if there is a prior conflict or history to this threat.)

6. What are you going to do now? (Ask questions to determine if the student intends to carry out the threat.) Inquire about access to weapons if appropriate.

7. Have you been exposed to violence? (Probe to see if student is a victim or perpetrator of violence.)

8. Is there anything else you want to tell me?

9. Did you post anything related to the threat on social media? Please explain.

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# Threat Assessment: Witness Interview Form

| Directions: This form should be completed by a member of the threat assessment team; not the witness. Use these questions as a guide to interview witnesses who have direct or indirect knowledge of the threat. Complete separate forms for each witness. Other questions can be asked as appropriate. Use quotation marks to indicate witness' exact words when possible. | |
|---|---|
| Person completing the form: | Position: |
| Center/Classroom: | Date Form Completed: |
| Witness Interviewed: | |

1. What exactly did the student/person who made the threat say or do? (Record witness's exact words for key statements, if possible)

2. What do you think he or she meant when saying or doing that?

3. How do you feel about what he or she said or did? (Gauge whether the witness feels frightened or intimidated.)

4. Are you concerned that he or she might actually do it?

5. Why did he or she say or do that? (Find out whether the witness knows of any prior conflict or history behind the threat.)

6. Is there anything else you want to tell me?

7. Do you know of any social media posts related to the threat (please explain)?

8. Other information:

# Threat Assessment Screening Summary Worksheet

| | LOW RISK | MEDIUM RISK | HIGH RISK |
|---|---|---|---|
| **Plans** | | | |
| A. Details<br>B. How Prepared<br>C. Immediacy<br>D. Lethality<br>E. Chance for intervention | □ Vague<br>□ Means unavailable; lacks realism<br>□ No specific time<br>□ Fists/fighting/kicking<br>□ Others present most of the time | □ Some specifics<br>□ Has means close by or thoughts to act<br>□ Within a few days or hours; indication of time<br>□ General statements about weapon availability<br>□ Others available if called upon | □ Direct, plausible, specific, very detailed<br>□ Means at hand; steps taken toward action<br>□ Immediately<br>□ Has lethal weapons or makes statements about acquiring such<br>□ No one nearby; intended victim is isolated |
| **Negative Emotions** | | | |
| A. Tolerance<br>B. Desperation<br>C. Coping | □ Emotions are bearable<br>□ Wants emotional pain to stop, but not desperate<br>□ Identifies nonviolent ways to address emotional pain | □ Emotions are almost unbearable<br>□ Becoming desperate for relief from emotional pain<br>□ Has limited ways to cope with emotional pain | □ Emotions are unbearable<br>□ Desperate for relief from emotional pain<br>□ Few ways to cope with emotional pain |
| **Resources** | | | |
| A. Availability/Quality<br>B. Accomplices | □ Help available<br>□ No accomplices for plan | □ Family and friends available, but not perceived as willing to help<br>□ Indicates passive support from friends/family for ideas/plans | □ Family and friends are not available and/or are hostile, injurious, or exhausted<br>□ Indicates active support from friends/family for plan |
| **Prior Violent Behaviors** | | | |
| A. Self<br>B. Significant Others<br>C. Bullying Others | □ No prior violent behavior<br>□ No significant others have engaged in violent behavior<br>□ No prior bullying behavior | □ At least 1 violent incident in the past year, or a history of making threats/stalking<br>□ Significant others have recently engaged in violent behaviors<br>□ At least 1 bullying incident in the past year | □ History of multiple (2+) violent acts in the past year, and/or following through on a violent threat/stalking<br>□ Significant others have a significant history of violent behaviors<br>□ History of multiple (2+) bullying act in the past year |
| **Mental Health** | | | |
| A. Coping Behaviors<br>B. Medical Status<br>C. Other psychopathology | □ Not currently considered mentally ill, but may have a history of such<br>□ No significant medical problems<br>□ Stable relationships, personality and school performance | □ Mentally ill but currently receiving treatment<br>□ Acute but short-term illness (may be psychosomatic)<br>□ Recent acting out behavior and/or substance abuse; acute violent behavior in an otherwise stable personality | □ Mentally ill and not currently receiving treatment<br>□ Chronic debilitating or acute catastrophic illness<br>□ Violent behavior in unstable personality; emotional disturbance; repeated difficulty with peers, family and/or teachers. |
| **Stress** | | | |
| A. Current Levels<br>B. Bullying Victim | □ No significant stress<br>□ No prior incidents of being bullied | □ Moderate reaction to loss and environmental changes<br>□ At least 1 incident of being bullied in the past year | □ Severe reaction to loss or environmental changes<br>□ History of multiple (2+) incidents of being bullied in the past year |
| **Total # of Checks** | | | |
| **Multiplied by:** | 1 | 2 | 3 |
| **Weighted Scores** | | | |
| **Total Weighted Score** | | | |
| **Divided by:** | 3 | | |
| **Final Risk Score** | | | |
| **Risk Level** | **Transient Threat (≤9)** | **Serious Substantive Threat (10-14)** | **Severe Substantive Threat (≥15)** |

How to score this worksheet:

1. Multiply total checks in the low risk column by 1; the medium risk column by 2; and the high risk column by 3.
2. Add these three weighted scores.
3. Divide the total weighted scores by 3
4. The final score will help determine the risk level

| Possible Responses to Transient Threat | Possible Responses to Serious Threats | Possible Responses to Severe Threats |
|---|---|---|
| Contact parent/guardian if necessary | Notify parent/guardian and caution threat maker about consequences of carrying out the threat | Notify parent/guardian |
| Notify intended victim's parent/guardian if necessary | Protect and notify intended victim and parent/guardian of victim | Protect and notify intended victim and their parent/guardian |
| See that threat is resolved through explanation, apology or making amends | Provide direct supervision of threat maker. | Provide direct supervision of threat maker |
| Refer for counseling if appropriated | Consult with law enforcement | Consult with law enforcement |
| Follow established discipline procedures | Refer threat maker for mental health assessment | Refer for mental health assessment |
| Maintain threat screening documentation | Follow established discipline procedures | Develop BIP |
| | Maintain threat screening documentation | Maintain threat screening documentation |

**Note: The risk of threat is fluid and can change as risk factors change. The team should determine appropriate actions for each individual as the above list is just possible responses.**

# 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:** | | |