Miss. Admin. Code 15-11-55 APPENDIX A

15-11-55 APPENDIX A.

§ 43-21-353. Duty to inform state agencies and officials; duty to inform individual about whom report has been made of specific allegations.

(1) Any attorney, physician, dentist, intern, resident, nurse, psychologist, social worker, family protection worker, family protection specialist, child caregiver, minister, law enforcement officer, public or private school employee or any other person having reasonable cause to suspect that a child is a neglected child or an abused child, shall cause an oral report to be made immediately by telephone or otherwise and followed as soon thereafter as possible by a report in writing to the Department of Human Services, and immediately a referral shall be made by the Department of Human Services to the youth court intake unit, which unit shall promptly comply with Section 43-21-357. In the course of an investigation, at the initial time of contact with the individual(s) about whom a report has been made under this Youth Court Act or with the individual(s) responsible for the health or welfare of a child about whom a report has been made under this chapter, the Department of Human Services shall inform the individual of the specific complaints or allegations made against the individual. Consistent with subsection (4), the identity of the person who reported his or her suspicion shall not be disclosed. Where appropriate, the Department of Human Services shall additionally make a referral to the youth court prosecutor.

Upon receiving a report that a child has been sexually abused, or burned, tortured, mutilated or otherwise physically abused in such a manner as to cause serious bodily harm, or upon receiving any report of abuse that would be a felony under state or federal law, the Department of Human Services shall immediately notify the law enforcement agency in whose jurisdiction the abuse occurred and shall notify the appropriate prosecutor within forty-eight (48) hours, and the Department of Human Services shall have the duty to provide the law enforcement agency all the names and facts known at the time of the report; this duty shall be of a continuing nature. The law enforcement agency and the Department of Human Services shall investigate the reported abuse immediately and shall file a preliminary report with the appropriate prosecutor's office within twenty-four (24) hours and shall make additional reports as new or additional information or evidence becomes available. The Department of Human Services shall advise the clerk of the youth court and the youth court prosecutor of all cases of abuse reported to the department within seventy-two (72) hours and shall update such report as information becomes available.

(2) Any report to the Department of Human Services shall contain the names and addresses of the child and his parents or other persons responsible for his care, if known, the child's age, the nature and extent of the child's injuries, including any evidence of previous injuries and any other information that might be helpful in establishing the cause of the injury and the identity of the perpetrator.

(3) The Department of Human Services shall maintain a statewide incoming wide-area telephone service or similar service for the purpose of receiving reports of suspected cases of child abuse; provided that any attorney, physician, dentist, intern, resident, nurse, psychologist, social worker, family protection worker, family protection specialist, child caregiver, minister, law enforcement officer or public or private school employee who is required to report under subsection (1) of this section shall report in the manner required in subsection (1).

(4) Reports of abuse and neglect made under this chapter and the identity of the reporter are confidential except

when the court in which the investigation report is filed, in its discretion, determines the testimony of the person reporting to be material to a judicial proceeding or when the identity of the reporter is released to law enforcement agencies and the appropriate prosecutor pursuant to subsection (1). Reports made under this section to any law enforcement agency or prosecutorial officer are for the purpose of criminal investigation and prosecution only and no information from these reports may be released to the public except as provided by Section 43-21-261. Disclosure of any information by the prosecutor shall be according to the Mississippi Uniform Rules of Circuit and County Court Procedure. The identity of the reporting party shall not be disclosed to anyone other than law enforcement officers or prosecutors without an order from the appropriate youth court. Any person disclosing any reports made under this section in a manner not expressly provided for in this section or Section 43-21-261, shall be guilty of a misdemeanor and subject to the penalties prescribed by Section 43-21-267.

(5) All final dispositions of law enforcement investigations described in subsection (1) of this section shall be determined only by the appropriate prosecutor or court. All final dispositions of investigations by the Department of Human Services as described in subsection (1) of this section shall be determined only by the youth court. Reports made under subsection (1) of this section by the Department of Human Services to the law enforcement agency and to the district attorney's office shall include the following, if known to the department:

(a) The name and address of the child;

(b) The names and addresses of the parents;

(c) The name and address of the suspected perpetrator;

(d) The names and addresses of all witnesses, including the reporting party if a material witness to the abuse;

(e) A brief statement of the facts indicating that the child has been abused and any other information from the agency files or known to the family protection worker or family protection specialist making the investigation, including medical records or other records, which may assist law enforcement or the district attorney in investigating and/or prosecuting the case; and

(f) What, if any, action is being taken by the Department of Human Services.

(6) In any investigation of a report made under this chapter of the abuse or neglect of a child as defined in Section 43-21-105(m), the Department of Human Services may request the appropriate law enforcement officer with jurisdiction to accompany the department in its investigation, and in such cases the law enforcement officer shall comply with such request.

(7) Anyone who willfully violates any provision of this section shall be, upon being found guilty, punished by a fine not to exceed Five Thousand Dollars ($5,000.00), or by imprisonment in jail not to exceed one (1) year, or both.

(8) If a report is made directly to the Department of Human Services that a child has been abused or neglected in an out-of-home setting, a referral shall be made immediately to the law enforcement agency in whose jurisdiction the abuse occurred and the department shall notify the district attorney's office within forty-eight (48) hours of such report. The Department of Human Services shall investigate the out-of-home setting report of abuse or neglect to determine whether the child who is the subject of the report, or other children in the same environment, comes within the jurisdiction of the youth court and shall report to the youth court the department's findings and recommendation as to whether the child who is the subject of the report or other children in the same environment require the protection of the youth court. The law enforcement agency shall investigate the reported abuse immediately and shall file a preliminary report with the district attorney's office within forty-eight (48) hours and shall make additional reports as new information or evidence becomes available. If the out-of-home setting is a licensed facility, an additional referral shall be made by the Department of Human Services to the licensing agency. The licensing agency shall investigate the report and shall provide the Department of Human Services, the law enforcement agency and the district attorney's office with their written findings from such investigation as well as that licensing agency's recommendations and actions taken.

§ 43-21-355. Immunity for reporting information.

Any attorney, physician, dentist, intern, resident, nurse, psychologist, social worker, family protection worker, family protection specialist, child caregiver, minister, law enforcement officer, school attendance officer, public school district employee, nonpublic school employee, licensed professional counselor or any other person participating in the making of a required report pursuant to Section 43-21-353 or participating in the judicial proceeding resulting therefrom shall be presumed to be acting in good faith. Any person or institution reporting in good faith shall be immune from any liability, civil or criminal, that might otherwise be incurred or imposed.

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Mississippi State Department of Health

List of Reportable Diseases and Conditions

Reporting Hotline: 1-800-556-0003

Monday - Friday, 8:00 am - 5:00 pm

To report inside Jackson telephone area or for consultative services

Monday - Friday, 8:00 am - 5:00 pm: (601) 576-7725

Phone Fax

Epidemiology (601) 576-7725 (601) 576-7497

STD/HIV (601) 576-7723 (601) 576-7909

TB (601) 576-7700 (601) 576-7520

Class 1 Conditions may be reported nights, weekends and holidays by calling: (601) 576-7400

Class 1: Diseases of major public health importance which shall be reported directly to the Mississippi State Department of Health (MSDH) by telephone within 24 hours of first knowledge or suspicion. Class 1 diseases

and conditions are dictated by requiring an immediate public health response. Laboratory directors have an obligation to report laboratory findings for selected diseases (refer to Appendix B of the Rules and Regulations Governing Reportable Diseases and Conditions).

Any Suspected Outbreak (including foodborne and waterborne outbreaks)

(Possible biological weapon agents appear in ***bold italics***)

Anthrax	**Encephalitis (human)**	***Ricin intoxication (castor beans)***
Arboviral infections including but not limited to those due to:	***Glanders***	***Smallpox***
	Haemophilus influenzae Invasive Disease[d1r1]	*Staphylococcus aureus*,
California encephalitis virus	Hemolytic uremic syndrome (HUS), post-diarrheal	vancomycin resistant (VRSA) or vancomycin
Eastern equine encephalitis virus	Hepatitis A	intermediate (VISA)
LaCrosse virus	HIV infection, including AIDS	Syphilis (including congenital)
Western equine encephalitis virus	Influenza-associated pediatric mortality (<18 years of age)	Tuberculosis
St. Louis encephalitis virus	Measles	***Tularemia***
West Nile virus	***Melioidosis***	Typhoid fever

Botulism (including foodborne, infant or wound)	*Neisseria meningitidis* Invasive Disease[d1r1]	***Typhus fever***
Brucellosis	Pertussis	Varicella infection, primary, in patients
Chancroid	***Plague***	>15 years of age
Cholera	Poliomyelitis	***Viral hemorrhagic fevers*** (filoviruses [e.g.,
Creutzfeldt-Jakob disease, including new variant	***Psittacosis***	Ebola, Marburg] and arenaviruses [e.g., Lassa, Machupo])
Diphtheria	***Q fever***	
Escherichia coli O157:H7 and any shiga toxin-producing *E. coli* (STEC)	Rabies (human or animal)	Yellow fever

d1. Usually presents as meningitis or septicemia, or less commonly as cellulitis, epiglottitis, osteomyelitis, pericarditis or septic arthritis.

r1. Specimen obtained from a normally sterile site.

Any unusual disease or manifestation of illness, including but not limited to the appearance of a novel or previously controlled or eradicated infectious agent, or biological or chemical toxin.

Class 2: Diseases or conditions of public health importance of which individual cases shall be reported by mail, telephone, fax or electronically, within 1 week of diagnosis. In outbreaks or other unusual circumstances they shall be reported the same as Class 1. Class 2 diseases and conditions are those for which an immediate public health response is not needed for individual cases.

Chlamydia trachomatis, **genital**	**Lyme disease**	**Rubella (including congenital)**

infection

Dengue	Malaria	Salmonellosis
Ehrlichiosis	Meningitis other than meningococcal or *H. influenzae*	Shigellosis
Enterococcus, invasive infection[r1], vancomycin resistant	Mumps	Spinal cord injuries
Gonorrhea	*M. tuberculosis* infection (positive TST or positive IGRA[***]) in children < 15 years of age	*Streptococcus pneumoniae*, invasive infection[r1]
Hepatitis (acute, viral only) **Note** - Hepatitis A requires		
Class 1 Report	Noncholera vibrio disease	Tetanus
Legionellosis	Poisonings[*] (including elevated blood lead levels[**])	Trichinosis
Listeriosis	Rocky Mountain spotted fever	Viral encephalitis in horses and ratites

Blood lead levels (venous) of >10 mug/dL in children less than 16 years of age

Blood lead levels (venous) of >25 mug/dL in those 16 years or older

r1. Specimen obtained from a normally sterile site.

* Reports for poisonings shall be made to Mississippi Poison Control Center, UMMC 1-800-222-1222.

** Elevated blood lead levels (as designated below) should be reported to the MSDH Lead Program at (601) 576-7447.

*** TST-tuberculin skin test; IGRA-Interferon-Gamma Release Assay

Except for rabies, equine, and ratite encephalitis, diseases occurring in animals are not required to be reported to the MSDH.

Class 3: Laboratory based surveillance. To be reported by laboratories only. Diseases or conditions of public health importance of which individual laboratory findings shall be reported by mail, telephone, fax or electronically within one week of completion of laboratory tests (refer to Appendix B of the Rules and Regulations Governing Reportable Diseases and Conditions).

All blood lead test results	Chagas Disease (American Trypanosomiasis)	Hepatitis C infection
Blastomycosis	Cryptosporidiosis	Histoplasmosis
Campylobacteriosis	Hansen disease (Leprosy)	Nontuberculous mycobacterial disease

Class 4: Diseases of public health importance for which immediate reporting is not necessary for surveillance or control efforts. Diseases and conditions in this category shall be reported to the Mississippi Cancer Registry within six months of the date of first contact for the reportable condition.

The National Program of Cancer Registries at the Centers for Disease Control and Prevention requires the collection of certain diseases and conditions. A comprehensive reportable list including ICD9CM codes is available on the Mississippi Cancer Registry website, http://mcr.umc.edu/documents/ReportableCases10-09andlater.pdf.

Each record shall provide a minimum set of data items which meets the uniform standards required by the National Program of Cancer Registries and documented in the North American Association of Central Cancer Registries (NAACCR).

Laboratory Results that must be Reported to the Mississippi State Department of Health

Laboratories shall report these findings to the MSDH at least **WEEKLY**. Diseases in **bold type** shall be reported immediately by telephone. Isolates of organisms marked with a dagger (†) should be sent to the MSDH Public Health Laboratory (PHL). All referring laboratories should call the PHL at (601) 576-7582 prior to shipping any isolate. Confirmatory tests for some of these results may be obtained by special arrangement through the Epidemiology Program at (601) 576-7725.

Positive Bacterial Cultures or Direct Examinations

Result	Reportable Disease
Any bacterial agent in CSF	Bacterial meningitis
Bacillus anthracis[d1]	**Anthrax**
Bordetella pertussis	**Pertussis**
Borrelia burgdorferi[d1]	Lyme disease
Brucella species[d1]	**Brucellosis**
Burkholderia mallei[d1]	**Glanders**
Burkholderia pseudomallei[d1]	**Melioidosis**
Campylobacter species	Campylobacteriosis
Chlamydia psittaci	**Psittacosis**
Chlamydia trachomatis	*Chlamydia trachomatis* genital infection

Clostridium botulinum[d1**]	**Botulism**
Clostridium tetani	Tetanus
Corynebacterium diphtheriae[d1]	**Diphtheria**
Coxiella burnetii[d1]	**Q fever**
Enterococcus species,[*] vancomycin resistant	*Enterococcus* infection, invasive vancomycin resistant
Escherichia coli O157:H7 and any shiga toxin-producing *E. coli* (STEC)	***Escherichia coli* O157:H7 and any shiga toxin-producing *E. coli* (STEC)**
Francisella tularensis[d1]	**Tularemia**
Haemophilus ducreyi	**Chancroid**
Haemophilus influenzae[d1*]	***H. influenzae* infection, invasive**
Legionella species	Legionellosis
Listeria monocytogenes[d1]	Listeriosis

Mycobacterium species	Nontuberculous mycobacterial disease
Mycobacterium tuberculosis[d1]	**Tuberculosis**
Neisseria gonorrhea	Gonorrhea
Neisseria meningitidis[d1*]	**Meningococcal infection, invasive**
Rickettsia prowazekii	**Typhus Fever**
Rickettsia rickettsii	Rocky Mountain Spotted Fever
Salmonella species, not *S. typhi*	Salmonellosis
Salmonella typhi[d1]	**Typhoid fever**
Shigella species	Shigellosis
Staphylococcus aureus, vancomycin	***Staphylococcus aureus* vancomycin resistant**
resistant or vancomycin intermediate	**(VRSA) or vancomycin intermediate (VISA)**
Streptococcus pneumonia[*]	*Streptococcus pneumoniae*, invasive infection

Vibrio cholerae 01[d1]	**Cholera**
Vibrio species[d1]	*Vibrio* infection
Yersinia pestis[d1]	**Plague**

d1. Isolates of organism should be sent to the MSDH PHL. All referring laboratories should call the PHL at (601) 576-7582 prior to shipping any isolate.

* Specimen obtained from a normally sterile site (usually blood or cerebrospinal fluid, or, less commonly, joint, pleural, or pericardial fluid). **Do not report throat or sputum isolates.**

** Contact the MSDH Epidemiology Program at (601) 576-7725 or the PHL at (601) 576-7582 for appropriate tests when considering a diagnosis of botulism.

Positive Serologic Tests For:

Arboviral agents including but not limited to those due to:	**Dengue**	***M. tuberculosis* infection**
California encephalitis virus	Ehrlichiosis	**Plague**
Eastern equine encephalitis virus	**Hepatitis A** (anti-HAV IgM)	**Poliomyelitis**
LaCrosse virus	Hepatitis B (anti-HBc IgM)	**Psittacosis**
St. Louis encephalitis virus	Hepatitis C	Rocky Mountain Spotted Fever

Western equine encephalitis virus	**HIV infection** (refer to Section 113)	Rubella
West Nile virus	Legionellosis[h1]	**Syphilis** (refer to Section 116)
Brucellosis	Lyme disease	**Smallpox**
Chagas Disease (American Trypanosomiasis)	Malaria	**Trichinosis**
Cholera	**Measles**	**Varicella infection, primary in patients >15 years of age**
Chlamydia trachomatis genital infection	Mumps	
		Yellow fever

h1. Serologic confirmation of an acute case of legionellosis cannot be based on a single titer. There must be a four-fold rise in titer to >1:128 between acute and convalescent specimens.

Positive Parasitic Cultures or Direct Examinations		**Blood Chemistries**
Result	**Reportable Disease**	ALL blood lead test results are reportable to the
Any parasite in CSF	Parasitic meningitis	MSDH Lead Program at (601) 576-7447.

Cryptosporidium parvum Plasmodium species [r1]	Cryptosporidiosis Malaria

r1. Indicates the positive specimens may be submitted to the MSDH PHL for confirmation.

Positive Fungal Cultures or Direct Examinations	**Positive Toxin Identification**

Result	**Reportable Disease**	**Ricin toxin from *Ricinus communis* (castor beans)**
Any fungus in CSF	Fungal meningitis	
Blastomyces dermatitidis	Blastomycosis	
Histoplasma capsulatum	Histoplasmosis	

Positive Viral Cultures or Direct Examinations		**Surgical Pathology results**
Result	**Reportable Disease**	**Creutzfeldt-Jakob Disease, including new variant**
Any virus in CSF	Viral meningitis	Hansen disease

		(*Mycobacterium leprae*)
Arboviral agents including but not limited to those due to:		**Human rabies**
California encephalitis virus	**California encephalitis**	Malignant neoplasms Mycobacterial disease including **Tuberculosis** Trichinosis
Eastern equine encephalitis virus	**Eastern equine encephalitis (EEE)**	
LaCrosse virus	**LaCrosse encephalitis**	
St. Louis encephalitis virus	**St. Louis encephalitis (SLE)**	
Western equine encephalitis virus	**Western equine encephalitis (WEE)**	
West Nile virus	**West Nile encephalitis (WNV)**	
Arenaviruses	**Viral hemorrhagic fevers**	
Dengue virus, serotype 1, 2, 3 or 4	Dengue	
Filoviruses	**Viral hemorrhagic fevers**	

Poliovirus, type 1, 2 or 3	**Poliomyelitis**
Varicella virus	**Varicella in patients >15 years of age**
Variola virus	**Smallpox**
Yellow fever virus	**Yellow fever**

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Nutritional Standards

Introduction

Meals shall meet the nutritional standards as prescribed in this section. A child care facility shall provide adequate and nutritious meals prepared in a safe and sanitary manner.

Healthy diets help children grow, develop, and perform well in learning environments. Healthy diets contain the amounts of essential nutrients and calories needed to prevent nutritional deficiencies while preventing an excess amount of discretionary calories. Planned meals and snacks provide the right balance of carbohydrate, fat, and protein to reduce risks of chronic diseases, and are part of a full and productive lifestyle. Such diets are obtained from a variety of foods.

Nutrition and feeding practices for children strongly affect the development and long-term health of the child. Proper nutritional care during the early years is essential for intellectual, social, emotional, and physical growth. It is also necessary that an environment be provided which encourages the development of good food habits.

Meals and vending services shall meet the standards from the Offices of Healthy Schools and Child Nutrition for the Mississippi State Department of Education as well as USDA Food and Nutrition Service guidelines.

THE GOALS OF A CHILD CARE FACILITY IN RELATION TO NUTRITION SHALL BE:

1. Menus shall be nutritionally adequate and consistent with the Dietary Guidelines for Americans.

2. Foods shall be provided in quantities and meal patterns that balance energy and nutrients with children's ages, appetites, activity levels, special needs, and cultural and ethnic differences in food habits.

3. Parents shall be involved in the nutrition component of their child-care facility.

4. A variety of fruits, vegetables, and whole-grain products shall be offered to children for meals and snacks. Mealtime should be used as an opportunity to teach nutrition and/or food concepts.

5. The addition of fat, sugar, and sources of sodium shall be minimal in food preparation and service.

6. Food preparation and service shall be consistent with best practices for food safety and sanitation.

7. Furniture and eating utensils shall be age-appropriate and developmentally suitable to encourage children to accept and enjoy mealtime.

8. Child-care personnel shall encourage positive experiences with food and eating.

9. Caregivers shall receive appropriate training in nutrition, food preparation, and food service.

10. Child-care facilities shall obtain assistance as needed from the Child Care Licensure Division and the supportive staff.

11. Nutrition education for children and for their parents shall be encouraged as a component of the child-care program.

12. Child-care programs must comply with local and state regulations related to wholesomeness of food, food preparation facilities, food safety, and sanitation.

13. Family style dining is encouraged.

Based upon the American Dietetic Association Benchmarks for Nutrition Programs in Child-Care Settings

FEEDING SCHEDULE FOR INFANTS AND CHILDREN ONE YEAR AND OLDER

1. Children's food needs are based on the amount of time spent in the child care facility.

2. Any child in a child care facility at the time of service of a meal or snack will be served that meal or snack

3. Child care facilities that are open 24 hours are required to serve three meals and three snacks.

IF YOU ARE OPEN	**YOU MUST SERVE**		
Nine hours or less	Two snacks and one meal	OR	One snack and two meals
Over nine hours	Two snacks and two meals	OR	Three snacks and one meal
24 hours or during all meals	Three meal and three snacks: one snack should be a late night snack only served to children who are awake.		

II. [FN1] **Meal Time**

Meals and snacks shall be served at regularly scheduled times each day.

The same meal or snack shall not be served more than one time in any 24-hour (one-day) period.

No more than four and no less than a two and one-half hour period must elapse between the beginning of a meal and a snack.

If breakfast is not served, then a mid-morning snack shall be provided.

Since not all children arrive at the facility at the same time, certain parental options regarding breakfast will be allowed as follows:

1. Parent can feed the child prior to arrival at the child care facility.

2. The parent may have the meal provided by the child care facility.

Note: Either option above must be documented and included in the child's record.

Outside foods shall not be brought into the facility, with the exception of special dietary needs. Exempt facilities are facilities that operate less than six hours and as noted in the regulations, otherwise noted in other sections of the standards. Any outside foods shall meet the Office of Healthy School and MSDH Nutrition Standard guidelines.

II. **Meal Time Environment**

Age appropriate utensils, plates, bowls, cups, and dining area shall be provided.

Children shall not wait longer than fifteen minutes at the table for food to be served.

Sufficient time shall be allowed for children to wash their hands and prepare for the meal.

green & gray

Mealtime shall be used for socialization, and shall be a relaxed, happy time for the children. No media, e.g., televisions, videos, or DVD's may be viewed during meal and snack times. Family style dining is encouraged with serving platters, bowls, and pitchers on the table so that all present can serve him/her self. Children are encouraged to assist with table setting and bowling up fruits for dessert. All foods served must meet the serving guidelines, and be age appropriate. "Seconds" of foods can be served as indicated at the request of the child or by hunger cues.

A caregiver shall sit and join the children while they are eating. When caregivers are allowed to eat with the children, which is encouraged, staff will eat items that meet nutrition standards. It is suggested that the staff eat the same food items that are served to the children. The staff will encourage social interaction, conversation, and use the mealtime for education purposes. Extra assistance and time shall be provided for slow eaters.

Caregivers shall not eat foods outside of the foods served in the facility in front of the children.

Food shall not be used as a reward or punishment. Children will not be encouraged to "clean your plate," but encouraging children to try two bites of each food served is acceptable.

Additional servings shall be provided for the child who requests more food at a meal or snack. It is at the discretion of the facility and knowledge of the child's eating pattern to allow seconds on food items. This time to teach children on portion control, monitoring extra intake, and better food selections is higher in nutritional value.

Meals and snacks provided by a parent must not be shared with other children, unless a parent is providing baked goods for a celebration or party being held at the operation. Foods for a party or celebration shall meet the Office of Healthy School guidelines.

Children will be permitted in meal preparation areas when under the direct supervision of a staff person, when there is no danger of injury from equipment, and for instruction/teaching purposes only.

III. **Menus**

A complete two-week cycle of menu plans shall be submitted annually to Child Care Licensure as part of the renewal process. Although a minimum complete, two-week cycle menu is required to be submitted annually, child care facilities at their discretion may submit a 4 to 8 week cycle of menu plans.

Daily menus for all meals and snacks prepared and/or served in the child care facility shall be plainly posted. Any substitution shall be of comparable food value and shall be recorded on the menu and dated.

Menus shall be written at least one week in advance. Menus can be completed on a rotating cycle for 4-12 weeks.

Menus shall be posted in the food preparation area and in a conspicuous place in the child care facility at all times.

Menus shall be planned to include food with variety in texture, color, and shape. Record of dated menus served, and any substitutions made, shall be kept on file for a minimum of one year.

New food shall be introduced to help develop good food habits. Introduce only one new food per meal or snack. Foods used for activities/teaching can be included on the written record of foods served for the day.

It is the facility's responsibility to discuss recurring eating problems with the child's parent.

IV. **Child Requiring a Special Diet**

A child requiring a special diet due to medical reasons, allergic reactions, or religious beliefs, shall be provided meals and snacks in accordance with the child's needs. If medical reasons exist for the special diet, a medical prescription from the child's physician stating that the special diet is medically necessary is required. Information required for dietary modifications include:

- Child's full name and date of instructions, updated annually;
- Any dietary restrictions based on the special needs;
- Any special feeding or eating utensils;
- Any foods to be omitted from the diet and any foods to be substituted;
- Limitations of life activities;
- Any other pertinent special needs information;
- What, if anything, needs to be done if the child is exposed to restricted foods.

Religious or ethnic requests should include the above information as needed, plus a certified statement of request based upon the religious or ethnic beliefs of the family.

The facility shall not serve nutrient concentrates and supplements such as protein powders, liquid protein, vitamins, minerals, and other nonfood substances without written instructions from the child's physician.

The child's parent shall meet with the facility staff and/or director to review the written instructions. Such instructions shall list any dietary restrictions/requirements and shall be signed and dated by the child's physician requesting the special diet.

Parents of children with severe restrictions and dietary needs will be given a copy of the facility's menu to pre-select foods to be served. The parents will be responsible for ensuring the accuracy of foods served based upon the preplanned menu.

The child care facility may request the parent to supplement food served by the child care facility. When food is supplied by the parent, the child care facility shall be responsible for assuring that it is properly stored and served to the child in accordance with the diet instructions on file at the child care facility. Any food item that must cooked, shall be prepared by the facility, such as a soy patties. Meals and snacks provided by a parent must not be shared with other children, unless a parent is providing baked goods for a celebration or party being held at the operation.

Records of food intake shall be maintained when indicated by the child's physician.

Vegetarian/Vegan Dietary Requests

Request for a vegetarian/vegan diet shall be accommodated with the same information completed as for dietary modifications. Specialty items may be supplied by the parent to meet nutritional needs. Contact with the nutritionist with MSDH is recommended.

To the extent authorized by Federal laws, the facility may determine that the special nutritional needs of a child cannot be met at the facility and the child may be excluded from admission into the facility.

V. **Food Preparation**

Recipes shall be used and a file of recipes used to prepare the food shall be maintained.

Foods shall be prepared in a form that is easy for children to handle. Bite size pieces and finger foods are suitable. Bones shall be removed from any food served to any child in the child care setting.

Foods shall be prepared as close to serving time as possible to preserve nutrients, flavor, and color.

Food should not be highly seasoned. No extra salt or fats should be added to the foods in cooking. The use of salt free, low fat products is allowed. Children need to learn the flavors of food.

Raw vegetables and foods that may cause choking in young children shall not be served to children less than two years of age.

VI. **Choking Prevention**

A caregiver shall join the children while they are eating. This is an opportunity to teach socialization skills, nutrition education, and is a safety measure to help prevent choking.

Children should be encouraged to eat slowly, take small bites, and chew well before swallowing.

FOODS THAT MAY CAUSE CHOKING

Sausage shaped meats (hot dogs)*	Pop Corn
Hard Candy*	Chips*
Nuts	Thick Pretzels Rods* Thin pretzel sticks and rounds would be allowed
Grapes	Chunks of peanut butter
Gum*	Marshmallows
Dried Fruits	

* Not allowed to be served

To Reduce Choking Hazards

Cook food until soft and cut into thin slices or small pieces. Remove bones from meat, chicken, and fish, and remove seeds and pits from fruit. With toddlers, cutting foods into "pea" size is recommended.

VII. **Feeding of Infants**

When a pregnant mother is visiting the facility to consider enrollment, breastfeeding should be encouraged.

Breast milk is the recommended feeding for infants and should be encouraged and supported by child care facility staff. The mother may choose to come to the child care facility to nurse her infant, or may choose to supply bottles of expressed breast milk for the child care facility staff to feed the infant. To help a mother be successful with breastfeeding the faculty may:

1. Encourage the mother to come to the facility to breastfeed and provide a

• Quiet, comfortable and private place to feed;

• Place to wash the hands;

• Pillow to support her infant if desired;

• A comfortable chair, stool for feet while nursing;

• The mother may opt to nurse while in the infants room;

2. Encourage the mother to provide a back-up supply of frozen breast milk that is labeled with the infant's name and date of expression. The mother's expressed milk shall be used for her infant only. Note: *Excessive shaking of human milk may damage some components that are valuable to the infant.*

The Centers for Disease Control's (CDC) guidelines for storage of frozen expressed breast milk are as follows:

• Freezer compartment of a refrigerator at a temperature of 5° F or -15° C the expressed breast milk can be safely stored for 2 weeks

• Freezer compartment of refrigerator with separate doors 0° F or -18° C the expressed breast milk can be safely stored for 3-6 months

• Freezer compartment of refrigerator with separate doors -4° F or -20° C the expressed breast milk can be safely stored for 6-12 months

Note: Store milk toward the back of the freezer, where temperature is most constant. Milk stored for longer durations in the ranges listed is safe, but some of the lipids in the milk undergo degradation resulting in lower quality. You can go to the CDC website at http://www.cdc.gov/breastfeeding/recommendations/handling_breastmilk.htm for more information.

3. Note: for the breast fed infant, it is acceptable to introduce iron-fortified cereal earlier, at four months if desired, but preferably at 6 months.

A written schedule for feeding the infant shall be provided by the parent and posted for reference by the child care facility staff.

Feeding should be by hunger cues whenever possible. Hunger cues may include:

• Sucking on his tongue, lips, hands, or fingers while asleep

• Moving his arms and hands toward his mouth

• Restless movements while asleep

• Rapid eye movements under his eyelids

• Opening his mouth when his lips are touched

• “Rooting” or searching for the nipple

• Making small sounds

Late hunger cues include:

• Crying

• Fussiness

Signals when an infant is full and feeding should stop:

• “Falls off” the breast, releasing the nipple;

• Falls asleep; or

• Relaxes his body and opens his fists.

Green & Pink

Breast milk or formula shall be brought to the child care facility daily, ready to be warmed and fed. Each bottle shall

Green & Pink

be labeled with the infant's name and the date. No cereal, juice or other foods may be added to the infant's breast milk/formula without a physician's written request, as done for a child with special needs.

Bottles should be warmed for five minutes in a pan of hot, not boiling water; **never** microwave. Before feeding, test the temperature by squirting a couple of drops on the back of your hand.

At the end of each feeding, discard any milk left in the bottle. Staff will send all used bottles home with the parent for proper cleaning and sanitizing.

Age-appropriate solid foods (complimentary foods) may be introduced no sooner than when the child has reached 4 months of age, but ideally at six months. The first food introduced usually is cereal mixed with breast milk or formula (not in a bottle). Adding juice to dry cereal is not allowed.

Commercially prepared baby foods shall be brought in unopened jars and labeled with the infant's name. Home prepared/blended and home canned infant foods shall not be served. A facility may chose to mash and puree the foods served to older children for the infants 7 months to one year -- no additional juice, sauces, or fats may be added to the pureed foods.

Iron-fortified dry infant cereal shall be brought in sealed container premeasured for each feeding and labeled with the infant's name.

Juice shall not be served to infants (children less than 12 months of age).

A small amount of water is encouraged at 8-12 months.

Infants shall be held cradled in the arms during feeding. At no time shall an infant be fed by propping a bottle.

Introduction of solid foods to an infant should be done in consultation with the parent and/or according to the schedule of the Mississippi State Department of Health Infant Feeding Guide.

Solid foods must be spoon-fed. No solid foods shall be fed by bottle or infant feeder without written direction from a physician.

Infants are fed when hungry by noting hunger cues, such as crying, being restless. Feeding is stopped when it is determined that the infant is satisfied. Signs of satiety include, refusing the nurse, turning away from the nipple, falling asleep.

Green & Pink

Infants are encouraged to start using a cup at six to nine months, based upon motor skills. When the cup is used, the breast milk or formula may be brought into the center in a clean closed container that is clearly labeled. By the age of one, all children should be off a bottle.

Older infants are encouraged to hold and drink from cups, to use child appropriate eating and serving utensils. Self-feeding should be encouraged. All food should be served in a manner to prevent choking, such as mashing, cutting in small "pea" size portions.

Breast or formula is served to at least 12 months. Cow's milk is not served until age one, unless provided with a written exception from the infant's physician. Children ages one to two, shall be served whole cow's milk, after age two, toddlers should be served fat free/skim milk. *When there are children older than two in the classroom with younger children, all children shall be served the whole milk.*

Guidelines for Milk Storage and Use for All Infants

Storage Method and Temperature	**Maximum Amount of Time For Storage**

Room (25 C or 77 F)	**4 hours**
Refrigerator (4 C or 39 F)	**48 hours**
Previously thawed -- Refrigerated milk	**24 hours**
Freezer (-20 C or 0 F)	**3 months**

From the ACOG/AAP publication: Breastfeeding Handbook for Physicians

When centers are reimbursed for meals and must supply formula for their infants, only ready to use formula may be purchased for use. The center may require the parents to supply clean bottles daily. If the center supplies the bottles, there must be provisions in place for the proper cleaning, sanitizing, and drying of all bottles and supplies outside of the infant room.

FEEDING SCHEDULE FOR INFANTS THROUGH ONE YEAR

INFANT'S FOOD NEEDS ARE BASED ON THE AMOUNT OF TIME SPENT IN THE CHILD CARE FACILITY.

ANY INFANT IN A CHILD CARE FACILITY AT THE TIME OF SERVICE OF A MEAL OR SNACK SHALL BE SERVED FOODS APPROPRIATE TO THE AGE.

MEAL/SNACK	**BIRTH THROUGH 5 MONTHS**	**6 THROUGH 12 MONTHS**
Breakfast	4-6 fl. oz. breast milk or formula	6-8 fl. oz. breast milk or formula
		2-4 Tbsp. prepared infant cereal (optional)
		1-4 Tbsp. fruit and/or vegetable(infant or mashed)
Lunch or Supper	4-6 fl. oz. breast milk or formula	6-8 fl. oz. breast milk or formula

		2-4 Tbsp. prepared infant cereal (optional)
		1-4 Tbsp. fruit and/or vegetable(infant or mashed)
		1-4 Tbsp. infant meat
Supplement/Snack	4-6 fl. oz. breast milk or formula	2-4 fl. oz. breast milk or formula
		0-1/2 dry bread or 0-2 crackers (optional)

Infant cereal and formulas shall be iron fortified. Infant feeding is individualized after consultation with the parent and by hunger cues from the infant.

MENU PLANNING

Dietary Guidelines for Americans provide assistance in planning meals for ages two and older, which will promote health and prevent disease.

The guidelines, applied to child care feeding are:

1. Offer a variety of foods.

2. Serve meals and snacks that help maintain a healthy weight.

3. Serve fresh, frozen, canned, or dried vegetables, fruits whenever possible, and whole grain products.

4. Avoid excessive fat, saturated fat, and cholesterol. No fried foods or foods with transfats shall be served.

5. Use and serve sugar only in meal preparation and then in moderation. No concentrated sweets, such as candy, syrup, sweetened drinks sodas, or flavored milks may be served.

6. Limit sodium products and the use of salt.

7. Promote an alcohol, tobacco and drug free lifestyle for children, parents, and caregivers.

8. Promote and encourage daily physical activity.

PARTIES AND SPECIAL OCCASIONS

Parties and special party type events should not be held more that once a month. Food for parties should be prepared at the facility when possible. It is recommended that if foods for the event are brought to the facility by parents it should be "store bought" and not "home cooked."

It is suggested that a plain "store bought" cake be served. Other items may include ice cream, fresh fruit, cheese and crackers, and party favors such as stickers, books, toothbrushes, crayons, etc., are encouraged.

Meal Pattern Points to Remember

Keep in mind the following points when you plan menus to meet meal pattern requirements for each of the food groups.

• Plan your meats first. Then select fruits and vegetables, making sure that you have a Vitamin C source daily and a Vitamin A source every other day, or three times a week. Refer to the vitamin tables. Limit starchy vegetables to once/day - these include lima beans, butterbeans, white/sweet potatoes, English peas, black-eye peas, field peas, Crowder peas, cream and whole kernel corn, any dried pea/bean(unless counted for a meat substitute).

• Two vegetables or two fruits may be served at the mealtime, but it is recommended to serve a vegetable and a fruit for variety. Including brightly colored fruits and vegetables, such as tomatoes, broccoli, carrots, greens, strawberries, melon, peaches, will help to meet the vitamin requirements.

• The same meal may not be served more than once in a day (i.e. facilities who are open for lunch and supper may not serve the same meal for both meals).

• Snacks are to be served mid-morning (if required), early afternoon, and late afternoon, usually 30-60 minutes before closing. Water can be used as the beverage while foods are served. Snack time is an excellent time to introduce fruits and vegetables.

• Use only 100-percent-strength juice for snack no more than once a day. Give fruit for breakfast/morning snack instead of juice.

• Juice should not be served as part of the snack when milk is the only other component. It is poor menu planning to offer such a combination since it provides too much liquid for children.

• Fruit-flavored drinks, sport drinks, soft drinks, caffeinated beverages, artificially sweetened beverages shall not be served.

• Avoid serving two forms of the same fruit or vegetable in the same day. Example: an orange and orange juice or an apple and applesauce are combinations that should not be used. Serve a variety of vegetables and fruits to ensure a nutritionally well-balanced meal.

• Dry milk shall not be used as a milk beverage, but may be used for cooking purposes.

• Guidelines from USDA FNS (US Department of Agriculture Food Nutrition Supplement) program are used as the standard for menu planning and guidelines. However, when one set of guidelines are stricter then the stricter guidelines shall be enforced (in comparing MSDH and USDA FNS). Emphasis shall be placed on serving more whole grains and fewer foods high in fat, sugar, and sodium.

• Drinking water shall be freely available to children of all ages and offered at frequent intervals. Extra water served with meals, snacks, and during and after physical activity is encouraged. Facilities may have water fountains in the classroom or dining area. This water source should be encouraged before and after all meals and snacks and takes the place of water served at the table.

• To prevent nutrient and vitamin loss from foods during preparation, cooking, or storage, try to

○ Serve fruits and vegetables raw as appropriate for the age. The risk of choking is greater for the child under the age of two.

○ Steam, boil, or simmer foods in a very small amount of water, or microwave for the shortest time possible.

○ Cook potatoes in their skins. Be sure to wash the dirt off the outside of the potato.

○ Refrigerate prepared juices and store them for no more than two to three days.

○ Store cut raw fruits and vegetables in an airtight container and refrigerate--do not soak or store in water. Nutrients may be diluted from soaking in water. Manufacturer packaged fresh fruits and vegetables are the exception due to packaging processes.

MEAL PATTERNS FOR CHILDREN IN CHILDCARE FACILITIES: BREAKFAST

BREAKFAST	AGES 1YR-2YR	AGES 3 YR--5 YR	AGES 6 YR--12 YR
Milk (Must be fluid, skim/fat free), or 1% milk)	½ c.	¾ c.	1 c.
Fruit or Vegetable	¼ c.	½ c.	½ c.
Grains/Breads	½ slice	½ slice	½ slice

Enriched, Whole Grain Bread	¼ c. OR ⅓ oz.	⅓ c. OR ½ oz.	¾ c. OR 1**oz.**
OR	¼ c.	⅓ c.	½ c.
Enriched Dry Cereal	¼ c.	⅓ c.	½ c.
OR			
Enriched Hot Cereal			
OR			
Enriched, Whole Grain Pasta,			
Noodles, Rice			
Water	½ c.	¾ c.	1 c.

Milk:

Milk shall be served at Breakfast. The milk shall be pasteurized fluid milk, fortified with vitamin A and D. Whole milk is served to infants and toddlers less than 2 years of age. After age two, skim/fat free or 1% milk shall be served

Soymilk may be served when indicated with dietary restrictions.

Bread and Bread Alternates:

Use enriched whole-grain breads and bread alternatives. Dry cereals need to be of high fiber and not sugar coated. Hot cereals cannot be instant. Whole grain pasta, noodles, or brown rice may be used occasionally for the breakfast meal.

Breakfast breads may include muffins, biscuit, toast, breakfast bread, no more than weekly pancake or waffle (with no syrup). Crust used as part of the main dish (i.e., for quiche) is allowed as a bread alternate. These items may not be served: doughnuts, honey buns, breakfast tarts, pastries, packaged snack cakes, and other high fat/sugar foods.

Fruits and Vegetables:

Use fresh, canned, dried, or frozen fruit for breakfast. No sugar may be used in the packaging or preparation of the fruit. Canned or frozen fruit should be packed in juice or water - not syrup or sugar packed.

Vegetables, such as tomatoes, may be used occasionally for the breakfast meal. Cultural differences may also dictate that items such as tomatoes, peppers, onions, or salsas may be served with brown rice for the vegetable and bread component at breakfast.

Water:

Water is to be made available with all meals and snacks. Tap or bottled water may used. Facilities may have water fountains in the classroom or dining area. This water source should be encouraged before and after all meals and snacks and takes the place of water served at the table.

Meat and Meat Alternates:

The Meat component is not required for the breakfast meal. IF the facility desires to serve a meat item with the breakfast, that would be allowed. Meats and meat alternates that would be acceptable include eggs, fat free yogurt, low fat cheese, fat free cottage cheese, lean ham, Canadian bacon, and peanut butter. Bacon is not considered a meat and shall not be served due to the high fat and high sodium content.

MEAL PATTERNS FOR CHILDREN IN CHILDCARE FACILITIES: LUNCH/SUPPER/DINNER

LUNCH/SUPPER/DINNER	AGES 1YR--2YR	AGES 3 YR--5 YR	AGES 6 YR--12 YR
Meat/Meat Alternate	1 oz.	1 ½ oz.	2 oz.
Cooked Meat, No Bone	1/4 c.	3/8 c.	½ c.
Cooked Dry Beans/Peas	1 oz.	1 ½ oz.	2 oz.
Low Fat Cheese	1 small	1 medium	1 medium
Egg	2 Tbsp.	3 Tbsp.	4 Tbsp.

Peanut Butter	4 oz/1/2 c.	6 oz./3/4 c.	8 oz./1 c.
Fat Free Yogurt/Cottage Cheese			
Fruit or Vegetable: Must include 2	1/4 c. total	½ c. total	3/4 c. total
different foods-1 vegetable/1 fruit OR 2	1/8 c. of 2 foods	1/4 c. of 2 foods	3/8 c. of 2 foods
vegetable OR 2 fruit			
Grains/Breads	½ slice	½ slice	½ slice
Enriched, Whole Grain Bread	1/4 c. OR 1/3**o**z.	1/3 c. OR ½ oz.	¾ c. OR 1 oz.
OR	1/4 c.	1/3 c.	½ c.
Enriched Dry Cereal	1/4 c.	1/3 c.	½ c.
OR			
Enriched Hot Cereal			
OR			

Enriched, Whole Grain Pasta,

Noodles, Rice

Milk (Must be fluid, skim/fat free), or 1% milk)	½ c.	3/4 c.	1 c.
Water	½ c.	3/4 c.	1 c.

Meat and Meat Alternates:

It is recommended to have at least one meatless meal a week. An alternate for meat could be cooked, dried beans, or peas. Cooked dried beans and peas cannot count for a vegetable and meat alternate in the same meal. Canned beans and peas will include the canned kidney, black bean, garbanzo, etc. Note: Canned beans are much higher in sodium/salt.

Edible portion for meats and meat alternates is used. Bone and skin shall not be counted as servings. No bones may be served. Note: 1 ounce of cooked meat is equal to one medium cooked chicken leg wtih bone removed.

Processed, pre-fried meats are not allowed due to the sodium/salt and fat content. Meats not allowed include hot dogs, corndogs, bologna, bacon, sausage, pancake sticks, small chicken nuggets, fish sticks, and steak fingers.

Processed cheese, such as cheese spread, canned cheese sauce, and cheese in packaged snack crackers is not allowed. Low fat or fat free cheese would be a meat alternate that is allowed.

For menu variety, use meat, and low fat cheese in combination to equal a full serving portion.

It is not recommended serving nuts and seeds due to nut/seed allergies prevalent in the youth today.

Bread and Bread Alternates:

Use enriched whole-grain breads and bread alternatives. Whole grain pasta, noodles, brown rice, wheat rolls, and cornbread are encouraged for the lunch/supper/dinner meals.

Bread alternates may include crust used as part of the main dish (i.e. pizza or quiche), Dry oatmeal used in a fruit crisp.

Pre-fried items, such as hash browns, French fries, and tater tots are not recommended due to the fat and sodium content Any pre-fried item served is limited to once a week.

Cookies, pastries, packaged snack cakes, and other high fat/sugar foods cannot be counted for any bread serving at the lunch/supper/dinner meal.

Fruits and Vegetables:

Must serve a Vitamin C source daily and must serve a Vitamin A source every other day, three times a week - refer to the guidelines. Fruits and vegetables supply these nutrients. More than once vitamin source a day is also encouraged.

Use a different combination of two or more servings for the meal service. Use fresh, canned, dried, or frozen vegetables and fruits for lunch/supper/dinner. No sugar may be used in the packaging or preparation of the fruit. Canned or frozen fruit should be packed in juice or water - not syrup or sugar packed.

Vegetables and fruits may be served as combination dishes (i.e., beef stew with meat, potatoes, carrots, English peas, OR shredded carrot salad with diced pineapple).

Avoid serving two forms of the same fruit or vegetable in the same day. Example: an orange and orange juice or an apple and applesauce are combinations that should not be used. **Serve a variety of vegetables and fruits to ensure a nutritionally well-balanced meal.**

It is highly recommended to either serve at least one raw vegetable and two raw fruits per week, for a meal or snack

Limit serving starchy vegetables to once per meal. Starchy vegetables include white/sweet potatoes, lima beans, butter beans, English peas, black-eye peas, field peas, Crowder peas, cream and whole kernel corn, any dried bean/pea (unless counted for a meat alternate).

Vegetables shall be seasoned with powders, spices, and herbs. The use of high sodium/salt and high fat seasonings should be restricted as much as possible.

Small amounts (less than 1/8 cup) of lettuce, tomatoes, onions, relish, catsup, salsa, jams, jellies, or other condiments may be added for flavor or garnish as “other foods,” but do not count as a fruit or vegetable.

Milk:

Milk shall be served at Lunch/Supper/Dinner. The milk shall be pasteurized fluid milk, fortified with vitamin A and D. Whole milk is served to infants and toddlers less than 2 years of age. After age two, skim/fat free milk or 1% milk shall be served. Flavored milk may be served no more than once a week, using flavoring added to whole/skim/fat free milk or 1% milk.

Soymilk may be served when indicated with dietary restrictions.

Provisions must be made to serve calcium in alternate forms when no milk/substitute may be served to the child due to dietary restrictions.

If a child cannot be served milk for medical reasons or upon parent’s instructions, then that child is not to be served high content milk products, e.g., pudding, ice cream, cheese, etc.

All milk equivalent used as a meat alternate must be low in fat.

Water:

Water is to be made available at all meals and snacks. Tap or bottled water may used. Facilities may have water fountains in the classroom or dining area. This water source should be encouraged before and after all meals and snacks and takes the place of water served at the table.

MEAL PATTERNS FOR CHILDREN IN CHILDCARE FACILITIES: SNACK

SNACK -- MUST SELECT TWO OF THE FOUR COMPONENTS, PLUS WATER	AGES 1YR--2YR	AGES 3 YR--5 YR	AGES 6 YR--12 YR

Meat/Meat Alternate	1/2 oz.	½ OZ.	1 oz.
Cooked Meat, No Bone	1/8 c.	1/8 c.	1/4 c.
Cooked Dry Beans/Peas	1/2 oz.	1/2 oz.	1 oz.
Low Fat Cheese	1 small	1 medium	1 medium
Egg	1 Tbsp.	1 Tbsp.	2 Tbsp.
Peanut Butter	2 oz/1/4 c.	2 oz./1/4 c.	4 oz./1/2 c.
Fat Free Yogurt/Cottage Cheese			
Fruit or Vegetable	1/2 c.	½ c.	3/4 c.
Grains/Breads	½ slice	½ slice	½ slice
Enriched, Whole Grain Bread	1/4 c. OR 1/3***o***z.	1/3 c. OR ½ oz.	3/4 c. OR 1 oz.
OR	1/4 c.	1/3 c.	½ c.
Enriched Dry Cereal	1/4 c.	1/3 c.	½ c.

OR

Enriched Hot Cereal

OR

Enriched, Whole Grain Pasta,

Noodles, Rice

Milk (Must be fluid, skim/fat free), or 1% milk)	½ c.	1/2 c.	1 c.
Water	½ c.	1 c.	1 c.

Meat and Meat Alternates:

It is recommended to have at least one meatless meal a week. An alternate for meat could be cooked, dried beans or peas. Cooked dried beans and peas cannot count for a vegetable and meat alternate in the same meal. Canned beans and peas will include the canned kidney, black bean, garbanzo, etc. Note: Canned beans are much higher in sodium/salt.

Edible portion for meats and meat alternates is used. Bone and skin shall not be counted as servings. No bones may be served. Note: 1 once of cooked meat is equal to one medium cooked chicken leg with bone removed.

Processed, pre-fried meats are not allowed due to the sodium/salt and fat content. Meats not allowed include hot dogs, corndogs, bologna, bacon, sausage, pancake sticks, small chicken nuggets, fish sticks, and steak fingers.

Processed cheese, such as cheese spread, canned cheese sauce, and cheese in packaged snack crackers is not allowed. Low fat or fat free cheese would be a meat alternate that is allowed.

For menu variety, use meat, and low fat cheese in combination to equal a full serving portion.

Nuts or seeds *may be used* as a meat alternate for snack time, but is not recommended due to nut/seed allergies prevalent in the youth today.

Bread and Bread Alternates:

Use enriched whole-grain breads and bread alternatives. Whole grain pasta, noodles, brown rice, wheat rolls, and cornbread are encouraged for the lunch/supper/dinner meals.

Bread alternates may include crust used as part of the main dish (i.e. pizza or quiche), dry oatmeal used in a fruit crisp.

Pre-fried items, such as hash browns, French fries, tater tots are not recommended due to the fat and sodium content Any pre-fried item served is limited to once a week. Fresh, “homemade” oven baked fries or wedges would be allowed.

Plain, low sugar type cookies may be served occasionally for a snack component. These cookies may include animal crackers, graham crackers, vanilla wafers, oatmeal, oatmeal raisin, peanut butter, and ginger snaps. Items that may not be served include chocolate chip, most packaged cookies/cakes.

Low fat granola bars, cereal bars, whole grain fruit bars, rice krispie treats may be used for a snack bread component. Packaged crackers with cheese/peanut butter filling are discouraged due to the fat/sodium content. The cheese/peanut butter filling cannot count as a meat serving.

Baked chips, chips, popcorn, hard pretzels, and other low-moisture, high sodium foods cannot meet the bread requirement for a snack. Crackers, cheese and vegetable flavored crackers are allowed. Trail mixs made of various dry, no sugar coated cereals, dried fruits, and small marshmallows are a suggested snack item to meet a bread component.

Fruits and Vegetables:

Use fresh, canned, dried, or frozen vegetables and fruits for snack. No sugar may be used in the packaging or preparation of the fruit. Canned or frozen fruit should be packed in juice or waternot syrup or sugar packed.

Vegetables and fruits may be served as combination dishes (i.e., shredded carrot salad with diced pineapple, fat free yogurt parfait with fresh fruit).

Avoid serving two forms of the same fruit or vegetable in the same day. Example: an orange and orange juice or an apple and applesauce are combinations that should not be used. **Serve a variety of vegetables and fruits to ensure a nutritionally well-balanced meal.**

It is highly recommended to either serve at least one raw vegetable and two raw fruits per week, for a meal or snack. Younger children may have an appropriate substitution due to the choking hazard or the item may be cooked first.

Small amounts (less than 1/8 cup) of lettuce, tomatoes, onions, relish, catsup, salsa, jams, jellies, or other condiments may be added for flavor or garnish as “other foods,” but do not count as a fruit or vegetable.

Juice should not be served as part of the snack when milk is the only other component. It is poor menu planning to offer such a combination since it provides too much liquid for children.

100% Fruit juice is allowed once a day. Vitamin fortified fruit juices, such as apple juice, with extra Vitamin C, will not be recognized as a good vitamin source.

The best time to serve this juice would be at the late 4:30/5:30 p.m., snack period.

Milk:

The milk shall be pasteurized fluid milk, fortified with vitamin A and D. Whole milk is served to infants and toddlers less than 2 years or age. After age two, skim/fat free milk, or 1% milk shall be served. Flavored milk may be served no more than once a week, using flavoring added to whole/skim/fat free milk, or 1% milk.

Soymilk may be served when indicated with dietary restrictions.

Provisions must be made to serve calcium in alternate forms when no milk/substitute may be served to the child due to dietary restrictions.

If a child cannot be served milk for medical reasons or upon parent's instructions, then that child is not to be served high content milk products, e.g., pudding, ice cream, cheese, etc.

All milk equivalents used as a meat alternate must be low in fat.

Water:

Water is to be made available with all meals and snacks. Tap or bottled water may used. Facilities may have water fountains in the classroom or dining area. This water source should be encouraged before and after all meals and snacks and takes the place of water served at the table.

VITAMIN C SOURCES

VITAMIN C SOURCE MUST BE SERVED DAILY

**BEST CHOICE

*GOOD CHOICE

#ACCEPTABLE CHOICE (ONLY COUNT FOR A VITAMIN SOURCE ONCE PER WEEK)

Fruits			**Vegetables**		
Food	Serving Size		Food	Serving Size	
Blackberries	1/4 c.	#	Asparagus	1/4 c.	*
Blueberries	1/4 c.	#	Artichoke	1/4 medium	*
Cantaloupe	1/4 c	**	Bok Choy	1/4 c.	*
Grapefruit	1/4 medium	**	Broccoli	1/4 c.	**
Grapefruit Juice	½ c	**	Brussel Sprouts	1/4 c.	**
Grapefruit-Orange Juice	½ c.	**	Cabbage	1/4 c.	*
Guava	1/4 c.	**	Cauliflower	1/4 c.	*
Honeydew Melon	½ c.	*	Chicory	1/4 c.	*

Kiwi	½ medium	**	Collard Greens	1/4 c.	*
Mandarin Orange Sections	1/4 c.	*	Kale	1/4 c.	#
Mango	1/4 medium	*	Kohlrabi	1/4 c.	**
Melon balls	1/4 c.	*			
Orange	½ medium	**	Mustard Greens	1/4 c.	#
Orange Juice	1/4 c.	**	Okra, not fried	1/4 c.	#
Papaya	1/4 c.	*	Peppers, green & red	1/4 c.	**
Peach, frozen only	1/4 c.	**	Potato, White, or Red Skinned Baked only- no instant/fries/tots	½ medium	*
Pineapple	1/4 c.	#	Rutabagas	1/4c.	#
Pineapple Juice	1/4 c.	*	Snow Peas	1/4 c.	#
Pineapple-grapefruit or orange juice	1/4c.	**	Spinach	1/4 c.	#
Raspberries	1/4 c.	*	Sweet Potato	½ medium	*
Starfruit	1/4 c.	#	Tomato	½ medium	*
Strawberries	1/4 c.	**	Tomato or V-8 Juice	1/4 c.	**
Tangelo	½ medium	**	Turnip Greens	1/4 c.	*
Tangerine	½ medium	**	**Miscellaneous**		
Tropical fruit mix	1/4 c.	*			
Watermelon	½ c.	#	Liver, beef	1 oz.	**

VITAMIN A SOURCES

VITAMIN A SOURCE MUST BE SERVED EVERY OTHER DAY, 3 TIMES PER WEEK

** BEST CHOICE

* GOOD CHOICE

#ACCEPTABLE CHOICE (ONLY COUNT FOR A VITAMIN SOURCE ONCE PER WEEK)

Fruits			**Vegetables**		
Food	Serving Size		Food	Serving Size	
Avocado	1/4 medium	#	Asparagus	1/4 c.	#
Apricot	2 halves	*	Artichoke	½ medium	#
Cantaloupe	1/4 c.	*	Bok Choy	1/4 c.	*
Cherries, red sour	1/4 c.	*	Broccoli	1/4 c.	*
Mandarin Orange Segments	1/4 c.	*	Brussels Sprouts	1/4 c.	*
Mango	1/4 medium	**	Carrots	1/4 c.	**
Melon Balls	1/4 c.	*	Collard Greens	1/4 c.	**
Nectarine	1/4 medium	#			
Papaya	1/4 c.	*	Kale	1/4 c.	**
Peaches	1/4 c.	#	Lettuce, Green, Romaine, or Red NOT Iceberg	½ c.	#
Plantain	1/4 c.	#	Mixed Vegetables	1/4 c.	**
Prunes	1/4 c.	*	Mustard Greens	1/4 c.	**
Tangerine	½ medium	*	Okra, not fried	1/4 c.	#
			Peas & Carrots	1/4 c.	**
			Peppers, red	1/4 c.	**
Miscellaneous			Pumpkin	1/4 c.	**
Egg	1 medium	*	Rutabagas	1/4 c.	#
Liver, beef	1 oz.	**	Spinach	1/4 c.	**

Liver, chicken	1 oz.	**	Sweet Potato	½ medium	**
			Tomato or V-8 Juice	1/4 c.	**
			Turnip Greens	1/4 c.	**
			Winter Squash, Butternut or Hubbard	1/4 c.	**

DENTAL CARE

Dental care is encouraged after each meal service. Parents shall supply toothbrushes and tooth powders or pastes for the child's individual use. Recommendations include replacing the brush every three months or when bristles are bent.

Each toothbrush and powder or paste must be:

- Labeled with the child's full name
- Stored out of children's reach when not in use
- Stored in a manner that prevents the toothbrushes from touching each other during storage

Staff is encouraged to attend trainings on dental care that includes:

- Proper tooth brushing technique as appropriate for the child's age and skills.
- Education to train parents about proper oral healthcare techniques.
- Education for staff and parents to learn the appropriate techniques to feed infants and children that minimize damage to teeth and facial development.

Children must have adult supervision during tooth brushing activities.

Green & Blue

GARDENING AND FRESH PRODUCE

Gardening is an excellent opportunity to incorporate physical activity with nutrition education. Facilities are encouraged to have gardening projects with the children. Produce that is grown in the gardens may be washed and handled properly to allow the items to be served for a snack time or education activity.

Purchasing local produce from Mississippi farmers is one way to offer fresh items to the children. This also helps the local economy and raising families' awareness of food sources. The child care center must ensure the safety of foods served. Steps must be taken to demonstrate reasonable care has been taken to ensure the safety of foods purchased. Steps include: Investigating the local farm and production practices, communicating with the local farmer on the needs of the facility including packaging, delivery, and payment procedures, and promoting the use of local produce with families and the community. There are several resources available to use as a safety checklist, such as the Iowa State University Checklist for Retail Purchasing of Local Produce. The checklist is on the www.Healthyms.com website under Nutrition and Farm

to School and Preschool.

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See Public Playground Safety Handbook. As published by the United States Consumer Product Safety Commission -- *Saving Lives and Keeping Families Safe.*

This document is located at http://www.cpsc.gov/. This document is available only in .pdf format. To read and print a PDF file, you must have Adobe® Acrobat® Reader installed on your PC. You can download a version suitable for your system, free of charge, from Adobe (http://www.adobe.com/).

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15-11-55 APPENDIX E. DISHWASHING PROCEDURE

The best way to wash, rinse, and disinfect dishes and eating utensils is to use a dishwasher with a sanitizing cycle. The final sanitizing rinse of a dishwasher must reach a temperature of 180 degrees. If a dishwasher is not available or cannot be installed, a three-compartment sink will be needed to wash, rinse, and disinfect dishes. A two-compartment or one-compartment sink can be used in child care facilities (located in an occupied residence) licensed for 12 or fewer children by adding one or two dishpans, as needed. In addition to three compartments or dishpans, you will need a dish rack with a drain board to allow dishes and utensils to air dry. To wash, rinse, and disinfect dishes by hand:

- ○ Fill one sink compartment or dishpan with hot tap water and a dishwashing detergent.
- ○ Fill the second compartment or dishpan with hot tap water.
- ○ Fill the third compartment or dishpan with hot tap water and 1-1/2 tablespoons of liquid chlorine bleach for each gallon of water.
- ○ Scrape dishes and utensils and dispose of excess food.
- ○ Immerse scraped dish or utensil in first sink compartment or dishpan and wash thoroughly.
- ○ Rinse dish or utensil in second dishpan of clear water.
- ○ Immerse dish or utensil in third dishpan of chlorinated water for at least 1 minute.
- ○ Place dish or utensil in a rack to air dry.

Note: Food preparation and dishwashing sinks should only be used for these activities and should never be used for routine hand washing or diaper changing activities.

Source: The ABCs of Safe and Healthy Child Care: A Handbook for Child Care Providers, Department of Health and Human Services, U.S. Public Health Service, Centers for Disease Control and Prevention.

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HAND WASHING PROCEDURE

!Always use warm, running water and a mild, preferably liquid, soap. Antibacterial soaps may be used, but are not required. Pre-moistened cleansing toweletts do not effectively clean hands and do not take the place of hand washing.

!Wet the hands and apply a small amount (dime to quarter size) of liquid soap to hands.

!Rub hands together vigorously until a soapy lather appears and continue for at least 15 seconds. Be sure to scrub between fingers, under fingernails, and around the tips and palms of the hands.

!Rinse hands under warm running water. Leave the water running while drying hands.

!Dry hands with a clean, disposable (or single use) towel, being careful to avoid touch the faucet handles or towel holder with clean hands.

!Turn the faucet off using the towel as a barrier between your hands and the faucet handle.

!Discard the used towel in a trash can lined with a fluid-resistant (plastic) bag. Trash cans with foot-petal operated lids are preferable.

!Consider using hand lotion to prevent chapping of hands. If using lotions, use liquids or tubes that can be squirted so that the hands do not have direct contact with container spout. Direct contact with the spout could contaminate the lotion inside the container.

!When assisting a child in hand washing, either hold the child (if an infant) or have the child stand on a safety step at a height at which the child’s hands can hang freely under the running water. Assist the child in performing all of the above steps and then wash your own hands.

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15-11-55 APPENDIX G. PROCEDURE FOR DIAPERING A CHILD

Either of the following two procedures is acceptable in a child care facility for licensing purposes.

Procedure #1

1. Organize needed supplies within reach:

    a. fresh diaper and clean clothes (if necessary)

b. dampened paper towels or premoistened toweletts for Cleaning child's bottom

c. child's personal, labeled, ointment (if provided by parents)

d. trash disposal bag

2. Place a disposable covering (such as roll paper) on the portion of the diapering table where you will place the child's bottom. Diapering surfaces should be smooth, nonabsorbent, and easy to clean. Don't use areas that come in close contact with children during play such as couches, floor areas where children play, etc.

3. If using gloves, put them on now.

4. Using only your hands, pick up and hold the child away from your body. Don't cradle the child in your arms and risk soiling your cloths.

5. Lay the child on the paper or towel.

6. Remove soiled diaper (and soiled clothes).

7. Put disposable diapers in a plastic-lined trash receptacle.

8. Put soiled reusable diaper and /or soiled clothes WITHOUT RINSING in a plastic bag to give to parents.

9. Clean child's bottom with some premoistened disposable toweletts or a dampened, single-use, disposable towel.

10. Place the soiled toweletts or towel in a plastic-lined trash receptacle.

11. If the child needs a more thorough washing, use soap, running water, and paper towels.

12. Remove the disposable covering from beneath the child. Discard it in a plastic-lined receptacle.

13. If you are wearing gloves, remove and dispose of them now in a plastic-lined receptacle.

14. Wash your hands. NOTE: The diapering table should be next to a sink with running water so that you can wash your hands without leaving the diapered child unattended. However, if a sink is not within reach of the diapering table, don't leave the child unattended on the diapering table to go to a sink; wipe your hands with some premoistened toweletts instead. NEVER leave a child alone on the diapering table.

15. Wash the child's hands under running water.

16. Diaper and dress the child.

17. Disinfect the diapering surface immediately after you finish diapering the child.

18. Return the child to the activity area.

19. Clean and disinfect:

a. The diapering area,

b. all equipment or supplies that were touched, and

c. soiled crib or cot, if needed.

20. Wash your hands under running water.

Procedure #2

1. Caregiver washes hands

2. Prepare for diapering by gathering wipes, diaper, plastic bag, clean clothes, gloves and other supplies needed. Bring materials to the diaper changing area but not on the changing table

3. Place child on diapering table. Remove clothing to access diaper. If soiled, place clothes into plastic bag.

4. Remove soiled diaper and place into plastic-lined, hands-free covered trash container. (To limit odor, seal in a plastic bag before placing into trash containers.)

5. Use wipes to clean child's bottom from front to back. Use a fresh wipe for each swipe.

6. If gloves were used, remove at this point.

7. Use a wipe to remove soil from adult's hands.

8. Use another wipe to remove soil from child's hands.

9. Throw soiled wipes into plastic-lined, hands-free covered trash container.

10. Put on clean diaper and redress child.

11. Place child at sink and wash hands using the proper hand washing procedure. Return child to a supervised play area without contaminating any surface

12. Spray the surface of the diapering table with soap-water solution to remove gross soil. Wipe clean using a disposable towel and throw away in a plastic-lined, hands-free covered trash container. Be sure the surface is dried completely.

13. Spray the surface of the diapering table with clear water (recommended). Wipe dry using a disposable towel and throw away in a plastic-lined, hands-free covered trash container.

14. Spray the diapering surface with disinfecting strength bleach-water solution (completely cover table; table should glisten) and wait for 2 minutes before wiping dry with a disposable towel or allow to air dry. Dispose of the towel in a plastic-lined, hands-free covered trash container.

15. Adult washes hands using the proper hand washing procedure.

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15-11-55 APPENDIX H. CLEANING AND DISINFECTION PROCEDURES

Keeping the child care environment clean and orderly is very important for health, safety, and the emotional well-being of both children and providers. One of the most important steps in reducing the number of germs, and therefore the spread of disease, is the thorough cleaning of surfaces that could possibly pose a risk to children or staff. Surfaces considered most likely to be contaminated are those with which children are most likely to have close contact. These include toys that children put in their mouths, crib rails, food preparation areas, and surfaces likely to become very contaminated with germs, such as diaper-changing areas.

Routine cleaning with soap and water is the most useful method for removing germs from surfaces in the child care setting. Good mechanical cleaning (scrubbing with soap and water) physically reduces the numbers of germs from the surface, just as hand washing reduces the numbers of germs from the hands. Removing germs in the child care setting is especially important for soiled surfaces which cannot be treated with chemical disinfectants, such as some upholstery fabrics.

However, some items and surfaces should receive an additional step, **disinfection**, to kill germs after cleaning with soap and rinsing with clear water. Items that can be washed in a dishwasher or hot cycle of a washing machine do not have to be disinfected because these machines use water that is hot enough for a long enough period of time to kill most germs. The disinfection process uses chemicals that are stronger than soap and water. Disinfection also usually requires soaking or drenching the item for several minutes to give the chemical time to kill the remaining germs. Commercial products that meet the Environmental Protection Agency's (EPA's standards for "hospital grade" germicides (solutions that kill germs) may be used for this purpose. One of the most commonly used chemicals for disinfection in child care settings is a homemade solution of household bleach and water. Bleach is cheap and easy to get. The solution of bleach and water is easy to mix, is nontoxic, is safe if handled properly, and kill most infectious agents. (Be aware that some infectious agents are not killed by bleach. For example, cryptosporidia is only killed ammonia or hydrogen peroxide.)

A solution of bleach and water loses its strength very quickly and easily. It is weakened by organic material, evaporation, heat, and sunlight. Therefore, bleach solutions should be mixed fresh each day to make sure it is effective. Any leftover solution should be discarded and the end of the day. NEVER mix bleach with anything but fresh tap water! Other chemicals may react with bleach and create and release a toxic chlorine gas.

Keep the bleach solution you mix each day in a cool place out of direct sunlight and out of the reach of children. (Although a solution of bleach and water mixed as shown in the accompanying box should not be harmful if accidentally swallowed, you should keep all chemicals away from children.)

If a child care facility uses a commercial cleaner, sanitizer, or disinfectant it must be a U.S. Environmental Protection Agency (EPA)-registered product that has an EPA registration number on the label. Such products shall only be used according to the manufacturer's instructions.

NOTE: All EPA-registered products may not be appropriate for use in a child care facility. Therefore, it is the responsibility of the facility to make sure any product use is appropriate for use in a child care facility.

Recipe for Bleach Disinfecting Solution

(For use on non-porous surfaces such as diaper change tables, counter tops, door and cabinet handles toilets, etc.)

1/4 - 3/4 cup bleach 1 gallon of cool water

OR

1 - 3 tablespoon bleach 1 quart of cool water

Apply as a spray or poured fresh solution, not by dipping into a container with a cloth that has been in contact with a contaminated surface.

Add the household bleach (5.25% sodium hypochlorite) to the water.

Recipe for Weaker Bleach Sanitizing Solution

For food contact surfaces sanitizing (dishes, utensils, cutting boards high chare trays), toys that children may place in their mouths, and pacifiers.

1 tablespoon bleach

1 gallon cool water

Add the bleach to the water

Washing and Disinfecting Toys

• Infants and toddlers should not share toys. Toys that children (particularly infants and toddlers) put in their mouths should be washed and disinfected between uses by individual children. Toys for infants and toddlers should be chosen with this in mind. If you cannot wash a toy, it probably is not appropriate for an infant or toddler.

• When an infant or toddler finishes playing with a toy, you should retrieve it form the play area and put it in a bin reserved for dirty toys. This bin should be out of reach of the children. Toys can be washed at a later, more convenient time, and then transferred to a bin for clean toys and safely reused by the other children.

• To wash and disinfect a hard plastic toy:

• Scrub the toy in warm, soapy water. Use a brush to reach into the crevices.

• Rinse the toy in clean water.

• Immerse the toy in a mild bleach solution (see above) and allow it to soak in the solution for 10-20 minutes.

• Remove the toy from the bleach and rinse well in cool water.

• Air dry.

• Hard plastic toys that are washed in a dishwasher or cloth toys washed in the hot water cycle of the hot water cycle of a washing machine do not need to be additionally disinfected.

• Children in diapers should only have washable toys. Each group of children should have its own toys. Toys should not be shared with other groups.

• Stuffed toys used by only a single child should be cleaned in a washing machine every week or more frequently if heavily soiled.

• Toys and equipment used by older children and not put into their mouths should be cleaned at least weekly and when obviously soiled. A soap and water wash followed by clear water rinsing and air drying should be adequate. No disinfection is required. (These types of toys and equipment include blocks, dolls, tricycles, trucks, and other similar toys.).

• Do not use wading pools for children in diapers.

• Water play tables can spread germs. To prevent this:

• Disinfect the table with chlorine bleach solution before filling it with water.

• Disinfect the all toys to be used in the table with chlorine bleach solution. Avoid using sponge toys. They can trap bacteria and are difficult to clean.

• Have all children wash their hands before and after playing in the water table.

• Do not allow children with open sores or wounds to play in the water table.

• Carefully supervise the children to make sure they do not drink the water.

• Discard water after play is over

Washing and Disinfecting Bathroom and Other Surfaces

Bathroom surfaces, such as faucet handles and toilet seats, should be washed and disinfected several times a day, if possible, but at least once a day or when soiled. The bleach and water solution or chlorine-containing scouring powers or other commercial bathroom surface cleaner/disinfectants can be used in these areas. Surfaces that infants and young toddlers are likely to touch or mouth, such as crib rails, should be washed with soap and water and disinfected with a nontoxic disinfectant, such as bleach solution, at least once every day, more often if visibly soiled. After the surface has been drenched or soaked with the disinfectant for at least 10 minutes, surfaces likely to be mouthed should be thoroughly wiped with a fresh towel moistened with tap water. Be sure not to use a toxic cleaner on surfaces likely to be mouthed. Floors should be washed and disinfected at least once a day and whenever soiled.

Washing and Disinfecting Diaper Changing Areas

Diaper Changing Areas should:

• Only be used for changing diapers.

• Be smooth and nonporous, such as Formica (NOT wood).

• Have a raised edge or low ☐fence☐ around the area to prevent a child from falling off.

- Be next to a sink with hot and cold running water.
- Not be used to prepare food, mix formula, or rinse pacifiers.
- Be easily accessible to providers.
- Be out of reach of children.

Diaper changing areas should be cleaned and disinfected after each diaper changer as follows:

- Clean the surface with soap and water and rinse with clear water.
- Dry the surface with a paper towel.
- Thoroughly wet the surface with the recommended bleach solution.
- Wipe dry with a clean disposable towel or air dry. If using a commercial disinfectant/sanitizer, follow labeled manufacturer's instructions.

Washing and Disinfecting Clothing, Linen, and Furnishings

Do not wash or rinse clothing soiled with fecal material in the child care setting. You may empty solid stool into the toilet, but be careful not to splash or touch toilet water with your hands. Put the soiled clothes in a plastic bag and seal the bag to await pick up by the child's parent or guardian at the end of the day. Always wash your hands after handling soiled clothing.

Explain to parents that washing or rinsing soiled diapers and clothing increases the chances that you and the children may be exposed to germs that cause diseases. Although receiving soiled clothes is not pleasant, remind parents that this policy protects the health of all children and providers. Each item of sleep equipment, including cribs, cots, mattresses, blankets, sheets, etc., should be cleaned and sanitized before being assigned to a specific child. The bedding items should be labeled with that child's name, and should only be used by that child. Children shall not share bedding. Infants' linens (sheets, pillowcases, blankets) shall be cleaned and sanitized daily, and crib mattresses shall be cleaned and sanitized weekly and when soiled or wet. Linens from beds of older children shall be laundered at least weekly and whenever soiled. However, if a child inadvertently used another child's bedding, you shall change the linen and mattress cover before allowing the assigned child to use it again. All blankets shall be changed and laundered routinely at least once a week.

Cleaning up Body Fluid Spills

Spills of body fluids, including blood, feces, nasal and eyed discharges, saliva, urine, and vomit shall be cleaned up immediately. Wear gloves unless the fluid can be easily contained by the material (e.g., paper tissue or cloth) that is being used to clean it up. Be careful not to get any of the fluid you are cleaning in your eyes, nose, mouth or any open sores you may have. Clean and disinfect any surfaces, such as counter tops and floors, on which body fluids have been spilled. Discard fluid-contaminated material in a plastic bag that has been securely sealed. Mops used to clean up body fluids should be (1) cleaned, (2) rinsed with a disinfecting solution, (3) wrung as dry as possible, and (4) hung to dry completely. Be sure to wash your hands after cleaning up any spill.

15-11-55 APPENDIX I.

INTRODUCTION

COMMUNICABLE DISEASES/CONDITIONS AND RETURN TO CHILD CARE

Childcare providers frequently must make decisions regarding when children with communicable diseases/conditions should be allowed to attend or return to the out-of-home child care setting (a large child care center or where child care is provided in a private residence for more than one child). We hope the information provided in this booklet will help with these decisions. It contains information about the most common or important communicable diseases/conditions and how they are spread. Information is listed about the different times during which infectious agents may be transmitted from one person to another, and when it is usually safe for someone who has one of these conditions to return to the center. The "return to child care times" are based on the usual period of time that a person is considered to be contagious -- **not** on the period of time that may be necessary for full clinical recovery from the signs or symptoms of an illness which may vary a great deal from person to person.

While **this booklet will serve as a guide** for child care attendance of children with communicable conditions, the Mississippi State Department of Health (MSDH) welcomes the opportunity to help with your decisions. You may contact your district health department office (see district map on page 18) or the Division of Epidemiology at the MSDH in Jackson to speak with a consultant.

***** THIS booklet is NOT intended to be used to DIAGNOSE an illness or infection. It SHOULD NOT REPLACE a diagnosis by trained MEDICAL personnel.*****

GENERAL INFORMATION

Small children who are cared for in out-of-home group settings are at a greater risk of acquiring and spreading a contagious disease. Small children are highly susceptible to contagious diseases since most of them have not been exposed to many of the most common germs and therefore do not have any immunity to them. Young children also have certain habits (e.g., putting their fingers and other objects in their mouths) that can easily spread germs. Even though contagious diseases/conditions will occur in a child care setting, the child care provider must do everything he or she can to prevent and control the spread of disease. **The use of common sense hygienic practices, especially frequent and thorough hand washing cannot be stressed enough!** Also, making sure that staff and children are up to date on their immunizations helps to lessen the risk of exposure to contagious diseases.

Reportable diseases: There are 4 classes of reportable diseases. Class I diseases are those of major public health importance and are to be reported upon first knowledge or suspicion and are usually reported by the physician, hospital or laboratory. However, the MSDH encourages child care providers who know of a child in their facility who has been diagnosed with a disease such as meningitis or measles to report it to the Health Department. This can sometimes help to expedite the investigation. Class II diseases may require public health intervention also, especially if there are several cases in one room (e.g., diarrheal diseases such as shigella and giardia).

When a Class I reportable disease is reported to the MSDH, there will be an investigation. The immediacy of the response by the MSDH and the extent of the investigation depends on the disease the person has. For example, if a child has been reported to have meningococcal meningitis, an investigation would take place as soon as the report is received. It is the goal of the MSDH to provide preventive medication to those for whom it would be indicated within 24 hours of receiving the report. A current list of the reportable diseases is provided in Appendix B of the Child Care Rules and Regulations.

Outbreaks/parental permission for laboratory tests: During times when there are outbreaks of *Giardia, Shigella* infection, etc., large numbers of stool specimens may be requested by the MSDH. The MSDH recommends that child care facilities obtain permission from parents or guardians at the time of enrollment for the child care facility to collect these stool specimens and receive the laboratory results if and when such an outbreak occurs. These laboratory tests would be done by the MSDH Laboratory free of charge. The laboratory test results would be sent to

the child care facility and given to the parents/guardians by the child care facility for them to give to the child's physician. (See sample permission slip on page 17)

Handouts: It is good practice to keep parents informed as to what diseases might be occurring in the child care facility so that they can be alert to signs and symptoms of diseases and observe their children for them. We have provided a packet with fact sheets/handouts on certain diseases for you to give to parents.

CHILD CARE IMMUNIZATION REQUIREMENTS (FOR ATTENDEES AND STAFF)

ATTENDEES

The MSDH regulations governing the licensure of child care facilities mandate that each child in a licensed facility have immunizations according to the recommended immunization schedule. These children are to be **age-appropriately immunized** and must have a Certificate of Immunization Compliance (Form 121) or a Certificate of Medical Exemption (Form 122) on file at the child care facility and readily accessible for review by the MSDH. The Form 121 must be signed by the District Health Officer, a physician, nurse or designee. The medical exemption, Form 122, **MUST** be signed by the District Health Officer. Children enrolled in licensed child care facilities and public and private schools in Mississippi may be exempt for *medical reasons only* and not for religious reasons.

Children usually begin their routine immunizations between 6 weeks and 2 months of age. The immunizations that are currently **required** at the age-appropriate times for child care are: DTaP (diphtheria, tetanus, pertussis), polio, MMR (measles, mumps, rubella), and HIB (*H. Influenzae* type b). Hepatitis B vaccine is a recommended vaccine, and is usually started at birth to 2 months of age. Hepatitis B is **not required for child care** attendance but **is required for entry into 5 year old kindergarten.**

As of August 01, 2002, one (1) dose of Varicella (chicken pox) vaccine is required on or after the 1st birthday and is required for entry into five (5) year-old kindergarten. Varicella is not required if a history of the disease is documented.

Children enrolled in a licensed child care facility or Head Start Center are expected to be age appropriately immunized. All children must have one of the following forms before enrollment in a licensed Child Care/Head Start facility.

1. Certificate of Immunization Compliance (Form 121). This form must be signed by the District Health Officer, a physician, nurse or designee.

2. Certificate of Medical Exemption (Form 122). This form must be approved and signed by the Mississippi Department of Health District Health Officer from the public health district or the State Epidemiologist.

STAFF

Anyone (whether full or part-time and even if they are the owner/director) who works in a licensed child care facility must have a Certificate of Immunization Compliance (Form 121) or a Certificate of Medical Exemption from Immunization Requirements for Adults (Form 132) on file and readily accessible for review by the MSDH. The requirement for adults is that they must show proof of immunity to **measles** (rubeola or "red" measles) and **rubella** ("German" or "3-day" measles).

Proof of immunity to measles: Persons born prior to 01-01-1957 are assumed to have natural immunity to measles. Persons born on or after 01-01-1957 must show proof of immunity in one of the following ways:

1. A **physician's statement** saying that the person has had measles disease.

2. **Serological (a blood test)** confirmation of measles immunity.

3. A record of **2 doses** of measles-containing vaccine (usually given as MMR) given on or after the first birthday and on or after 01-01-1968. There must be a minimum time interval of 30 days between the 2 doses.

Proof of immunity to rubella: All child care workers, **regardless of age**, must show proof of immunity to rubella in one of the following ways:

1. **Serological (blood test)** confirmation of rubella immunity.

2. A **rubella vaccination** received on or after 12 months of age and on or after 01-01-1969.

The MSDH does not provide serological testing for measles and rubella for the purpose of child care/school attendance or private employment. Those who wish to have a blood test for proof of immunity to measles and/or rubella should see their private physician.

The Child Care Licensure Division of the MSDH checks the immunization records in child care facilities during regular program reviews. District Immunization Representatives also visit child care centers on a random basis to inspect the immunization records of the children and the employees. The purpose of these visits is to verify the presence of the Certificates of Immunization Compliance. These visits also help to ensure adequate immunization of children enrolled in child care facilities.

EXCLUSION CRITERIA

Small children can become ill very quickly. The child care provider should observe each child's health throughout the time the child is in their care. If the child care provider observes signs and symptoms of illness that would require removal from the facility, he/she should contact the parents/guardians to have the child picked up and continue to observe the child for other signs and symptoms. **If the child is not responding to you, is having trouble breathing, or is having a seizure or convulsion, call 911.**

The following conditions require exclusion from child care:

Fever: Defined as 100°F or higher taken under the arm, 101°F taken orally, or 102°F taken rectally. For children 4 months or younger, the lower rectal temperature of 101°F is considered a fever threshold.

Diarrhea: Frequent (3 or more episodes in a 24-hour period) runny, watery, or bloody stools. **According to CDC recommendations, a child who is not toilet trained and has diarrhea should be excluded from child care settings regardless of the cause.**

Vomiting: Two or more times in a 24-hour period

Rash: Body rash with a fever

Sore throat: Sore throat with fever and swollen glands

Severe coughing: The child gets red or blue in the face or makes high-pitched whooping sound after coughing.

Eye discharge: Thick mucus or pus draining from the eye

Jaundice: Yellow eyes and skin

Irritability: Continuous irritability and crying

CHICKENPOX (VARICELLA)

Chickenpox is a highly infectious viral disease that begins with small red bumps that turn into blisters after several hours. The blisters generally last for 3-4 days and then begin to dry up and form scabs. These lesions (bumps/blisters) almost always appear first on the trunk rather than the extremities.

Mode of transmission: Airborne droplets of nose and throat secretions coughed into the air by someone who has chickenpox. Also by direct contact with articles freshly soiled with discharge from the blisters and/or discharge from the nose and mouth (e.g., tissues, handkerchiefs, etc.).

Notification: Notify parents/guardians and staff members that a case of chickenpox has occurred, especially those parents whose child is taking steroid medications, being treated with cancer or leukemia drugs or has a weakened immune system for some reason. Staff members who are pregnant and have never had chickenpox disease or the chickenpox vaccine should consult their physician immediately. A special preventive treatment may be indicated for those with a weakened immune system and non-immune pregnant women. This treatment must be given **within 96 hours** of the exposure to be effective.

Vaccine: As of August 01, 2002, one (1) dose of Varicella (chicken pox) vaccine is required on or after the 1st birthday and is required for entry into five (5) year-old kindergarten. Varicella is not required if a history of the disease is documented.

Return to child care: Once the diagnosis has been made, determine the day that the blisters first appeared. The child may return to child care on the 6th day after the blisters first appeared or earlier if all the lesions are **crusted and dry and no new ones are forming.** Keeping the child home until all the lesions are completely healed is unnecessary and results in excessive absences.

SHINGLES (VARICELLA ZOSTER)

Shingles (varicella zoster) is a reactivation of the chickenpox virus (varicella). After the initial infection with chickenpox, the virus continues to lie dormant (inactive) in a nerve root. We tend to think of the elderly and immunosuppressed individuals as the ones who have shingles; however, it can and does occur sometimes in children. The lesions or blisters of shingles resemble those of chickenpox and usually appear in just one area or on one side (unilateral) of the body and run along a nerve pathway. A mild shingles-like illness has been reported in healthy children who have had the chickenpox vaccine. This is a rare occurrence.

Mode of transmission: It is possible for someone who has never had chickenpox disease or the vaccine to get chickenpox by coming in contact with the fluid from the lesions of someone who has shingles. Shingles itself is not transmissible. A person who has shingles does not transmit chickenpox through the air as does someone who has chickenpox disease.

Return to child care: The child who has shingles may attend child care if the lesions can be covered by clothing. If the lesions cannot be covered, the child should be excluded until the lesions are crusted and dry. Staff members who have shingles pose little risk to others since the lesions would be covered by clothing or a dressing on exposed areas. **Thorough hand washing** is warranted whenever there is contact with the lesions.

NOTE: Staff members, especially those who are pregnant, who have no history of chickenpox disease or chickenpox vaccine, should not take care of children with shingles during the time they have active or fluid-filled lesions.

CYTOMEGALOVIRUS (CMV)

CMV is a viral illness that most people become infected with during childhood. Small children usually have no symptoms when they become infected, but older children may develop an illness similar to mononucleosis with a fever, sore throat, malaise or feeling very tired and an enlarged liver.

Mode of transmission: CMV is spread from person to person by direct contact with body fluids such as urine, saliva or blood. The virus can also be passed from the mother to the baby before birth.

Pregnancy: Rarely, a woman may contract the disease for the first time during pregnancy which may pose a risk to the fetus causing certain birth defects. CDC recommends that women who are child care providers and who expect to become pregnant should be tested for antibodies to CMV and if the test shows no evidence of previous CMV infection, they should reduce their contact with infected children by working, at least temporarily, with children 2 years of age and older where there is less circulation of the virus. Also, they should avoid kissing an infected child on the lips, and as with any child care situation, **wash hands** thoroughly after each diaper change and contact with a child's saliva. If contact with children does not involve exposure to saliva or urine, there should be no fear of potential infection with CMV.

Return to child care: There is no need to exclude children with CMV from child care as long as they do not have a fever since the virus may be excreted in urine and saliva for many months and may persist or there may be recurring episodes for several years following the initial infection. CMV is a virus that may persist as a latent infection and recur when a person becomes immunosuppressed with conditions such as cancer, AIDS, etc.

DIARRHEAL DISEASES (e.g., campylobacteriosis, cryptosporidiosis, giardiasis, rotavirus, salmonellosis, shigellosis) - See *E. coli* O157:H7 and Hepatitis A sections for specific return-to-child-care recommendations regarding these 2 diseases.

Diarrhea is defined as frequent (3 or more episodes within a 24 hour period), runny, watery stools and can be caused by different types of organisms such as viruses, bacteria and parasites.

Mode of transmission: Diarrheal diseases are generally transmitted or spread by ingesting food or water or by putting something in the mouth such as a toy that has been contaminated with the feces (stool/poop) of an infected person or animal. In some cases such as with *Salmonella* and *E. coli* O157:H7, the disease is transmitted by eating raw or undercooked meats (especially ground beef and poultry) and unpasteurized milk and fruit juices.

Notification: Notify parents/guardians of children in the involved room of the illness. Ask that they have any child with diarrhea, severe cramping or vomiting evaluated by a physician and that they inform the day care of diarrheal illness in their child and family.

Outbreak situation: Most diarrheal diseases are reportable to the State Department of Health. When there are 2 or more cases of a diarrheal disease in one room, more extensive notification may need to be done as stool specimens may need to be collected. In this case, the director of the child care should consult with the Public Health District Epidemiology Nurse or the Division of Epidemiology at the State Department of Health. (See Public Health District Map on page 18 for addresses and telephone numbers)

Return to child care: In most cases, a child may return to child care after a diarrheal illness once he or she is **free of fever** and the **diarrhea has ceased**.

***E.COLI* O157:H7**

Escherichia (E.) coli bacteria are found in the intestines of most humans and many animals. These infections are usually harmless. However, certain strains of the bacteria such as the O157:H7 can cause severe illness. Some persons who are infected with *E. coli* O157:H7 may have a mild disease while others develop a severe, bloody diarrhea. In some cases, the infection may cause a breakdown of the red blood cells which can lead to HUS or hemolytic uremic syndrome.

Mode of transmission: *E. coli* O157:H7 is usually the result of eating undercooked meat, especially hamburger. There have also been cases reported from drinking **unpasteurized** apple juice. Person-to-person transmission may

occur by contact with the feces or stool of an infected person.

Notification: Notify the staff and parents/guardians that a case of *E. coli* O157:H7 has occurred and ask that they have their child evaluated by a physician if they have diarrhea, especially bloody diarrhea. *E. coli* O157:H7 is a Class I reportable disease and a follow-up investigation will be done by the Health Department.

Return to child care: The **infected child should not be in or allowed to return to a child care center until his/her diarrhea has ceased and 2 consecutive negative stool samples are obtained** (collected not less than 24 hours apart and not sooner than 48 hours after the last dose of antibiotics).

FIFTH DISEASE (ERYTHEMA INFECTIOSUM)

This is an infectious disease characterized by a “slapped-face” (redness) appearance of the cheeks followed by a rash on the trunk and extremities.

Mode of transmission: Person-to-person spread by direct contact with nose and throat secretions of an infected person. Transmission of infection can be lessened by routine hygienic practices which include hand washing and the proper disposal of facial tissues containing respiratory secretions.

Notification: Notify parents/guardians and staff members that fifth disease is occurring in the child care facility. Staff members who are pregnant should consult their obstetrician if children in their room have fifth disease.

Return to child care: Children with fifth disease may attend child care if they are **free of fever**, since by the time the rash begins they are no longer contagious. The rash may come and go for several weeks.

“FLU” (INFLUENZA)

Influenza is an acute (sudden onset) viral disease of the respiratory tract characterized by fever, headache, muscle aches, joint pain, malaise, nasal congestion, sore throat and cough. Influenza in children may be indistinguishable from diseases caused by other respiratory viruses.

Mode of transmission: Direct contact with nose and throat secretions of someone who has influenza - airborne spread by these secretions coughed into the air.

Return to child care: The child may return to child care when **free of fever** and feeling well. The closing of individual schools and child care centers has not proven to be an effective control measure. By the time absenteeism is high enough to warrant closing, it is too late to prevent spread.

HAND-FOOT- AND- MOUTH DISEASE

This is a common childhood disease caused by a strain of coxsackievirus. In some people, the virus causes mild to no symptoms. In others, it may result in painful blisters in the mouth and on the palms of the hands and the soles of the feet.

Mode of transmission: The virus can be spread through saliva from the blisters in the mouth and from the fluid from the blisters on the hands and feet. It is also spread through the feces or stool of an infected person.

Notification: Notify parents/guardians and staff that there are cases of hand-foot-and-mouth disease in the child care facility so that they can be alert to the signs and symptoms.

Return to child care: The virus may be excreted in the stool for weeks after the symptoms have disappeared. **Children who have blisters in their mouths and drool or who have weeping or active lesions/blisters on their hands should be excluded from child care until the lesions are crusted and dry and the child is free of fever.**

HEAD LICE

This is an infestation of the scalp by small “bugs” called lice. They firmly attach egg sacs called “nits” to the hairs, and these nits are difficult to remove. Treatment may be accomplished with prescription or over-the-counter medicines applied to the scalp.

Mode of transmission: Direct contact with an infested person’s hair (head-to-head) and, to a lesser extent, direct contact with their personal belongings, especially shared clothing and headgear. Head lice do not jump or fly from one person to another, but they can crawl very quickly when heads are touching.

Notification: When a case of head lice occurs in a room, notify the parents/guardians that a case of head lice has occurred. Check the other children in that room for head lice and if found, notify their parents/.guardians that the child needs treatment. Ask the parents/guardians to be alert to anyone in their family who may have signs and symptoms of head lice (e.g., excessive itching of the scalp, especially at the nape of the neck and around the ears) so that they may also receive treatment.

Infants and children less than 2 yrs. of age: It is a rare occurrence for children in this age group to have head lice. It is generally not recommended to treat this age group prophylactically or just because someone else in the family has been treated. If a child of this age is found to have head lice, the parent/guardian should consult the child’s physician for treatment recommendations.

Return to child care: The child may return to child care after the first treatment has been given. **(See Attachment A - “Recommendations for the Control of Head Lice in the Child Care Setting”)**

HEPATITIS A

This is an infectious viral disease characterized by jaundice (yellowing of the eyes and skin), loss of appetite, nausea, and general weakness. Child care centers can be a major source of hepatitis A spread in the community. This is because small children usually do not show any specific signs and symptoms of the disease. Symptomatic illness primarily occurs among adult contacts of infected, asymptomatic children.

Mode of transmission: Hepatitis A virus is found in the stool of persons infected with hepatitis A. The virus is usually spread from person to person by putting something in the mouth that has been contaminated with the stool of an infected person; for this reason, the virus is more easily spread under poor sanitary conditions, and when good personal hygiene, **especially good handwashing**, is not observed. Rarely, the virus is contracted by eating raw seafood (e.g., raw oysters) that has been collected from contaminated waters.

Notification: Notify the staff and parents/guardians that a case has occurred. Hepatitis A is a Class I reportable disease. A follow-up investigation will be done by the MSDH to determine who in the center may need to receive preventive treatment.

Return to child care: The child may return to child care one week after the onset of jaundice (yellowing of the eyes and skin) or one week after the onset of other signs and symptoms if no jaundice is present.

HEPATITIS B

Hepatitis B is a viral disease that affects the liver. It is a contagious condition characterized by loss of appetite, abdominal discomfort, jaundice (yellowing of the eyes and skin), joint aches, and fever in some cases. It is different from Hepatitis A. There should not be any risk of exposure to hepatitis B in a normal child care setting unless a child who is infected with hepatitis B is bleeding. Also, since the hepatitis B vaccine is now a part of the routine immunization schedule, more and more children should be immune.

Mode of transmission: The most common mode of transmission is through having sex with someone who has the virus; however, it can be transmitted when infected blood enters the body through cuts, scrapes or other breaks in the skin. Injecting drug users are at risk when they share needles with an infected person. It is also possible for infected pregnant women to transmit the virus to their babies during pregnancy or at delivery.

If an exposure to a person who is infected with hepatitis B has occurred, the person exposed should be referred to

his/her physician since hepatitis B vaccine and hepatitis B immune globulin may be indicated. **Since hepatitis B and HIV/AIDS are both transmitted through blood exposure, the precautionary measures for HIV/AIDS would also apply to hepatitis B. (See HIV/AIDS section below)**

HEPATITIS C

Hepatitis C is also a viral disease that affects the liver. Again, hepatitis C should pose no risk of exposure in the normal child care setting unless the infected child is bleeding. There is no vaccine available for hepatitis C at this time. **Since it is also transmitted through blood exposure, the same precautionary measures for hepatitis B and HIV/AIDS would be apply to hepatitis C. (See HIV/AIDS section below)**

HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION/ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

Mode of transmission: The most common mode of transmission is through having sex with someone who has the virus; however, it can be transmitted when infected blood enters the body through cuts, scrapes or other breaks in the skin. Injecting drug users are at risk when they share needles with an infected person. It is also possible for infected pregnant women to transmit the virus to their babies during pregnancy or at delivery. Although HIV and hepatitis B are transmitted in the same way, HIV is much more difficult to transmit from one person to another than hepatitis B.

HIV infection in children causes a broad spectrum of disease manifestations and a varied clinical course. Children with HIV infection should be monitored closely by their physician. They are more susceptible to infectious diseases than other children. Parents of children known to have HIV infection should be notified when certain infectious diseases occur in the child care facility. There is no vaccine available for HIV at this time. According to CDC, HIV is not likely to be spread from one child to another in the child care setting and no case has ever been reported. Parents or guardians of HIV-positive children should inform the child care director of their child's HIV status.

Because of concern over stigmatization, the person aware of a child's HIV infection should be limited to those who need such knowledge to care for the children in the child care setting. In a situation where there is concern of possible exposure of others to the blood or body fluids of an infected person, CDC recommends that a team including the child's parents or guardians, the child's physician, public health personnel, and the proposed child care provider evaluate the situation to determine the most appropriate child care setting. The team should weigh the risks and benefits to both the infected child and to others in the child care setting.

It should always be remembered that there those who are known to be infected with HIV, hepatitis B and C and other blood borne diseases, but on the other hand there are those we do not know about and some people are not even aware themselves that they may have an infectious blood borne disease. Therefore, we must always employ universal precautions (treating everyone's blood as though it is infectious) when dealing with blood and body fluids. There is no evidence that HIV, hepatitis B or hepatitis C is transmitted through tears, perspiration, urine or saliva unless these body fluids contain visible blood.

Child care providers should be prepared to handle blood and blood-containing body fluids using the principles of universal precautions. Supplies of gloves, disposable towels and disinfectants should be readily available.

The Mississippi State Department of Health is available for consultation in these situations.

IMPETIGO

This is a contagious skin disease characterized by spreading pustular lesions (sores with pus) and should receive medical treatment. This is quite important to avoid the risk of complications involving the heart and kidneys.

Mode of transmission: Skin-to-skin contact with the sores.

Return to child care: The child may return to child care 24 hours after treatment has been started if free of fever and the lesions are not draining.

MEASLES

Measles is a serious viral infection characterized by a rash (red, flat lesions) starting on the head and neck, which enlarge and coalesce (run together), and spread to the trunk, then to the extremities. Other symptoms include a high fever, conjunctivitis (red, inflamed eyes), cough and nasal congestion. The Health Department must be notified on first suspicion. With our present immunization laws, measles is a rare occurrence today. It is imperative, however, that immunization records be kept current.

Mode of transmission: Direct contact with nose and throat secretions of an infected person. May be airborne by droplets of these secretions coughed into the air. Tiny droplets can be suspended in the air for two hours or more. Measles is very easily spread.

Notification: Notify staff and parents/guardians that a case has occurred. Measles is a Class I reportable disease and there will be a follow-up investigation by the Health Department. Parents of children with weakened immune systems (those being treated for cancer, leukemia or taking steroid medication, etc.) should consult their child's physician and keep the child out of the center until after the investigation by the Health Department and it is considered safe for them to return.

Return to child care: The child may return to child care when free of fever and the rash is fading (this usually takes 5-7 days).

MENINGITIS

Meningitis is an inflammation or infection of the meninges (the membranes that cover the brain and spinal cord). Meningitis can be caused by a variety of organisms or germs. Most people exposed to these germs do not develop meningitis or serious illness. Some people may carry a particular germ and have no symptoms at all. Anyone exhibiting signs and symptoms of meningitis (e.g., severe headache, fever, vomiting, stiffness and pain in the neck, shoulders and back, drowsiness) should seek medical attention promptly.

Meningitis is a reportable disease. The Department of Health evaluates each case individually to determine what public health intervention, if any, might be required. The two types of meningitis that require public health intervention most often are caused by the organisms *Haemophilus influenzae* type b (HIB) and *Neisseria meningitidis* (meningococcal).

Mode of transmission: These germs are most commonly spread by direct contact with nose and throat secretions from a infected person.

Notification: Notify parents/guardians that a case has occurred and to have their children evaluated by a physician should they have any of the signs or symptoms listed above.

Return to child care: The child may return to the center whenever he or she has been released by his/her personal physician.

MUMPS

Mumps is an infectious disease that is characterized by swelling and pain of the salivary glands. **Mode of transmission:** Person-to-person spread by direct contact with the saliva of an infected person.

Return to child care: The child may return to child care 9 days after the beginning of the salivary gland swelling.

"PINK EYE" (CONJUNCTIVITIS)

This is an infectious disease characterized by redness of the eye(s), excessive tearing, itching, and discharge. Some cases may require antibiotics; therefore, the child should see a physician.

Mode of transmission: Contact with discharges from the eye, nose or throat of an infected person. Also, from

contact with fingers, clothing and other articles that have been contaminated with the discharge.

Return to child care: Children may return to child care after they have seen a physician or when the redness/discharge is improving.

PINWORMS

Pinworms are tiny worms that live in the large intestine and can cause anal itching, sleeplessness and irritability. They may also be present without any symptoms. Pinworms occur worldwide and affect all socioeconomic classes. They are the most common worm infection in the United States. Prescription medication must be obtained to treat the infection.

Mode of transmission: Pinworms can be spread when an uninfected person touches the anal area of an infected person and then puts their hands/fingers in their mouth. They can also be spread when an infected person scratches the anal area and then contaminates food or other objects that are touched or eaten. Pinworms can be spread as long as the worms or the eggs are present.

Return to child care: The child may return to child care **24** hours after they have received the first treatment. Employ **thorough hand washing** especially before eating and after toilet use and change and wash any bed linens and towels in hot water that have been used for those children. Ask the parents/guardians to do the same at home. Also, discourage children from scratching the anal area.

RESPIRATORY SYNCYTIAL VIRUS (RSV)

RSV can cause an upper respiratory disease like a cold or a disease of the lower respiratory tract such as pneumonia. It is the most common cause of lower respiratory tract infections and pneumonia in infants and children under the age of 2. Almost 100% of children in child care programs get RSV during the first year of life. This usually occurs during outbreaks in the winter months. RSV can range from a very mild disease to life-threatening.

Mode of transmission: Direct contact with nose and throat secretions of an infected person. A young child can be infectious with RSV 1 to 3 weeks after signs and symptoms have subsided.

Return to child care: Most of the time a child is infectious before signs and symptoms appear. An infected child does not need to be excluded from child care unless he/she has a fever and/or is not well enough to participate in the activities. Make sure that **procedures pertaining to hand washing, proper disposal of tissues and disinfection of toys are followed.**

RINGWORM

Ringworm is a skin infection caused by a fungus that can affect the scalp, skin, fingers, toe nails and feet. Ringworm anyplace except on the scalp or under the nails can be successfully treated with several over-the-counter medicines. Ringworm of the scalp is characterized by inflammation, redness, and hair loss and does not respond to over-the-counter medicines; therefore, the child should see his/her physician.

Mode of transmission: Direct skin-to-skin contact or indirect contact (e.g., toilet articles such as combs and hair brushes, used towels, clothing and hats contaminated with hair from infected persons or animals).

Notification: When the lesions (red, circular places) are found, notify the parent/guardian that the child needs treatment.

Return to child care: The child may return to child care after the treatment has been started. Treatment for ringworm of the scalp and nails usually lasts for several weeks. Strict infection control measures should be taken (e.g., blankets, towels or anything that is used on the infected child should not be used on another child, make sure that staff caring for these children **practice good handwashing** and that disinfecting procedures are followed.

SCABIES

Scabies is a disease of the skin caused by a mite. The mite burrows beneath the skin and causes a rash that is usually found around finger webs, wrists and elbows. The rash may appear on the head, neck and body on infants. Any child with evidence of severe itching especially in these areas should be referred to his/her physician. Scabies requires treatment by prescription drugs.

Mode of transmission: Direct skin-to-skin contact with an infested person. Transfer of the mites from undergarments and bedclothes can occur, but only if contact takes place immediately after the infested person has been in contact with the undergarments and bedclothes.

Notification: Notify parents/guardians and staff that scabies has occurred in the facility so that they can be alert to signs and symptoms and seek treatment.

Return to child care: The child may return to child care 24 hours after the treatment has been completed. It must be noted that itching may continue for several days, but this does not indicate treatment failure or that the child should be sent home.

"STREP THROAT" (STREPTOCOCCAL PHARYNGITIS) & SCARLET FEVER

Strep throat is a communicable disease characterized by sore throat, fever, and tender, swollen lymph glands in the neck. The child should see a physician to obtain prescription medication; this is quite important to avoid the risk of complications involving the heart and kidneys. **Scarlet fever** is a streptococcal infection with a rash (scarlatinaform rash). It is most commonly associated with strep throat. In addition to the signs and symptoms of strep throat, the person with scarlet fever has an inflamed, sandpaper-like rash and sometimes a very red or "strawberry" tongue. The rash is due to a toxin produced by the infecting strain of bacteria. The treatment and exclusion criteria for scarlet fever would be the same as for strep throat.

Mode of transmission: Direct or indirect contact (e.g., contaminated hands, drinking glasses, straws) with throat secretions of an infected person.

Return to child care: The child may return to child care **24** hours after treatment has been started **if free of fever**.

TUBERCULOSIS (TB)

Mode of transmission: Airborne droplets of respiratory secretions coughed or sneezed into the air by a person with active TB disease.

Notification: TB is a class one reportable disease. If a child or a staff member in a child care facility is diagnosed with active TB, the MSDH will conduct an investigation. The MSDH will notify the facility and the parents/guardians of the type of follow-up that will be necessary.

Return to child care: Persons diagnosed with TB infection are evaluated by the Mississippi State Department of Health on an individual basis. Those who have a positive TB skin test *only* may attend child care since they have no disease process that is contagious. **Persons suspected of or diagnosed with active TB disease will need written permission from the Mississippi State Department of Health Tuberculosis Control Program to return to the center.**

Small children are highly susceptible to contracting TB disease, but do not transmit the disease as easily as an older child or adult. Children who do not have active TB disease, but who have been exposed to an active case in their household are considered high risk contacts and are placed on preventive medication. These children may attend child care since they are not infectious.

WHOOPING COUGH (PERTUSSIS)

Pertussis or whooping cough is a contagious disease characterized by upper respiratory tract symptoms with a cough, often with a characteristic inspiratory (breathing in) whoop.

Mode of transmission: Direct or indirect contact (contaminated articles) with nose and throat secretions of an infected person. Airborne transmission can also occur by droplets of these secretions coughed into the air.

Notification: Notify parents/guardians that a case has occurred. Pertussis is a class one reportable disease. The Health Department will conduct an investigation to determine those who may need preventive treatment.

Return to child care: The child may return to child care 5 days after their treatment has begun.

PERMISSION TO COLLECT STOOL SPECIMENS AND RECEIVE TEST RESULTS

If and when an outbreak of diarrheal diseases such as giardiasis, salmonellosis, shigellosis, etc. occurs in a child care facility, the Mississippi State Department (MSDH) investigates and may request that stool specimens be collected. In an outbreak situation, the stool specimen collection bottles are provided by the MSDH and the tests are done in the MSDH Lab free of charge. The collection bottle, with instructions, would either be given to the parent/guardian to collect the stool specimen or it may need to be collected at the child care facility. The child care facility would receive the test results and recommendations would be made by the MSDH. The test results would be given to the parents/guardians by the child care facility and the parents/guardians should give them to their child's physician.

I give my permission for (name of child care facility) to collect stool specimens from (name of child) when it is recommended by the MSDH and also for them to receive the test results. I understand that I will receive a copy of the test results and be informed of the recommendations made by the MSDH.

Date

Parent/Guardian

ATTACHMENT - A

RECOMMENDATIONS FOR THE CONTROL OF HEAD LICE IN THE CHILD CARE SETTING

Head lice, *Pediculus humanus capitis*, are a common problem in children who attend child care in Mississippi. Although they do not transmit any human disease, they may be a considerable nuisance, and require conscious effort on the part of the child care staff and parents to control. **It should be understood that head lice can only be controlled in the child care center, not eliminated; they will occur sporadically, and will recur even after control efforts. The goal of control efforts is to reduce the problem and its impact, and minimize spread.**

Head lice are not a product of poor personal hygiene or lack of cleanliness, and their presence is not a reflection on the child care center or the family. More harm is probably caused by misconceptions about head lice than by the lice themselves.

1. IDENTIFYING INFESTED CHILDREN

By Screening: It is important to establish a screening program. Children should be screened for head lice upon entry into the child care setting and periodically during the year. Staff members should be instructed in the technique of detecting head lice.

By Individual Case: Any child suspected of having head lice (usually because he/she is scratching his/her head a lot) should be examined by a staff member who has been instructed in the technique.

If infested, the child should be handled as described in Section 2, "HANDLING OF INFESTED CHILDREN."

If one child in a room is found to be infested, the whole room should be screened.

2. HANDLING OF INFESTED CHILDREN

Exclusion: An infested child's parent/guardians should be notified that the child has been found to have head lice and must receive the proper treatment before returning to child care. Treatment and removal of nits are described in Section 3, "TREATMENT." Care must be taken not to embarrass or stigmatize the child.

Return to Child Care: The child should return to the child care center as soon as the first treatment has been given. **Nits (eggs) may still be seen even in an adequately treated child. This is not evidence of continuing infestation if the child has been properly treated and no adult lice are present.**

3. TREATMENT

Individual: Several effective pediculicides (lice-killing products) are available such as Nix®* (permethrin) creme rinse (10 minute hair rinse) which is available over the counter and has ovicidal (egg or nit-killing) capability. It is the only over-the-counter pediculicide covered by Medicaid. The pyrethrin/pyrinate products (10 minute shampoos) include such products as Rid®*, A-1000®*, R&C®*, Clear®* and Triple-X®* and are available over the counter at pharmacies. Kwell®* (1% lindane), a 4 minute shampoo, requires a prescription. Central nervous system toxicity with lindane has been documented with prolonged administration. Ovide®* lotion (Malathion 0.5%) has been re-approved by the Food and Drug Administration (FDA) as a prescription drug for the treatment of head lice infestation in the United States. Treatment with any approved pediculicidal (lice-killing) product should be adequate.

One Treatment vs. Two Treatments: Most products require 2 treatments. An initial treatment will kill adult and larval lice, but will not kill all the eggs. **A second treatment 7 to 10 days later, after the eggs left by the first treatment have all hatched, will kill the newly hatched lice before they mature and reproduce and will complete the treatment process.** Nix®* requires only one treatment since it is an ovicidal (also kills the eggs or nits); however, a second treatment is desirable since the product is not likely to kill 100% of the nits. Ovide®***** lotion is also ovicidal and requires a second treatment 7 to 10 days after the first one **only** if crawling lice are seen.

Retreatment: Pediculicides should kill lice soon after application. However, in some situations (e.g., a person is too heavily infested, pediculicide is used incorrectly, reinfestation or possible resistance to the medication), the lice may still be present. Immediate retreatment with a **different class or type** of pediculicide is generally recommended if live lice are detected on the scalp 24 hours or longer after the initial treatment.

Treatment of Infants and Children Less Than 2 Years of Age: It is a rare occurrence for children in this age group to have head lice. It is generally not recommended to treat this age group preventively or just because someone else in the family has been treated. If a child of this age is found to have head lice, the parent/guardian should consult the child's physician for treatment. The safety of head lice medications has not been tested in children 2 years of age and under.

Removal of nits: The need to remove nits is somewhat controversial. However, removing the nits may prevent reinfestation by those nits hatching that may have been missed by the treatment. It may also decrease confusion about infestation when the person who has been treated is being re-examined for the presence of head lice, and it will avoid possible embarrassment to the infested child. Nits may be removed by the use of a nit comb or by manually ("nit-picking") removing them. Most of the nits that are easily seen and more easily removed with the nit comb are those that are grayish-white in color, have grown out one or more inches on the hair shaft and have already hatched. The new, viable nits are closer to the scalp (within about 1/4 inch) and are more of a brownish color. These nits are firmly attached to the hair shaft with a glue-like substance. There are commercial products available to help loosen the glue-like substance for easier removal.

Family: Household members of a child with head lice should be examined for lice (by a family member who knows how or someone else knowledgeable about lice) and any infested persons treated as described above. **The one exception is any person over 2 years of age who shares a bed with the infested child should simply be treated presumptively.** If the child is less than 2 years of age, consult the child's physician for treatment recommendations.

4. ENVIRONMENTAL CONTROL

Child Care Facility/Household: Clothing, cloth toys, and personal linens (such as towels and bedclothes used within the previous 48 hours by an infested person) can be disinfected by washing in hot water and drying in the dryer using hot cycles. Non-washables should be dry cleaned, or stored in airtight plastic bags for 2 weeks. Spraying with insecticides is **NOT** recommended. Fumigants and room sprays can be toxic if inhaled or absorbed through the skin. If there are cloth surfaces, such as furniture or carpet, with which the infested person's hair has had extensive contact, they should be **vacuumed** thoroughly. The head louse will not survive off the human scalp for more than 24 - 48 hours.

Questions about control methods, specific treatments, or special problems can be addressed to the local health department, the district public health office, or to the Office of Community Health Services - Division of Epidemiology, State Department of Health in Jackson.

(*Use of specific product names is for example purposes only, and is not intended as endorsement of specific brands over others.)

SAMPLE LETTER TO PARENTS/GUARDIANS

Dear Parent or Guardian:

Your child _____ has been found to have head lice. Head lice do not transmit disease and they are not a result of lack of cleanliness. Children in child care settings get them commonly, sometimes more than once.

You should consult a pharmacist or your child's physician for a recommendation as to which of several effective products to use to treat your child. **As soon as you have treated your child with an approved pediculicidal (lice-killing) product, he or she may return to child care.**

There are 3 steps in the successful management of head lice:

1. Treatment (killing the lice with an approved medical treatment) - It is very important to follow the instructions given by your physician when using prescription medication. If you use over-the-counter medication, you should follow the package directions. The other members of your family should be checked for head lice and treated if they are found to have them. Persons over 2 years of age who sleep in the same bed with the infested child should be treated regardless. If a child less than 2 years of age is found to have head lice, consult the child's physician for treatment recommendations.

2. Removal of the nits - The Mississippi State Department of Health recommends that you attempt to remove the nits to avoid reinfestation by those nits hatching that may have been missed by the treatment. The nits can be removed by dividing the hair into sections and working each section separately. Look for small grayish-white or yellowish-brown specks that are attached to the hair shaft close to the scalp. Nits are attached to the hair shaft very firmly with a glue-like substance and are not easily brushed out. They must be picked out with the fingernails or combed with the nit comb that usually comes with the lice-killing product. This can be done outdoors under bright sunlight or indoors with a good reading lamp as nits are sometimes hard to see.

3. Environmental control - Clothing and personal linens (such as towels and bedclothes used by infested persons) should be machine washed using hot water and dried using the hot cycle. Non-washables can be dry cleaned or stored in an airtight plastic bag for 2 weeks. Cloth-covered furniture and carpet that have been in extensive contact with an infested person's head should be thoroughly vacuumed. Lice-killing sprays are generally not necessary.

Signature: Date