Health and Safety Plan

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Appendices

ALL ABOUT KIDS HEALTH AND SAFETY PLAN

All personnel, administrative, clerical, and providers, (employees or independent contractors) are mandated to comply with all health and safety and sanitation practices set forth by the approving NY State and local Early Intervention programs and ALL ABOUT KIDS' Health & Safety Plan, as appropriate. This is mandated regardless of authorized setting (home and community, school-based services or service at ALL ABOUT KIDS Treatment Centers), and regardless of programs served (EIP, CPSE, CSE, Private Pay), as appropriate.

ALL ABOUT KIDS must inform any employees/contractors delivering services on their behalf regarding NYSDOH health and safety standards and agency health and safety policies and procedures. This information must be provided prior to the employee providing services. Agency employees/contractors must be provided a copy of the agency health and safety policies and procedures, and must receive training on health and safety requirements. Employees/contractors must be notified on a timely basis when modifications to NYSDOH EI health and safety standards and agency health and safety policies and procedures are made. Documentation must be maintained in employee personnel files that these requirements have been met. Upon completion of training, a certificate of training will be issued to the provider and a copy of the certificate maintained in provider's personnel file.

HOME SETTING:
A home setting is defined as the child's or caregiver's home. Providers are responsible to observe and report any unsafe conditions in the home setting. If the provider determines the home setting may pose potential harm to children, the provider must immediately contact an ALL ABOUT KIDS supervisor/manager to assist and provide educational resource information for the parent if needed (see Appendix R). An alternate setting must be used immediately in the event that a home setting poses an imminent health and safety risk, and an ALL ABOUT KIDS manager/supervisor must contact the EIO or school district to report this risk.

FACILITY SETTING:
In ALL ABOUT KIDS's facility settings, evaluation of standards compliance will be accomplished by direct inspection and observation. ALL ABOUT KIDS will complete the **IPRO "Quality Improvement Monitoring Review - Self-Assessment Tool Facility-Based Providers "** and **Home/Community Based Providers survey (see Appendices N & U)** of The Treatment Center and the **Nassau County Health and Safety Checklist (see Appendix S)** two times annually for each site. These reviews will be completed by an assigned manager, regional director, director, assistant director, or clinical supervisor by direct observation and inspection. If as a result of the inspection, or at any time during the year, the manager, provider or office staff views or identifies a health and safety problem, they are to take immediate and appropriate action as outlined in this policy manual. Results of the inspection must be reported to the head office manager/director of the office and executive directors.

COMMUNITY SETTING:
A community setting is defined within the EIP as a setting in which children under three years of ages are typically found. Examples of community settings include libraries, YMCA's, or day care centers (a community setting for a preschooler within CPSE does not include daycares).

EARLY INTERVENTION COMMUNITY HEALTH & SAFETY SURVEY

It is required that each individual provider servicing an EI Child assess the safety of those community settings accessed and used on a regular basis, and those settings where a parent/caregiver will not be present during service delivery, through the use of The Department of Community Health & Safety Survey, (Appendices O and P). The provider can be accompanied by a parent, if they are interested and available to observe the community site. If the parent is not available to accompany the provider when the assessment is completed, the provider may collaborate with the parent to discuss the results of the assessment if it is not appropriate for the provision of services. The parent is not required to be present.

It is required that the survey describing the date and results of the survey (on indication of daycare license) are submitted to ALL ABOUT KIDS for review and filing. If there is any situation identified as an immediate threat or risk and requires immediate attention, the individual provider must immediately contact an administrator at ALL ABOUT KIDS who will contact the EIO to discuss immediate corrective action plan.

Day Care

The only exemption for completion of the Community Survey is if the site is a licensed day care center certified by either OCFS or the NY City Bureau of Day Care. If the location where EI services are provided is a licensed day-care center, the community survey does not need to be completed; however, if the community site is not located at the same premises as the licensed day care facility, the community survey must be completed.

Library or Church/Synagogue

If services are offered at a library or church/synagogue, the Community Health & Safety survey must be completed.

Playgrounds

If the playground is at a licensed day care center certified by either OCFS or the NYC Bureau of Day Care a Community Health & Safety Survey does not need to be completed. A Community survey will need to be completed for all other playgrounds.

ALL SETTINGS:

Individual providers are to always document their actions related to the above in their session logs (i.e., completing survey, providing parent with health and safety information, contacted ALL ABOUT KIDS manager/supervisor regarding at risk conditions, etc.)
All, ALL ABOUT KIDS managers/supervisors must document all their contacts and actions regarding the above.

Individual therapists are only allowed to provide sessions at locations authorized in the child's IFSP or IEP and known and authorized by ALL ABOUT KIDS. **In particular, this applies to location other than the child's home, daycare/school or ALL ABOUT KIDS Treatment Centers.**
Absolutely no individual therapist working for ALL ABOUT KIDS is permitted to provide sessions for ALL ABOUT KIDS' in their own home, home office, or own professional office.

I. Admissions

A. Admissions Policy

ALL ABOUT KIDS admits and services children from the ages of birth to 21 without regard to race, culture, sex, religion, national origin, ancestry, or disability. The program will accommodate children with special needs consistent with the requirement of the American with Disabilities Act, and the child's Individual Family Service Plan/Individual Education Plan.

B. Enrollment

Prior to the child's services, ALL ABOUT KIDS must receive the following information and forms. The information in these forms will remain confidential and will be shared with team providers and authorized personnel, as required, to meet the needs of the child:

i. ***Child Health Assessment***

No child may have a completed evaluation or enter into an ALL ABOUT KIDS therapy program without:

- An up to date physical exam in accordance with the American Academy of Pediatrics on file at ALL ABOUT KIDS. The child's Health Assessment will prominently list relevant medical conditions.

- A certificate of immunization prepared by a physician or other authorized person who administered the immunization that specifies the products administered, the dates of administration, and the physician-verified history of measles, mumps and other diseases.

OR

- The official New York State immunization record card completed by the administering physician or health care facility.

- During the IFSP/IEP evaluation process, ALL ABOUT KIDS can provide the parent/guardian with a medical physical exam for their child at no cost to the family, if needed.

Once a child is in an ALL ABOUT KID'S Therapy Program:
Child's schedule of immunizations ***must be kept current with annual updates*** while attending a developmental group on ALL ABOUT KIDS sites**.**

ii. **Child's IFSP/IEP and Most Recent Evaluations and/or Progress Reports:**

ALL ABOUT KIDS is to distribute copies of above to each provider to ensure coordination of program.

Confidentiality of information about the child and family will be maintained. All information concerning the child and family will be maintained in each child's chart and will be accessible only to the parent or legal guardian and authorized ALL
ABOUT KIDS personnel, child's therapy team providers, members of child's IFSP/IEP committee, and designated state and county program auditors.

Information concerning the child will not be released to additional people by any means, without the express written consent of the parent or legal guardian. (See confidentiality section of Policy and Procedures.)

CHILDREN WITH HIV INFECTION and ACCESS TO EARLY INTERVENTION SERVICES

Medical conditions such as HIV-Infection, HIV Related Illness, or AIDS (hereafter referred to as HIV Infection) do not in and of themselves generally constitute a basis for a referral to Early Intervention services. Services for children with HIV – Infection, as well as for other children, should be based on the individual child's developmental status. However, unless medical documentation provided by a child's treating physician precludes the child's participation, a child with HIV – Infection is not to be restricted from Early Intervention services. All information regarding the child's/family's HIV status will be kept confidential in compliance with Federal laws.

***Policy*:** CONFIDENTIALTY OF HIV STATUS INFORMATION

Article 27 of the New York State Public Health Law strictly protects the confidentiality of information about people who have HIV-Infection, or who have considered undergoing HIV testing. In accordance with this law, Early Intervention providers are obligated to maintain the confidentiality of this information if learned during the course of providing service so as to ensure that the person is not discriminated against as a result of his/her HIV positive status. As such, the identity of any child with HIV infection cannot be disclosed without specific consent to release of such protected information by the parent or legal guardian. The information may not be disclosed verbally or contained in any written record (e.g., evaluation, progress reports, etc.)

***Procedure*:**

Consent for the disclosure of HIV confidential information can only be obtained by completion of the "Authorization for Release of Confidential HIV Related Information Form" (EIP-INFEC-1). This form must be fully completed by the parent or legal guardian and must include the following information:

- Name of person whose HIV-Related information will be released.
- Name and address of person signing release.
- Relationship to person whose HIV information will be released.
- Name and address of person who will be given HIV-Related information.
- Reason for release of HIV-Related information.
- Length of time during which release is authorized.
- Release may be withdrawn at any time.

- If during the course of a meeting with a child's parent or legal guardian a child's HIV status is disclosed, the Initial Service Coordinator will keep this information confidential.
- If a medical report or evaluation is received that discloses a child's HIV status that information will be included in the child's record only if the information is accompanied by an appropriate "Authorization for Release of Confidential HIV-Related Information" form that permits the disclosure of this information to the NYC Early Intervention Program. All providers will be informed of the NYC Early Intervention HIV policy.
- If information regarding a child's HIV status is included in his/her record, accompanied by a previously completed "Authorization for Release of Confidential HIV-Related Information", that information will not be disclosed to any party without a new release being executed by the child's parent or legal guardian if the previously completed release was not properly executed by the parent or legal guardian. The information will be redacted from the child's record before the record is released.

II. Supervision

A. Supervision of Children

- Children must be supervised at all times by sight throughout the therapy session by provider.
- No child can be released by ALL ABOUT KIDS personnel to any person other than his or her parent, or legal guardian, or to the same adult that brought the child for service on site to ALL ABOUT KIDS that same day; or child's assigned teacher at a childcare or school site.
- Visitors are required to sign in and identify their purpose for being in the facility. Visitors are to be given a visitor name tag to wear when entering the treatment center.

1. Home Based Services/On Site ALL ABOUT KIDS Center:

A parent/legal guardian or an adult (over 18 years of age) must be present in the home or remain on site at ALL ABOUT KIDS for the entire length of the treatment session. The provider may not ask any other person (except child's designated teacher in a school) to watch a child, no matter how short the time.

2. *School Based Services:*

The provider may not ask any other person (except a child's teacher in a school) to watch a child, no matter how short the time. A provider may not agree to stay in a child's classroom to oversee a class while a teacher steps out, no matter how short a time. A provider may not take other children from the classroom during a pull out session with a child unless the children are also authorized to receive services from the same provider. A provider may not transport (i.e. by car, bus, etc.) a child or family at any time to another location. If a child is authorized to receive services in the community, the provider is to meet the child and parent/legal guardian at the location.

B. Child: Staff Ratios

Child: staff ratios followed by this program will always comply with the authorized ratios on the child's IFSP/IEP.

C. Family/Therapist Partnership

ALL ABOUT KIDS is committed to encouraging partnership between parents, therapists, community agencies and schools. As an agency, we acknowledge that parents are constant in a child's life and know their child best.

Our agency's greatest successes in providing services are always the result of our parents and therapists working together in partnership with a strong parent involvement.

Parent involvement is crucial in achieving desired outcomes. Family involvement is expected in therapeutic sessions. The therapist will coach parents and design therapeutic activities that parents/caregivers can practice during family routines.

III. Discipline

A. Philosophy of Discipline

Providers will equitably use positive guidance, redirection, planning ahead to prevent problems, encouragement of appropriate behavior, consistent clear rules, where the child understands words, discipline will be explained to the child before and at the time of any disciplinary action. Providers will encourage children to respect other people, to be fair, and respect property. Aggressive physical behavior toward staff or children is unacceptable. Providers will intervene immediately when a child becomes physically aggressive to protect all of the children and encourage more acceptable behavior. Providers will use discipline that is consistent, clear, and understandable and developmentally appropriate to the child and always in compliance with Federal, State and local regulations and AAK SED approval in 'Guidelines for Behavior Intervention Plans'.

B. Permissible Methods of Discipline

For acts of aggression and fighting (e.g., biting, hitting) providers will set appropriate expectations for children and guide them in solving problems. This positive guidance will be the usual technique for managing children with challenging behaviors rather than punishing them for having problems they have not yet learned to solve. In addition, the following are guidelines for a crisis intervention for aggressive or self-injurious behaviors:

If a child has a temper tantrum, where he/she reacts aggressively or engages in self-injurious behavior (i.e. head banging, throwing objects, etc.):

- Group Therapy: Separate the children involved. This may mean escorting other children out of a therapy room and asking an adult to monitor those children escorted out. Call for assistance and ask for the parent/caregiver of the tantrum child to be summoned to the room. If the student engages in injurious behaviors to self or others, document incident on ALL ABOUT KIDS'

"Behavior Emergency Intervention Incident Report" (see Appendix H. 1), which needs to be completed by the staff member who initiated the Emergency Behavior Intervention with the student. Directly contact ALL ABOUT KIDS' Clinical Supervisor immediately following incident and submit the "Behavior Emergency Intervention Incident Report" incident report to ALL ABOUT KIDS within 24 hours. The parent/caregiver of the student must be notified when an Emergency Intervention has been used with his/her child. ALL ABOUT KIDS' Post Intervention Emergency Intervention Analysis and Debriefing" Form (Appendix H. 2) must always be completed the following day after the Emergency Behavior Intervention and must also submit to the designated ALL ABOUT KIDS' Clinical Supervisor. Within two (2) days after the Emergency Behavior Intervention, the ALL ABOUT KIDS' Clinical Supervisor must schedule an internal IEP team meeting to review the Behavior Emergency Intervention report and determine the need for a Functional Behavior Assessment (FBA) and/or need for an interim plan. See ALL ABOUT KIDS' Guidelines for Behavioral Interventions Supports for Service Providers on how to complete an FBA & BIP and for all related forms.

- On Site: Close the door and block the doorway with your body to prevent the child from exiting the room. Do not lock the door or leave child in the room unattended. Call for assistance and ask for the parent/caregiver of the child to be summoned to the room. Document incident on ALL ABOUT KIDS" "Behavior Emergency Intervention Report" (BEIRs) (Appendix H. 1) and the required follow-up on ALL ABOUT KIDS' "Post Intervention Emergency Intervention Analysis and Debriefing" Form (Appendix H. 2). Providers must notify the student's parent/caregiver and the designated ALL ABOUT KIDS' Clinical Supervisor immediately after any incident.

- All Therapies:
    - Remove all object(s) from the child's reach.
    - Tuck in necklaces and ties (to prevent child from grabbing them) and remove dangling earrings and all rings.
    - Remain calm – speak calmly to the child – do not argue with the child or raise your voice.
    - Attempt to distract the child with another activity or preferred toy/game.
    - If child is engaging in head banging behavior, remove the child from the vicinity – do not allow child to continue to bang his/her head on the hard surface, i.e. wall, floor, table.
    - If the child exhibits self-injurious behavior, the provider must adjust the immediate environment to meet the health and safety of the child and prevent injury.
- School setting: Assist the classroom staff in ensuring the safety of the child, staff and other children present. Coordinate with the classroom teacher on classroom or building wide behavioral interventions. Classroom teacher should be intervening with assistance from therapist if necessary

- Permissible discipline includes such interventions as voice control, limited to loud, firm commands; time-limited ignoring of a specific behavior; token fines as part of a token economy system; brief physical prompts to interrupt or prevent a specific behavior; interventions medically necessary for the treatment or protection of the student; or other similar interventions.
- Emergency interventions must be used only in situations in which alternative procedures and methods not involving the use of physical force cannot reasonably be employed. Only providers who are certified providers will apply the "Handle With Care Behavior Management System" to deescalating a crisis situation. Certified Providers will assess the severity of the crisis, determine the appropriate level of support (i.e., support, limit setting, or physical intervention), and execute the plan after collaborating with staff/parents, as applicable. See Emergency Intervention Policy for more details.

If there is no behavior management program in the child's IFSP/IEP, but the child shows a pattern of disruptive behaviors, the provider is required to contact the designated ALL ABOUT KIDS' Clinical Supervisor to discuss the child's overall behavior.

If it is determined that the child needs an amended program, an ALL ABOUT KIDS' Clinical Supervisor (i.e., OT, PT, SP, and/or ABA Supervisor) is to contact the child's IFSP/IEP team members and the child's OSC (EIP) for the purpose of submitting a request for an EI/CPSE/CSE team meeting to discuss the potential need for a Functional Behavior Assessment (FBA) and Behavior Intervention Plan (BIP). If at the EI/CPSE/CSE meeting the team (including child's providers, authorizing EIP representative and/or CPSE/CSE Chairperson, and parent or guardian) decides an FBA/BIP is necessary, the team must obtain written parental consent before beginning the FBA. All FBA/BIPs will be conducted by a BCBA, Licensed Behavior Analyst (LBA), Licensed Psychologist or other professional as designated by the local municipality. See ALL ABOUT KIDS' Guidelines for Behavioral Interventions Supports for Service Providers on how to complete an FBA & BIP and for all related forms.

C. Prohibited Practices (Child Abuse)

i. *<u>Corporal Punishment</u> (Please see below the NYS Prohibition of Corporal Punishment)*

Prohibition of Corporal Punishment 8 NYCRR §§19.5(a) and 100.2(l)

- State regulations prohibit the use of corporal punishment against a student by a teacher, administrator, officer, employee or agent of a school district in this State, a board of cooperative educational services (BOCES), a charter school, State-operated or State-supported school, an approved preschool program, an approved private school, an approved out-of-State day or

residential school, or a registered nonpublic nursery, kindergarten, elementary or secondary school in this State.

Corporal punishment means any act of physical force upon a pupil for the purpose of punishing that pupil, except as otherwise provided below.

- In situations in which alternative procedures and methods not involving the use of physical force cannot reasonably be employed, nothing contained in the regulations must be construed to prohibit the use of reasonable physical force for the following purposes: to protect oneself from physical injury; to protect another pupil or teacher or any person from physical injury; to protect the property of the school, school district or others; or to restrain or remove a pupil whose behavior is interfering with the orderly exercise and performance of school or school district functions, powers and duties, if that pupil has refused to comply with a request to refrain from further disruptive acts.
- Each school district and BOCES is required to submit a written semiannual report to the Commissioner of Education that reports each complaint about the use of corporal punishment received by the local school authorities during the reporting period, the results of each investigation, and the action, if any, taken by the school authorities in each case. Information on complaints about the use of corporal punishment by public schools, BOCES or Charter schools, is available at: http://www.p12.nysed.gov/sss/ssae/schoolsafety/CorplPunish/CorporalPunishment.html

ii. *Aversive Interventions- (Please see below NYS Prohibition of the Use of Aversive Interventions)*

ALL ABOUT KIDS prohibits the use aversive interventions and restraint. The use of high chairs for purposes other than feeding is also prohibited as it is considered restraint.

Prohibition of Use of Aversive Interventions 8 NYCRR §§19.5(b) and 200.22(e)

- State regulations prohibit the use of aversive interventions to reduce or eliminate maladaptive behaviors of a student by a public school, BOCES, charter school, approved preschool program, approved private school, State-operated or State-supported school in this State, approved out-of-State day or residential school, or registered nonpublic nursery, kindergarten, elementary or secondary school in this State, except as provided pursuant to §200.22(e) and (f) of the Regulations of the Commissioner of Education relating to a child-specific exception to use aversive interventions to reduce or modify student behaviors and program standards for the use of aversive interventions. Only those students whose individualized education programs (IEPs) include a recommendation for aversive interventions as of June 30, 2009 may be granted a child-specific

exception to the prohibition on the use of aversive interventions in each subsequent school year after June 30, 2009, unless the student's IEP is revised to no longer include such exception.

- Aversive intervention means an intervention that is intended to induce pain or discomfort to a student for the purpose of eliminating or reducing maladaptive behaviors, including such interventions as: contingent application of noxious, painful, intrusive stimuli or activities; any form of noxious, painful or intrusive spray, inhalant or tastes; contingent food programs that include the denial or delay of the provision of meals or intentionally altering staple food or drink in order to make it distasteful; movement limitation used as a punishment, including but not limited to helmets and mechanical restraint devices; or other stimuli or actions similar to the interventions described above.
- The term does not include such interventions as voice control, limited to loud, firm commands; time-limited ignoring of a specific behavior; token fines as part of a token economy system; brief physical prompts to interrupt or prevent a specific behavior; interventions medically necessary for the treatment or protection of the student; or other similar interventions.

iii. *Exclusionary Time Out*

Regardless if the location of services is in an educational setting or the child's home, ALL ABOUT KIDS will only utilize Non-Exclusionary Time Out whereas the child remains in the instructional setting but is temporarily prevented from engaging in reinforcing activities. Examples include planned ignoring, and removal of reinforcing objects or activities.

All forms of Exclusionary Time Out are prohibited:

- Contingent Observation - The student is removed from the instructional setting to another part of the classroom or home. The student is instructed to continue to watch the instructional activities, but cannot otherwise participate in them.
- Exclusion - The student is removed from the instructional setting to another part of the classroom or home. The student is prevented from watching or otherwise participating in group activities (with adult supervision).
- Isolation/Seclusion - The student is removed from the instructional setting to a separate time-out room (with adult supervision).

If an ALL ABOUT KIDS' provider is working in a school where Time Out Rooms are utilized it is up to the school staff to ensure that the school is implementing these procedures appropriately and effectively. ALL ABOUT KIDS' providers are not to be involved in the implementation of these procedures. Please be advised of the NYS Use of Time Out Rooms guidelines included below. If you have any questions about the techniques used at your particular school placement please contact an ALL ABOUT KIDS' Office Administrator.

iv. *Use of Time Out Rooms 8 NYCRR §200.22(c)*

A time out room is an area for a student to safely deescalate, regain control and prepare to meet expectations to return to his or her education program. Time out rooms are to be used in conjunction with a behavioral intervention plan in which a student is removed to a supervised area in order to facilitate self-control or to remove a student from a potentially dangerous situation and as provided below.

- Except for unanticipated situations that pose an immediate concern for the physical safety of a student or others, the use of a time out room can only be used in conjunction with a behavioral intervention plan that is designed to teach and reinforce alternative appropriate behaviors.
- Each school which uses a time out room as part of its behavior management approach must ensure that the school's policy and procedures on the use of the time out room are developed and implemented consistent with §200.22(c) of the Regulations of the Commissioner of Education, including the physical and monitoring requirements, parental rights and IEP requirements for students with disabilities.
- The school's policy and procedures must minimally include: prohibiting placing a student in a locked room or space or in a room where the student cannot be continuously observed and supervised; factors which may precipitate the use of the time out room; time limitations for the use of the time out room; staff training on the policies and procedures related to the use of time out room; data collection to monitor the effectiveness of the use of time out rooms; and ƒ information to be provided to parents.
- A student's IEP must specify when a behavioral intervention plan includes the use of a time out room for a student with a disability, including the maximum amount of time a student will need to be in a time out room as a behavioral consequence as determined on an individual basis in consideration of the student's age and individual needs.
- The school district must inform the student's parents prior to the initiation of a behavioral intervention plan that will incorporate the use of a time out room for a student and must give the parent the opportunity to see the physical space that will be used as a time out room and provide the parent with a copy of the school's policy on the use of time out rooms.
- The physical space used as a time out room must meet certain standards. The room must provide a means for continuous visual and auditory monitoring of the student and be of adequate width, length and height to allow the student to move about and recline comfortably. Wall and floor coverings should be designed to prevent injury to the student, and there must be adequate lighting and ventilation.
  The temperature of the room must be within the normal comfort range and consistent with the rest of the building. The room must be clean and free of objects and fixtures that could be potentially dangerous to a student and must meet all local fire and safety codes. The time out room must be unlocked and

the door must be able to be opened from the inside. The use of locked rooms or spaces for purposes of time out or emergency interventions is prohibited.

- Staff must be assigned to continuously monitor the student in a time out room. The staff must be able to see and hear the student at all times.
- The school must establish and implement procedures to document the use of the time out room, including information to monitor the effectiveness of the use of the time out room to decrease specified behaviors.

D. Suspected Child Abuse & or Maltreatment

ALL ABOUT KIDS does not tolerate or in any manner condone an act of abuse or maltreatment by any personnel, volunteer, or any other person. All observations or suspicions of child abuse or neglect will be immediately reported to the Child Protective Services agency no matter when the abuse might have occurred. The provider/personnel, regardless if he/she is a mandated reporter or not, will call the **Child Abuse/Maltreatment Hotline (1-800-342-3720)** to report suspected abuse or neglect. That same person will follow the direction of the **Child Protection Services Agency** regarding completion of written reports. **(Appendix A: CPS Form)** Reporters of suspected child abuse will not be discharged for making the report unless it is proven that a false report was knowingly made. Personnel who are accused of child abuse may be suspended or given leave without pay pending investigation of the accusation. No accusation or affirmation of guilt will be made until the investigation is complete.

Providers/personnel found guilty of child abuse will be summarily dismissed or relieved of their duties. Please refer to http://www.ocfs.state.ny.us/main/cps/ for frequently asked questions and clarification.

i. How to Report Abuse: (Complete Steps 1 and 2)

1. Notify CPS Organization

- ***In New York State:***

  The provider or personnel who observed the abuse or signs of abuse must report the case of suspected child abuse immediately. Reports of suspected child abuse or maltreatment should be made immediately at any time of the day and on any day of the week, by a mandated reporter or ALL ABOUT KIDS personnel by telephone to the New York Statewide Central Register of Child Abuse and Maltreatment (sometimes referred to as the State Central Register or SCR.) The telephone number is **CHILD ABUSE HOTLINE 1-800-342-3720.**

  If the allegation involved abuse by a non-family member, notify the Special Victims Squad of the local police department by telephone.

- ***Outside of New York State:***

  To report a case of child abuse or neglect, call the **National Child Abuse Hotline (800) 4-A-CHILD.**

To report a case of online child sexual exploitation, harassment, or solicitation notify the Special Victims Squad of the local police department and call the

National Center for Missing and Exploited Children (800) 843-5678 or contact them at www.cybertipline.com.

2. For All Instances of Abuse:

Contact ALL ABOUT KIDS

The provider must inform ALL ABOUT KIDS immediately of the suspicion and action taken.

ALL ABOUT KIDS manager is to immediately notify the local program authorities including the administration of the Early Intervention Program (EIP) at the Regional Department of Health including the OSC and/or EIOD (Early Intervention Official Designee) or CPSE/CSE administrations of the school district. ALL ABOUT KIDS manager is to immediately contact Cathy/Mike Grossfeld.

Who Are Mandated Reporters:

New York State Education laws of 1988 require that some health and school professional, as mandated reporters must complete the required courses in "Training in the Identification and Reporting of Child Abuse and Neglect." Those mandated reporters are:

- Physicians and Surgeons
- Hospital Personnel, Residents and Interns
- Christian Science Practitioners
- School Officials
- Social Service Workers and Foster Care Workers
- Residential Care Custodians, Service Providers and Child Care Workers
- Family and Group Day Care Providers and Child Care Workers
- Psychologists and Mental Health Professionals
- Peace officers, Police Officers, District Attorneys and Law Enforcement Officials **(Appendix B: Summary Guide for Mandated Reporters in New York)**

SCR Personnel Requirement:

All personnel being considered for hire as personnel and volunteers at ALL ABOUT KIDS who have the potential for regular and substantial contact with the children serviced by ALL ABOUT KIDS must complete an application for the State Central Register of Child Abuse and Maltreatment (SCR) to verify and screen if he/she is the subject of an indicated report of child abuse or maltreatment. This screening by ALL ABOUT KIDS will take place prior to unsupervised contact with children.

ALL ABOUT KIDS must review and maintain documentation of database checks completed. If notice is received from the SCR that a person is the subject of an indicated report of child abuse or maltreatment, ALL ABOUT KIDS will seek appropriate counsel for making a determination as to whether to hire an applicant for employment; retain a current employee; enter or continue a contract; engage a volunteer; or, hire a consultant who will have the potential for regular and substantial contact with children receiving Early Intervention services. Guidelines for evaluating persons who are the subjects of indicated

reports of child abuse and maltreatment have been developed for use by the NYS Office of Children & Family Services and will be utilized in decision making.

All SCR letters as well as current licenses, and approval letters must be on file for employees and contractors. Annual medical examinations are required for all employees and contractors stating that there is no communicable disease or disorder preventing them from working with children.

IV. Exclusion of Ill Children/Providers from Services

A. Exclusion of Ill Children from Services

- Parents/legal guardians are asked to cancel therapy sessions if their child has a communicable disease or fever within the last 24 hours.
- Whether a child is seen at home, school community, or on site at ALL ABOUT KIDS a provider may decide to not provide services to a child if they observe symptoms in a child that require exclusion.

The decision to exclude a child from service is based on the following reasons:

1. The child's illness prevents child from participating comfortably in activities.
2. On site groups: The illness requires more care than the provider is able to provide without compromising the needs of other children in the group.
3. The illness if any of the specifically diagnosed conditions listed in **(Appendix C Exclusion/Readmission Due to Illness.)**

B. What to Do If a Child Requires Exclusion from Service

On Site at ALL ABOUT KIDS:

- Immediately separate the child from the other children in such a way that the child can be seen and supervised and does not feel punished in anyway.

All Sites and Providers:

- Speak to the parent about the child and the need for the session to end for the child and ask the parent to take the child to a health care provider. The purpose of the provider's communication with the parent at this time is to get more information on the child's condition, as well as request the parents to notify ALL ABOUT KIDS regarding the recommendation from the health care provider when the child can return.
- **Appendix D: Suspected Illness or Communicable Disease Exclusion Form:** may be used for parents for this communication. If the child experiences a significant medical issue, a medical clearance and/or renewed OT/PT prescription or medical clearance for feeding therapy must be requested prior to returning to therapy.
- If the child does not respond to you, is having trouble breathing, or is having a seizure call 9-1-1.
- Document your actions in the child's log notes with date, time, symptoms, actions taken, by whom add your signature.

- Contact ALL ABOUT KIDS office administrator immediately. ALL ABOUT KIDS Program Director is to ensure that a medical clearance and/or renewed PT/OT Rx or medical clearance for feeding therapy is obtained for child's return to therapy. Program Director is to follow protocol for reporting communicable diseases. (See below)

C. Provider Illness/Emergencies/Inability to Provide Services

Providers must contact family to cancel sessions if they have a communicable disease or fever, [personal emergency or other] and arrange for a makeup session. Providers must notify ALL ABOUT KIDS Program Director (PD) if they have communicable disease. PD must follow protocol for reporting communicable disease (see below). Provider may resume provision of services when non-communicable or 24 hours fever free **(Appendix E: Staff Illness and Exclusion.)**

D. Reporting Communicable Diseases

ALL ABOUT KIDS is not a childcare facility and therefore is not a mandated reporter of communicable diseases. However, ALL ABOUT KIDS will report those communicable diseases known to the agency that must be reported. A copy of this list **(Appendix F List of Communicable Diseases)** will be shared with each parent and legal guardian at the time of enrollment. Families and provider personnel will be reminded to notify the ALL ABOUT KIDS Manager within 24 hours after the child, a provider / personnel of ALL ABOUT KIDS has developed a known or suspected communicable disease (or any member of the immediate household).

While respecting the legal boundaries of confidentiality of medical information, the Program Director will notify the appropriate health department authority about any suspected or confirmed reportable disease among the children, personnel, or family members of the children and personnel. The telephone number of the responsible local or state health authority to whom to report communicable diseases is posted in the office: local state health departments: Nassau county (516) 571-3471, Suffolk County (631) 853-3055, New York State Department of Health Bureau of Communicable Disease Control (518) 473-4439, or New York City 1 (866) NYC DOH1. Families of children who may have been exposed to a child or provider / personnel with a communicable disease or reportable condition will be informed about the exposure according to the recommendations of the local health department. **(Appendix G: Sample Letter to Families about Exposure to Communicable Diseases).**

If consecutive therapy sessions are missed therapist must inform region Therapy Staffing Coordinator and Service Coordinator. It is All About Kids policy that when a session is missed a make-up session must be scheduled according to the municipal make-up policy. Percentage of absenteeism is tracked monthly by utilizing the AAK CLAIMS system. When missing two or more sessions providers must inform the parent and the AAK Therapy Coordinator and arrange for session make-up according to municipality regulation.

V. Medication Policy

A. No provider or personnel with ALL ABOUT KIDS is permitted to administer at any time non-prescription or prescription medications to any child in ALL ABOUT KIDS program. All providers are required to keep their own medication safely out of the reach of children.

VI. Emergency Plans

A. Reporting an Emergency or Child's Injury

All incidents of a child's medical emergency, accident, injuries, signs of abuse, including but not limited to the following emergencies, in this section; must be reported. Provider / personnel must perform steps 1-5. Clinical Supervisors must perform Step 4.

1. Notify emergency authorities if needed: police, fire, ambulance, poison control, and/or child abuse.
2. Maintain up to date information for contacting parents in the event of an emergency.
3. Notify the child's parent/legal guardian immediately of any incident. Provider may not make any medical or other judgments about the child for the purpose of deciding whether or not to report incident or seek medical help.
4. Immediately report incident to an ALL ABOUT KIDS' Clinical Supervisor and then complete and submit an **Incident Report Form (see Appendix Ha, H.1, H.2)** to the ALL ABOUT KIDS's Clinical Supervisor at ALL ABOUT KIDS' office within 24 hours. The ALL ABOUT KIDS' Clinical Supervisor ensures that health care and emergency plans are implemented, including contacting local Program Authorities. The ALL ABOUT KIDS' Clinical Supervisor must immediately contact Cathy / Mike Grossfeld to inform them of all incidents and ensure they receive back from Cathy / Mike Grossfeld an acknowledgement of receiving and reviewing the report and submit the **Incident Report** to Cathy/Mike Grossfeld in the Executive Office and to ALL ABOU KIDS' Regional Compliance Manager either through All About Kids' secure encrypted e-mail system (if an All About Kids' Employee) or by other encrypted e-mail communication and/or facsimile if an independent contractor. The treating provider must follow-up the next day after the incident by contacting the parent of the child to inquire and document the medical status of the child on ALL ABOUT KIDS' **Incident/Accident Follow-up Form (Appendix H).**The Clinical Supervisor ensures that the follow-up report is completed and obtained and submitted to Cathy/Mike Grossfeld in ALL ABOUT KIDS' Executive Office and to ALL ABOUT Kids' Reg. Compliance Manager by All About Kids' secure encrypted e-mail system (if an All About Kids' Employee) and/or facsimile.
5. When an injury occurs in the service area that requires first aid or medical treatment for the child, the provider shall complete an **Incident Report Form**. Four copies of the injury report form shall be completed. One copy will be given to the child's parent or legal guardian. The second copy will be

forwarded to the EIO school or district of the county with which the agency is contracted. The third copy will be kept in the child's record and the fourth copy will be kept in an injury log that is periodically reviewed by a staff member for injury patterns. Additionally the ALL ABOUT KIDS' Clinical Supervisor must provide Cathy Grossfeld and the ALL ABOUT KIDS' Reg. Compliance Manager with a copy of the Incident Report and all information related to the incident in order that an immediate review of the incident can be discussed for the purpose of determining if a corrective action plan needs to be implemented.

B. Incident/Accident Policy & Affiliated Forms

Incident/Accident is defined as an unfortunate event that happens unexpectedly and unintentionally, typically resulting in damage or injury including, but are not limited to trips and falls, collision with furniture, mild aggressive behaviors without the use of Behavior Emergency intervention, and/or exhibition of the target behavior that was resolved using the strategies listed in the child's Behavior Intervention Plan (BIP). Reporting of Incidents/Accidents as defined above are distinct from reporting Behavior Emergency Interventions which are strictly regulated by Federal, State, and company policies. Please see the sections for Behavior Emergency Interventions following incidents/accidents section

- All providers must complete an ALL ABOUT KIDS'" Incident Report Form" and forward it to their designated ALL ABOUT KIDS' Clinical Supervisor within 24 hours of the incident. All sections of the ALL ABOUT KIDS' "Incident Report Form" must be completed (Appendix H)
- All providers must complete an ALL ABOUT KIDS' "Accident/Incident/Emergency Intervention Follow-up Report" by the next day following the incident and must forward the follow-up report to their designated ALL ABOUT KIDS' Clinical Supervisor within 24 hours of completion. All sections of the "Accident/Incident/Emergency Intervention Follow-up Report" must be filled and include the following:
    - Detailed description of the incident;
    - All follow-up details including: date of follow-up, time of follow-up, name of the person conducting the follow-up, any and all comments made by parent or guardian about the status and well-being of their child after the incident;
    - Person conducting the follow-up must ask and document on the follow-up form whether the parent or guardian sought and received any medical services for their child (including see a doctor, going to the emergency room, etc. and date and time medical services were provided);
    - Follow-up form must have signature of the person completing the report and the parent's/guardian's signature;

C. Behavior Emergency Intervention Regulations, Policies and Affiliated Forms

REGULATIONS

Pursuant to Education Law sections 207, 210, 305, 4401, 4402, 4403, and 4410:

- Emergency intervention is defined as the use of physical restraint or force or isolation or a strategy that is not listed in the student's BIP due to the fact that the students self-injurious or aggressive behavior are of such severity as to create imminent threat of serious injury to the child or another person.
- Emergency interventions must be used only in situations in which alternative procedures and methods not involving the use of physical force cannot reasonably be employed. Only providers who are certified providers will apply the "Handle with Care Behavior Management System" to deescalating a crisis situation. Certified Providers will assess the severity of the crisis, determine the appropriate level of support (i.e., support, limit setting, or physical intervention), and execute the plan after collaborating with staff/parents, as applicable. See Emergency Intervention Policy for more details.
- Aggressive behaviors are defined as behaviors that threaten the physical wellbeing of the student (e.g., eye-gouging, biting, hitting, heading banging, and/or scratching self) or that of others (e.g., biting, hitting, kicking, scratching, punching, and/or choking others).
- The student's self-injurious or aggressive behaviors are of such severity as to create imminent threat of serious injury to the child or another person that poses a significant health and safety concerns that warrant the use of Emergency Intervention to suppress the behavior after the range of alternative prevention and reactive strategies in the child's BIP have been employed and have failed to provide a sufficient level of safety.
- All providers are to employ the least restrictive emergency intervention for only as long as needed to deescalate the behavioral episode.
- Only providers who are certified providers will apply the "Handle With Care Behavior Management System" to deescalating a crisis situation. Certified Providers will assess the severity of the crisis, determine the appropriate level of support (i.e., support, limit setting, or physical intervention), and execute the plan after collaborating with staff/parents, as applicable.

Emergency Interventions 8 NYCRR §§200.15(f) and 200.22(d):

- Emergency means a situation in which immediate intervention involving the use of reasonable physical force is necessary to protect oneself from physical injury; to protect another pupil or teacher or any person from physical injury; to protect the property of the school, school district or others; or to restrain or remove a pupil whose behavior is interfering with the orderly exercise and performance of school or school district functions, powers and duties, if that pupil has refused to comply with a request to refrain from further disruptive acts.
- Residential schools must provide, or ensure the provision of, child abuse prevention training to all administrators, employees and volunteers on a regular, but at least annual, basis. The purpose of such training must be to increase the participants' level of awareness, encourage positive attitudes

and enhance knowledge and skill development in areas including techniques of group and child management, including crisis intervention and appropriate restraint training [8 NYCRR §200.15(f)(1)].

- Staff who may be called upon to implement emergency interventions must be provided with appropriate training in safe and effective restraint procedures, as applicable.
- Emergency interventions must not be used as a punishment or as a substitute for systematic behavioral interventions that are designed to change, replace, modify or eliminate a targeted behavior.
- Emergency interventions must be used only in situations in which alternative procedures and methods not involving the use of physical force cannot reasonably be employed.
- Certified Providers will apply the "Handle With Care Behavior Management System" to deescalating a crisis situation. Certified Providers will assess the severity of the crisis, determine the appropriate level of support (i.e., support, limit setting, or physical intervention), and execute the plan after collaborating with staff/parents, as applicable.
- When physically intervening, the least restrictive method of physical intervention/restraint should be used that is effective to maintain safety.
- The Modified Primary Restraint Technique (MPRT) and Primary Restraint Technique (PRT) should only be used in the following circumstances, but not limited to injurious behaviors to self and others and when all alternative procedures including providing support and setting limit have been employed, but are ineffective.

ALL ABOUT KIDS' Behavior Emergency Intervention Protocol

- Provider should be with other staff members/parents at all times. In the event that the provider is alone with the child, the provider will use all reasonable measures to call for help. Child needs to be attended at all times.
- The provider must notify the child's parent and/or caregiver and the designated ALL ABOUT KIDS' Clinical Supervisor immediately afterwards.
- The school and provider must maintain documentation on the use of Emergency interventions for each student. Providers must complete ALL ABOUT KIDS' "Behavior Emergency Intervention Incident Report (BEIRs)" immediately and forward it to the designated ALL ABOUT KIDS' Clinical Supervisor (see Appendix H. 1). A copy shall be maintained in the student's IEP file. ALL ABOUT KIDS' "Behavior Emergency Intervention Report" must be completed by the staff member who initiated the Emergency behavior intervention with the student. All BEIRs must be forwarded immediately to, and reviewed by the designated ALL ABOUT KIDS' Clinical Supervisor. Any time a BEIR is written regarding a student who does not have a behavioral intervention plan (BIP), the provider shall, within (2) days schedule an internal IEP Team meeting. In addition, the school district will be notified to request a

CPSE/CSE meeting. See ALL ABOUT KIDS' Guidelines for Behavioral Interventions Supports for Service Providers on how to complete an FBA & BIP and for all related forms. All sections on the Emergency Intervention Incident Report must be filled with details (Appendix H)

- The parent of the student must be notified when an Emergency Intervention has been used with his/her child. The documentation of Emergency Interventions must be reviewed by school supervisory personnel and, as necessary, the school nurse or other medical personnel. Date of parent notification must be documented on the "Behavior Emergency Intervention Incident Report." If parent is unavailable to answer any calls, provider must leave a voicemail and note date and time of call on the report.
- ALL ABOUT KIDS' "Post Intervention Emergency Intervention Analysis and Debriefing Form" (Appendix H. 2) must always be completed the following day after the Emergency Behavior Intervention and must submit to the designated ALL ABOUT KIDS' Clinical Supervisor.
- Within two (2) days after the Emergency Behavior Intervention, the provider must schedule an IEP team meeting in house to review the emergency report and determine the need for a Functional Behavior Assessment (FBA) and/or need for an interim plan. **ALL ABOUT KIDS' "Post Behavior Emergency Intervention Analysis and Debriefing Form"** must have all sections completed.

D. *First Aid & CPR*

First Aid On Site:

First Aid kits will be located in each therapy room and reception area and kept inaccessible to children, and will be restocked following use to maintain the following supply of items: band aids, butterfly, triangle bandage, sterile gauge pads, antiseptic towelette, surgical tape, antibiotic cream, first aid ointment, thermometer, etc. All first aid kits include a checklist of items required to be enclosed in the kit and a monthly check is made in order to re-stock items in first aid kit. Cold Packs will be kept readily available at each office site. All therapy rooms will have posted choking/first aid instructions.

CPR On Site:

All About Kids' will have present at each facility providing services to children a designated staff person who is certified to administer First Aid and in infant/toddler/adult Cardiopulmonary Resuscitation (CPR). A copy of each designate staff person's First Aid & CPR certification will be maintained in All About Kids' personnel files and will be monitored for renewal compliance by All About Kids' Human Resources department.

E. *Emergency Phone Number/Consents*

On Site:

All providers will have immediate access to a phone that allows them to summon help in an emergency.

The telephone numbers of the Fire Department, Police Department, Hospital, and Poison Control, Child Abuse Hotline will be posted by /on each phone with an outside line. Telephone numbers for superintendent/building manager who provides specific types of building repairs for this facility are kept by the Program Director and at reception desk.

Off Site:
All providers will have readily available access to phone and emergency number to contact Police/Fire Department, Poison Control 1-800-222-1222, Child Abuse / Maltreatment 1-800-342-3720. ALL ABOUT KIDS issues a yellow emergency contact card to all therapists upon hire and training.

F. When to Get Help Immediately for a Child

Some conditions require immediate medical help. In emergencies, call the Emergency Medical System (EMS) or 911 immediately.

Situations That Require Medical Attention Right Away:

- You believe the child's life is at risk or there is a risk of permanent injury.
- The child is acting strangely, much less alert, or much more withdrawn as usual
- The child has difficulty breathing or is unable to speak.
- The child's skin or lips look blue, purple or gray.
- The child has rhythmic jerking or arms and legs and a loss of consciousness (seizer).
- The child is unconscious
- The child is less and less responsive
- The child has any of the following after a head injury: decrease in level of alertness, confusion, headache, vomiting, irritability, or difficult walking
- The child has increasing or severe pain anywhere
- The child has a cut or burn that is large, deep, and/or wont stop bleeding
- The child is vomiting blood
- The child has a severe stiff neck, headache and fever
- The child is significantly dehydrated: sunken eyes, lethargic, not making tears, not urinating.

Once 9-1-1 is on its way, then notify the parents or legal guardian immediately.

G. Serious Illness, Hospitalization, and Death

Provider is to notify ALL ABOUT KIDS Program Director / Administrator of a child's serious illness, hospitalization, or death, and complete appropriate forms indicating the child's absence from therapy. ALL ABOUT KIDS will notify local Program Authorities for EIP / CPSE or school district.

H. Poisonings

In the event it is thought that a poisoning, including lead poisoning (ingestion of lead paint) has occurred, call the Poison Control Center at 800-222-1222. Be prepared to have the name of the product or substance involved. Do not try to make the person vomit or give anything by mouth unless you are told to do so by the Poison Control Center or doctor.

Follow directions. If the patient becomes unconscious, convulsing or having trouble breathing, call an ambulance (911) right away.

I. Suspicion of Lead Poisoning

In the event lead poisoning from chipped paint is suspected, because of observed chipped lead paint, but ingestion has not been observed or confirmed, the provider is required to: instruct parent to obtain lead testing for child through child's pediatrician; immediately contact ALL ABOUT KIDS manager regarding unsafe home condition. The ALL ABOUT KIDS manager is to immediately contact EIO regarding unsafe home situation and need for child's lead testing.

J. Severe Allergies or Anaphylaxis (Life Threatening)

Medical Verification:

- Upon the Initial Service Coordination meeting with the parent the ISC will check off any allergy alerts on their initial checklist. Additionally all, ALL ABOUT KIDS' intake for both evaluations and services must include the question to parents if their child has any severe or life-threatening allergies (anaphylaxis). If yes, this must be supported on the child's health status form filled out by the healthcare physician, and the healthcare physician must also provide specific information and medical management required for the condition. Any medical management is the responsibility of the parent/legal guardian of the child when serviced through ALL ABOUT KIDS or the daycare/preschool the child attends when serviced through ALL ABOUT KIDS.
- All health status forms for each child must carefully be reviewed for any indication of serious severe allergy or anaphylaxis, as for any other serious health issues. This includes health status forms from each initial evaluation for all programs, initial start of services with ALL ABOUT KIDS, and annual health status forms for children in developmental groups on-site at ALL ABOUT KIDS.

- **If there is an indication of severe allergy or anaphylaxis, a **red alert allergy stamp** must go on the child's health status form, on the outside of all charts for that child, on all copies of the child's IFSP or IEP distributed to the teams and in child's chart; and must be reported to the EIP or school district if not known, and indicated in all of the child's evaluations and/or progress reports. Another label with "allergy" and the specific allergens is to go on the inside cover of child's chart.

K. *Allergens Which Cause Life-Threatening Allergies*

Food Allergies:
The most common foods that students are allergic to include peanuts, shellfish, fish, tree nuts (walnuts, cashews, pecans, etc.), eggs, milk, soy, and wheat (NASN, 2001) [currently there is no cure for food allergies and strict avoidance is the only way to prevent a reaction]. Food allergies are the leading cause for anaphylaxis outside of the hospital setting.

Other Allergens:
Other common causes of the anaphylaxis include allergies to latex, medications, and insect stings.

Steps To Take To Prevent Exposure to Allergens During Provision of Evaluations & Services

Food Allergens:

All providers regardless of location of therapy are to follow a non-specific child protocol and child specific protocol for the child regarding allergen prevention measures. All providers must know and have documentation of the specific allergens causing anaphylactic reactions for the child.

- Use only "safe" reinforces, snack, foods.
- Reinforce hand washing before and after eating for yourself and child(ren).
- Avoid cross-contamination of foods by cleaning surfaces with soap and water before and after eating with designated cloth (not shared), and before and after each session.
- Antibacterial hand sanitizers have not shown to be sufficient at removing food allergens. Clean table thoroughly with a disposable cloth that is not placed in a solution with other cloths to avoid cross-contamination.
- Present any food to a child on a paper dish or napkin if placed on table.
- ALL ABOUT KIDS facility or child's daycare/school: have child eat in area that is allergen safe.
- Consider non-food treat when possible.

Insect Sting Allergies:
If an ALL ABOUT KIDS provider must work with food with a child allergic to bee stings, eating areas must be inside school buildings for the child at risk.

Latex Allergies:
Every All About Kids provider must ensure that non-latex gloves are carried and used for purposes of Universal Precautions with children with latex allergies.

Signs & Symptoms of Allergic /Anaphylactic Reactions:
Allergies can affect almost any part of the body and cause various symptoms. Anaphylaxis includes the most dangerous symptoms; including but not limited to breathing difficulties, a drop in blood pressure, or shock, which are potentially fatal (see Appendix Q for a list of common symptoms of allergic/anaphylactic reactions).

L. Review Medical Plan:

When first assigned a child identified with allergic/anaphylactic reactions, service provider must review with parent or daycare/school personnel the medical intervention and plan in place for child including any specific preventative measures required. The parent or daycare/school personnel are solely responsible for providing the medical intervention (i.e., epinephrine pen).

M. How To Respond To An Emergency Allergic Anaphylactic Reaction:

Parent on-site:

Provider must immediately alert parent to reaction. Do not leave child alone to do so. Either call or send another parent to get parent (if parent is outside session room) or yell for parent if in home. The parent is responsible for any immediate medical intervention (i.e., epinephrine pen). Call 911.

Services in daycare/preschool:

Provider must immediately alert the school nurse or designated emergency contact in that location. Do not leave a child alone to do so. Call or send other personnel to get the nurse or designated emergency contact. Daycare/school officials are responsible for medical intervention and plan (i.e., epinephrine pen). Call 911 if above is not able to be immediately contacted.

As with all emergencies or incidents, the provider must contact an ALL ABOUT KIDS manager/supervisor immediately following the incident and complete an ALL ABOUT KIDS' incident form. Any subsequent follow-up that may be required with the EIO or school district will be determined and carried out by an ALL ABOUT KIDS manager/supervisor. Please follow the link to "Caring for Students with Life-Threatening Allergies" manual for NYS DOH protocols and guidance. http://www.health.state.ny.us/professionals/protocols_and_guidance/docs/caring_for_students_with_life_threatening_allergies.pdf

All About Kids will ensure that all providers, volunteers, aides, with parent's permission, are informed of child's allergies and safeguards necessary on a need to know basis.

VII. Security and Evacuation Plan, Drills and Closings

A. *Security Plan:*

On Site:

Entrances will be protected from unauthorized access by keeping all the doors except the main entrance office door into the facility locked (to the outside).

Visitor Arrival:

- All parents and visitors at an ALL ABOUT KIDS site are to sign in and out of the reception area prior to further entering the site. Sign in for parents and visitors are kept in separate logs.
- All Logs will have date and time in, signature, destination and sign out time. However, parent logs for groups will be per group and have destination at the top of the page that will be coded with date and time and not state type of group or therapy, or child's name. A separate Parent Log for individual sessions will use the personnel name as the destination.
- All vendors will be asked to show ID and given a visitor's badge.
- All parents must be accompanied by provider / personnel within treatment area.

Badges

All providers are to wear identifying ALL ABOUT KIDS badge

Providers in a School:
Follow policy of school for wearing a badge.

Policy for Handling Persons Who May Pose a Safety Risk

1. The child will not be released to anyone who cannot safely care for the child. (Includes abusive parents or legal guardians and any adults who cannot take the child safely from the facility).
2. Program Director will notify the local police to manage an adult under the apparent influence of drugs / alcohol or an individual who poses a safety risk or threatening behavior.
3. All providers / personnel, children and families will avoid the area where the threatening individual is located.
4. If needed, Program Director will immediately call Cathy / Mike Grossfeld.
5. Program Director will contact the emergency contact person to make arrangements for the child's transport to a place of safety. If no one is available to care for the child, Program Director will contact child protective services for guidance.

B. *Facility Evacuations:*

Evacuation drills will be held quarterly. The timing of the drills will be varied. Children will be appropriately prepared for and reassured during drills. Program Director will complete the **Record of Fire Drills (see Appendix II)** at the end of each drill.

C. *Emergency Evacuation Plan for ALL ABOUT KIDS Office Sites*

The safe evacuation of children is the first priority
Children must never be left without adult supervision

D. *Emergency Alert*

Staff and children will be alerted to an emergency evacuation with the sound of a "smoke detector" or building fire alarm.
Whether a child is in an individual or group session, the child must remain with ALL ABOUT KIDS provider / personnel and proceed immediately with the provider / personnel if evacuation is indicated. Parents are to evacuate on their own or they may follow their child. Parents are not to take children away from the provider or group. Providers are not to stop and look for children's parents but instead proceed immediately with child(ren) to evacuate if needed.

Building Maintenance

Fire and building inspections are not required for buildings we lease space from as they are not buildings of public assembly. The buildings are required to have a permanent or temporary Certificate of Occupancy. Since these buildings are large and construction

for tenants is commonplace, temporary Certificates of Occupancy are common. Anyone of many tenants may be moving in or remodeling their space which will cause the issuance of a Temporary Certificate of Occupancy.
All About Kids has and will continue to request Certificates of Occupancy (Permanent or Temporary) on a yearly basis. The following is the criteria for each All About Kids office:

Plainview: Fire Inspector has confirmed that only public assembly buildings are inspected annually, others are inspected on an as needed basis. Upon request the building is inspected by the Nassau County Fire Marshall on an annual basis or sometimes up to 14 months from prior inspection.

Westchester: There is no requirement for a fire or building inspection unless the building is used for public assembly according to the Fire Marshall. The Building Management Company does the following monthly: Elevator service by private company, sprinkler/standpipe visual inspection, alarm system by private co. Every 6 months: fire drills in cooperation with the New Rochelle fire department. Annually: Manual pull stations, alarms and strobes, tenant warden updates, smoke detectors, fire extinguishers by private company. Every 5 years-Flow test-sprinkler-standpipe system by private company.

Washingtonville: The is no requirement for a fire or building inspection unless the building is used for public assembly according to the Village of Washingtonville Fire Inspector. Upon request the building can be inspected by Village of Washingtonville Fire Inspector. The Building Management Company cooperates with the Village of Washingtonville Fire Inspector upon receipt of any notice for inspection which is determined at the discretion of the Village of Washingtonville on an as needed basis; and the Building Management Company maintains the buildings' exit notices/light signs which are posted as per the Village of Washingtonville's fire requirements.

NYC:

Brooklyn:
Every 6 months-Smoke detectors (tested and cleaned)
Annually-Sprinklers, Emergency Lights, Water Flow Detectors inspected, Fire Extinguishers (services and recharged), Elevators inspected by NYC Building Dept., and NYC Fire Inspections requested.
Every Five Years-Siamese Connections (Standpipe, flow test, Siamese connections hydrostatically tested) by NYC Fire Dept.
Fire Drills- conducted by building's engineer

Queens:
Monthly- Fire Sprinkler system, sprinkler/standpipe and hoses inspected by private company, Heating/cooling system-rooftop package inspected by building eng., and Elevators inspected by private company.
Every 3 months- Fire extinguishers inspected by private company.
Every 6 months-Fire Alarm system, manual pull stations, alarms and strobes inspected by private company.
Fire drills- conducted by building's engineer.
Annually-NYC Fire inspections are requested.

Bronx:
Annually-Heating/cooling unit-inspected by NYC Fire Dept., Fire Extinguishers & Exit Lights inspected by private co., and NYC Fire inspections are requested.

FIRE SAFETY NOTICE
(TO BE POSTED IN ALL ROOMS)

In the event of a fire, stay calm, notify administrative personnel to call 911 to notify Fire Department and evacuate the premises with the child or children who are under your supervision. The safe evacuation of children is the first priority. Prominently located Exit signs are located above each exit. Exits are free of obstruction at all times, the below evacuation process must be followed.

*****Children must never be left without adult supervision*****

- Evacuate all children according to the closest exits designated and lead them to the outside evacuation meeting area.
- Do not go looking for a child's parents. All children are to evacuate with ALL ABOUT KIDS personnel.
- Take the attendance list (see Appendix T) with you if you are leading a group of children.
- Do not use elevator.

E. *Fire Drills*

1. Each office is to conduct a fire drill minimally on a quarterly basis. The executive directors are to be informed of the schedule of fire drills prior to each one's occurrence. Vary the times and days with each drill. Record each fire drill on the attached **Record of Fire Drills (see Appendix II).** It is important to record all information, including time it took for fire drill, number of children and exits utilized. After each fire drill, a copy of the Record of Fire Drills is to be sent to Cathy Grossfeld, Executive Director.

2. Providers / personnel of groups of children are to take daily attendance records with them and ensure that the classroom / therapy door is shut as the last child exits the room.

3. Provider takes attendance of children once providers and children have arrived at outside evacuation meeting point.

F. *Evacuation Routes:*

All Evacuation Route Diagrams are to be posted in all rooms on back of doors.

1. **Plainview LL 108:**
   Primary- All staff and children are to exit into hall and turn right and leave by the first door at the Exit sign. Proceed to go up the steps to the outside of the building. Go out nearest door on the first floor – proceed to go to the (VEECO building) adjacent to 255 Executive Drive. Do not re-enter the building until authorized to do so by firefighters.

   Secondary – All staff and children are to exit into hallway, turn right and proceed to the second Exit sign. Us the stairway to the first floor, go out to closest exit on the

first floor and proceed to building adjacent to 255 Executive Drive on East Ames Court (VEECO Building). Do not re-enter the building until authorized to do so by firefighters.

2. **Queens:**
   Primary- Front half of office exits through front entrance office door, turn left and make immediate right to stairs. Continue down to the first floor, go to the corner light and cross the street, wait at corner. Do not re-enter the building until authorized to do so by firefighters.

   Secondary – Back half of office exits through the fire exit stairwell near freight elevator. Exit out to the street, at the light to the corner across the street. Do not re-enter the building until authorized to do so by firefighters.

3. **Brooklyn:**
   Primary – Exit out of All About Kids' office and turn right into the hallway. Walk to the end of the hallway and turn left and go through the door and turn right. Proceed forward to take the stairs down to the 1st Fl. At the bottom of the stairs turn left into the hallway and proceed out the main front building entrance/exit and turn right. Proceed to the corner of 36th & 3rd Ave. and meet in front of the Cafe La Morena Deli. Do Not re-enter the building until authorized to do so by firefighters.

   Secondary – Exit out of All About Kids' office and turn left into the hallway. Walk to the end of the hallway & turn right. Walk to the end of the hallway and turn left to exit out the Emergency Exit Door to the Fire Escape. Take the Fire Escape down to the Ground Level. Once at Ground Level turn left and proceed through the gate & then turn right onto the walkway and proceed to the corner of 36th & 3rd Ave. and meet in front of the Cafe La Morena Deli. Do Not re-enter the building until authorized to do so by firefighters.

4. **Bronx:**
   Primary- All staff and children are to Exit into hallway, turn right and proceed to leave by first door Exit sign to East Tremont Avenue. by firefighters.

   Secondary – All staff and children are to Exit into hallway and turn left into the kitchen area. Proceed to second Exit door and turn left to East Tremont Avenue. by firefighters.

5. **Westchester:**
   Primary- Exit office and turn left. Go down the hallway and turn left into the stairwell. Go down 8 flights of stairs to the 1st Fl. Exit out the main Front Entrance/Exit of the building and turn left. Proceed to the corner of Huguenot Street and River Street. Do not re-enter the building until authorized to do so by firefighters.

   If the stairwell nearest your suite or office is blocked by fire or smoke, use the other available stairwell. If all of the stairwells nearest the suite or office are blocked by fire or smoke, return to the office and close the doors, call the management office and/or the fire department and notify them of your location.

   Secondary -Exit office and turn right. Go down the hallway and turn right into the stairwell. Go down 8 flights of stairs to the 1st Fl. Exit out the rear "Corp. Entrance/Exit". Turn right and proceed to the corner of Radisson Plaza & River Street. Do not re-enter the building until authorized to do so by firefighters.

6. **Washingtonville**
   Primary- All staff are to exit via the main & only entrance/exit door out into the parking lot and should proceed across the parking lot to the rear lot of the Monell Fire House. Do not re-enter the building until authorized to do so by firefighters.

G. *To Operate Fire Extinguisher*

Facility/ Home / Community

- **P** -pull pin
- **P** -point nozzle at just above base of fire
- **P** -press handle
- **S** -sweep and fan nozzle side-to-side starting with fire nearest you.

If fire is electrical in source – unplug device.

H. *Home Fire Safety Plan*

- Evacuate client, family members and others in house.
- Call 911

I. *School/Community – Based Fire Plan*

- Read and know the evacuation plan and exit routes in the building.
- Evacuate child(ren) and yourself.
- Call 911 is not already called by other administration.

J. *Emergency/ Disaster Plan*

Lockdown/Facility:
This procedure is used when there is an immediate and imminent threat within the building. ALL ABOUT KIDS personnel and children and families are secured in the rooms they are currently in and no one is allowed to leave until the situation has been curtailed. Most commonly used practice when an intruder has been identified. This area is not to be publicly posted but will be known by on-site staff.

Steps to implement lockdown after threats been identified:

1. Lockdown signal is given – "we are under immediate lockdown" to be stated over PA system.
2. Call 911.
3. Call Cathy/Mike Grossfeld,
4. Providers/personnel to turn out lights, and move children, family, and themselves out of line or sight of room and windows.
5. Providers/personnel take attendance and record all that are in the room or missing and wait until further instructions.
6. No one is allowed to open doors for ANYONE under ANY circumstances.
7. All activities cease.

K. *Lockout/Facility:*

This is a procedure, which allows the center to continue with the normal routine day, but curtails outside activity, and allows no unauthorized personnel into the building. Most commonly used when an incident is occurring outside the building, on or off the property.

Steps to implement Lockout after possible threats have been identified:

1. Announce, "Lockout is in effect" over PA system.
2. Call 911 and Program Director to maintain contact with authorities for instruction.
3. Contact Cathy/Mike Grossfeld.
4. Administrators/Assigned staff – locks and secure exterior office doors.
5. Monitor main entrance and allow only AUTHORIZED personnel into office.
6. Program Director to consider contacting families to cancel future therapy that day.

L. *Power Failures on Site:*

- The emergency lighting systems in hallways should be automatically activated, to light up the hallways. Flashlights are stored in outlets in each therapy room.
- Caregivers will comfort the children, explain the situation, and model for them how to remain calm.
- Program Director/Administrator will discover if the power outage is confined to the facility or includes the neighborhood or surrounding areas.
- Unless the power failure is accompanied by an emergency situation requiring evacuation (e.g. fire, flood, etc.) children will be kept outside. Parents will b given the choice whether they wish to take their child and leave, or to wait inside with the child. Should it be necessary to leave the building, staff will follow emergency evacuation procedures. Staff will look for and avoid any downed power lines.
- Program Director/Administrator will call the local power facility to explain the situation, and request assistance.
- If weather conditions do not permit the maintenance of safe temperatures within the facility, families will be given the choice to leave with their child.

M. *Closing Due to Snow/Storm:*

1. If Cathy and/or Michael Grossfeld Executive Directors decide prior to opening hours not to open facility, they will contact each office Director who will initiate snow lists to contact all on site personnel. Families will be notified by telephone, by providers to cancel on site services. Program Director will contact the transportation companies if applicable.
2. If the facility must close during operating hours because of a snowstorm, Program Director will ensure that families who have not yet come to the facility with their child will be notified by telephone.
3. If public/private schools are closed due to snow, providers may still choose to service children at the child's own home as long as the child's IFSP/IEP does not designate "school" as location of service. Providers are also expected to base the decision to service a child on their ability to safely navigate through the snow.

N. *Communications during an on-Site Emergency or Disaster/Crisis Plan:*

- Personnel are to be trained how to make a 911 call and the importance of maintaining contact with the 911 dispatcher until the police arrives at the scene.
- Use the intercom system or two-way radios if needed. Two-way radios should be used by Program Director and other administrative staff.
- Program Director is the designated person in command on behalf of agency during a crisis/disaster situation until the police arrive. **(Appendix J: Notification to Authorities)**

O. *Media Inquiries:*

Refer all media inquiries to Michael L. Grossfeld, Executive Director. ALL ABOUT KIDS will not allow access by the media to the facility during a crisis situation. Media access will be prearranged at times when staff and families have been informed and when such visits will cause the least amount of disruption to the program.

VIII. Safety Surveillance

A. Physical – Site Safety

Facility:
The facility provides a safe physical environment for children, persons delivering services, and other individuals that access the premises.

- The site is in compliance with applicable federal, state, and local building, fire, and safety standards or codes.
- The site has documentation of the facility's Certificate of Occupancy/Certificate of Compliance or other proof of building code compliance, based on federal, state and local code requirements, for the purpose of providing services to children.
- Provider maintains a record of any authority that has conducted an inspection of the facility, and corrections made in response to identified deficiencies, if any.
- Building and hallway access and egress are secure, including preventing children from accidental access to outside areas.
- All windows have locking devices, window guards, or other barriers to prevent children from accidental egress.
- Cleaning products and toxic materials are stored and locked up away from children to prevent access.
- If a sprinkler system is available, it is in working order.
- No obstructions in hallways and exits.
- Ceilings do not leak or have hanging electrical wires.
- No insect/rodent infestation.
- Toxic materials, including cleaning supplies, flammable substances, prescription drugs, over the counter medicine, plants, lighters, and matches are stored appropriately, and are restricted from children and away from food.

- Access to building hazards is restricted, including portable heaters, pools, ditches, well, open or easily accessible windows etc.
- For areas accessible to children, closet doors allow children to open the door from the inside. Bathroom doors permit opening of the locked door from the outside. Exit doors open from the inside without using a key.
- Playground equipment that is used in the provision of services is securely mounted, clean, safe, and appropriate for the children's age and developmental skill level.
- Any pets on premises pose no threat to children.
- Stairs, walkways, ramps and porches are free of ice snow and hazards.
- Furniture is safely arranged & secure including highchairs with safety straps.
- Fire extinguishers and smoke detectors are available in working order as demonstrated by recent documented inspection or gauge showing full charge; extinguishers with seals must have unbroken seals, and providers must have a knowledge of how to work extinguishers. Smoke detectors must be tested on a monthly bases and a log maintained of testing.
- Evacuation routes are known to all staff and clearly posted.
- Evacuation drills are conducted at least monthly.
- Radiators and electrical outlets are properly covered and child proof.
- No peeling or significantly damaged paint and plaster.
- Bathroom facilities are clean and appropriately sanitized and supplied with toilet paper, soap, and disposal towels.
- Water temperature must not exceed 115 degrees Fahrenheit in areas where children are present or have access.
- **Diapering Policy:** diapering facilities are available for parents, caregivers, and/or guardians and are located near a sink not used for food preparation and include appropriate disposal containers. Diapering area and all surfaces are cleaned and sanitized after each use.
- Linens, blankets, bedding, cribs, cots, mats, are clean and are sanitized before use by another child.
- Small objects, plastic bags, Styrofoam and other potentially harmful objects are inaccessible to children.
- No obvious dampness or odors.
- Trash is covered and stored appropriately.
- No clutter in hallways.
- Toilets/sinks are accessible to children. No ALL ABOUT KIDS provider/personnel are to diaper or toilet a child receiving service from ALL ABOUT KIDS regardless of location of service.
- Portable electric heaters or other portable heating devices may not be used in rooms accessible to children regardless of the type of fuel used. Rooms containing heaters or furnaces must be separated from the areas accessible to children by approved fire resistant materials in the walls, ceilings, connecting doors and doorframes.
- Radiators and pipes located in rooms occupied by children must be covered to protect children from injury.
- Kitchen area is not accessible to children.

Plants:

- No plants are permitted that are toxic; generate a lot of pollen, or that drop small flowers or leaves.

- All plants brought on site to ALL ABOUT KIDS must be checked against the list of poisonous plants from the local poison control center at: https://www1.nyc.gov/site/doh/health/health-topics/poison-plants.page
- Poison control center telephone number (1-800-222-1222)

Pets:

- No pets are allowed on site at ALL ABOUT KIDS, or to be brought to any session by an ALL ABOUT KIDS provider.

Home Cases:

- Providers have the right to respectfully ask parents to place the family animal in another room during the therapy session.

B. Home – Site Safety:

A provider must observe the home setting to ensure the home is maintained in a manner that protects the health and safety of children during provision of services.
Provider policies and procedures are in place to address unsafe conditions encountered in the home environment that would pose harm to children during service delivery (e.g., peeling or chipping paint, leaking ceilings, or hanging electrical wires). It is recommended that providers observe the specific area where EI services will be provided to ensure that safe conditions exist for each therapy session.

If the provider determines the home setting may pose imminent danger to children, the provider should report this to the EIO and refer the parent to the EIO or the service coordinator to provide educational resources available in the county. The provider may recommend an alternate service location to the parent and EIO. For dangerous circumstances that may potentially constitute child abuse and maltreatment, the provider should if circumstances warrant, make a report to the child abuse hotline. Additionally, the provider should report the circumstances to the EIO and discuss alternate service locations for service provision.

Examples of abuse and maltreatment, including neglect, which would require a report to the child abuse hotline include, but are not limited to the following:

- when a parent or other person legally responsible for care inflicts serious physical injury upon a child or commits a sex offense against a child;
- situations where a parent or other persons legally responsible knowingly allows someone else to inflict such harm on a child;
- failure to provide sufficient food, clothing or shelter;
- failure to provide proper supervision, guardianship or care;
- mis-using alcohol or other drugs to the extent that the child is placed in imminent danger.

C. Community - Site Safety

Providers are required to observe all community-based sites that they identify as the desired setting for EI service delivery on a regular basis, to ensure there are no potential hazards to the health and safety of children during the provision of services. Providers are recommended to observe the site for health and safety hazards when the parent has identified the community site as the desired location for their child to receive EI services. Providers must have procedures in place to report to the parent, and EIO any concerns the provider has with such setting, and if necessary, discuss an alternate location for services. The areas listed in the Community Health and Safety Items List that is provided in Appendix A are suggested areas to observe for the community based service setting.

If a provider is notified of, or observes a health and safety hazard that may pose a danger to the child receiving services at a community-based setting, the provider must report this to the EIO and the parent. The EIO, provider and parent must then discuss whether an alternate service location should be used. See Appendices O and P.

D. Toy Safety-Facility/Home/Community:

- All toys must be checked for lead hazard prior to use with children. Please subscribe to the site listed below to receive alerts via email each time a hazardous toy is identified. Visit the listed sites to view alerts on the following websites for lead hazard product recalls and product safety

  https://www.health.ny.gov/environmental/children/recalls.htm
  https://www.cpsc.gov/Recalls/ https://www.safekids.org/product-recalls
- All toys must be developmentally appropriate and be large enough in it' size and parts to not be able to be chocked on by a toddler. A gauge for this is larger than the width of a cardboard toilet paper roll.

- No toy can be broken with sharp edges or loose small parts.

IX. Universal Pre-Cautions/Infection Control Guidelines

Sound health practices must be followed by all providers. The guidelines are considered essential to health management. However, they are not substitutes for immunizations, regular check-ups and other aspects of child health care. These rules are important to follow when providing home-based services as well as school or office based services. **(Appendix K: Understanding the Spread of Disease)**

A. Hand Washing:

Hand washing is the most important infection control measure to prevent illness in yourself and the children you care for. When providers, children, and parents wash their hands at the proper times, and with the proper technique, the amount of illness in childcare can be drastically reduced.

When Should Hands Be Washed?

When and how often hands are washed is more important than what they are

washed with. Providers and children should wash their hands upon arrival and beginning of each service at the program, and at least:

Before:

- Eating/drinking or handling food
- Feeding a child

After:

- Handling blood fluids such as blood, urine, stool, vomit, saliva, mucus, etc. (including wiping noses)
- Cleaning up or handling garbage
- Playing or working outdoors
- Handling pets and other animals, their cages, or other pet objects
- Touching sick children, especially those who skin lesions
- Handling uncooked food, especially raw meat and poultry
- Serving food to a child
- Removing gloves used for any purpose
- Hands are visibly dirty
- Leaving rest room
- If lesions are on hands, gloves must be worn. All open lesions should be covered with a band-aid and/or other bandage.

All providers must practice hand washing/sanitization at all times. All providers must wash their hands and child's hands at the beginning of each session, whether it is in the child's home, school or ALL ABOUT KIDS Treatment Center. If session is in the home, hands are to be washed <u>after entering</u> home, in sight of parent/legal guardian.
All providers must have disposable gloves, disinfecting hand wipes/lotion and paper toweling immediately accessible to them at all times.
On Site: Box of gloves is to be available in each therapy room.
Home/Community: Providers are to carry gloves disinfecting hand wipes/lotion and paper toweling on their person.

B. Use of Disposable Gloves:

<u>When Must Disposable Gloves Be Used?</u>

- Giving assistance to someone who is bleeding
- Cleaning up blood or other bodily wastes from various surfaces
- When changing diapers or assisting a child with toileting
- Serving food to a child

<u>Putting On Disposable Gloves</u>

- A different pair of gloves must be used for each incident, never reuse a pair of gloves.
- Disposable gloves do not need to be sterile; they can be put on like any other type of glove.

- Some disposable gloves have powder inside for each in putting on and to absorb moisture and reduce friction. Powdered gloves, however, do not provide any additional protection.

Precautions While Wearing Gloves

- After the process of controlling the blood flow or cleaning soiled surfaces is completed, the wearer of gloves must not touch other people or surrounding surfaces (e.g. use paper towels, tissues). Any materials used to clean blood must be discarded before removing gloves.

Removing Disposable Gloves

- Pinch with two fingers the OUTSIDE of one glove with the other gloved hand. Turn the glove inside out as you pull it off. The soiled side of the glove is no on the inside. Discard the glove in an approved waste receptacle.
- Reach INSIDE the second glove with two fingers of your bare hand and pinch it. Turn the glove inside out as you pull it off. Discard it.
- Wash hands carefully with soap and water AFTER gloves have been removed and discarded. This is essential for good hygiene.
- DISCARD ALL CONTAMINATED MATERIALS AND USED GLOVES IN DESIGNATED PLASTIC-LINED RECEPTACLES. DISINFECT CONTAMINATED SURFACES. **(Appendix L: Gloving)**

Proper Hand washing

The following guidelines have been developed by the Nassau County Department of Health and are considered essential to health management. Hand washing is one of the most simple and effective means to protect yourself and others from infectious diseases:

1. Remove wristwatch and rings.
2. Turn on water
3. Wet hands with warm running water. Running water is necessary to carry away dirt and debris.
4. Apply soap, lather well.
5. Wash hands, using a circular motion and light friction, for 15 to 30 seconds. Include front and back surfaces of hands, between fingers and knuckles, around and under finder nails and entire wrist area.
6. Rinse hands well under warm running water. Pont fingers down under the water to that the water drains from the wrist area to fingertips.
7. Dry hands well with paper towels and turn off water using the paper towel instead of bare hands.
8. Discard the paper towels in receptacle.

C. Cleaning and Disinfecting:

Providers must use appropriate cleaning solutions depending on whether cleaning blood or other high-risk bodily fluids, or daily routine cleaning. Toxic and flammable materials and daily hand disinfectant must be stored and locked away from children to prevent access.

Blood Spills or Potentially Infectious Material:

Preparing Bleach Solution

For certain types of heavily contaminated, blood or other very high-risk body fluids, a solution of 1 tablespoon of bleach in 1 quart of water is necessary. This solution must be made fresh daily for use in order to be effective. Use this stronger solution, which might gradually eat away some surfaces or cause excessive wear if used routinely, in the following situations:

- To clean and disinfect all blood spills or blood contaminated items.
- To clean and disinfect gross contamination with body fluids, such as large amounts of vomit or feces. (This is not necessary for removing traces of feces or urine from a changing table or small amounts of "spit-up" from a high-chair tray).

You must use your judgment to decide which strength is needed. The use of rubber gloves is required whenever you must clean areas contaminated with body fluids.

Everyday / Routine Cleaning:

Bleach Solution:
The standard recommended bleach solution is 1 teaspoon bleach to one-gallon water. Use this solution for routine, everyday cleaning and disinfecting of items and surfaces, tabletops, toys, eating utensils and plates. Other food contact surfaces should be cleaned with ¼ teaspoon of bleach in 1 quart of water made fresh daily. Commercially available products can be used in lieu of the standard bleach solution (see below).

You do not need to buy commercially sold disinfectants, since recommended bleach solutions can be made easily at very little cost. However, you do need to make any bleach solution each day because bleach loses its strength (and thus its effectiveness) as it is exposed to air. It is best to store it in a carefully labeled spray bottle.

Commercial Disinfectants:
Weaker commercial disinfectants can be used for toys, equipment, etc.: **Clorox®** Anywhere Hard Surface™ - a new daily sanitizing spray that kills 99.9% of bacteria on hard, nonporous surfaces that is safe to use around children, food and pets.
It leaves no harmful residue, (We recommend it for daily toy/equipment cleaning).
This cannot be used for clean-up for blood or potentially infectious material (PIM).

Cleaning Up a Spill of Hazardous Materials
Blood or Potentially Infectious Material (PIM):
When clean up involves blood or PIM that is on a keyboard or flat surface, you should first delineate and mark the spill area so that others do not inadvertently enter the area until clean-up is complete. Put on personal protective equipment before beginning clean up. Minimal equipment consists of gloves, goggles, mask, and coveralls or other outer garment.

Small spills should be wiped up with paper towels, and then decontaminated with a proper disinfectant. Spill kits designed for cleaning up small spills (less than 8 ounces) of potentially infectious material are commercially available.

Large spills can be quickly contained by creating a circular barrier around the perimeter of the spill with absorbent material (hy-dri, kitty litter) Residual liquids in the center of the ring can be soaked up with additional absorbent or absorbent pads. Place the absorbent in a biohazard waste bag.

Soak the area for at least 20 minutes with a disinfectant (freshly-prepared 10% bleach solution). You can be liberal with disinfectant but don't apply so heavily that it begins to run. Allow at least 20 minutes for the disinfectant to complete the decontamination. You can use the small hand broom and dustpan to clean up the spill.

Deposit all clean up material in a disposal bag and labeled bio waste and close tightly. The bag should be secured in a biohazard "burn box". Call your local Hazardous Materials Handling Facility or Biological and Medical Waste Disposal Services and arrange for bio-waste pick up.

Carefully remove gloves, coveralls, and boots, (if used) and discard in a bio-waste bag. If used, the facemask should also be disposed. Goggles can be disinfected, rinsed and reused.

The dustpan and broom can also be disinfected, rinsed, air-dried and reused. After cleaning and disinfecting your equipment, return it to its proper storage area. Replace PPE, bags, and other items so that they will be available for future use.

Have These Materials on Hand for Cleaning Up Spills:

- A durable container to store up supplies
- Several biohazard labeled bags
- Disinfect – freshly painted 10% solution of household bleach (1 part bleach and 9 parts water; or add a scant ½ cup bleach to 1 quart of water) or other commercial chlorine or iodine based disinfectant)
- Inert absorbing material (e.g. hy-dri, kitty litter, absorbent pads)
- A small dustpan and hand brush
- Personal protective equipment, including several pairs of latex gloves, face-masks (goggles, coveralls, and paper boots)
- A heavy cardboard box
- A roll of paper towels
- Antiseptic wipes

***Home/Community Therapists:** If you are in the field and a spill of blood or PIM contaminates your therapy tools/personal item, you may, while using universal precautions, place item in a sealed plastic bag labeled bio-hazard for cleaning and disposing at a later time.

D. Toys/Equipment:

All providers will be responsible for checking that all toys equipment receive the appropriate care and meet the following guidelines:

Toys/Equipment that are Mouthed:

All toys or equipment that is mouthed during the course of the day will be set aside in an accessible container before another child plays with the toy. Mouthed toys or equipment will be thoroughly washed with a bleach and water solution before reuse. Toys may be washed and disinfected by hand or washing in a dishwasher.

To Disinfect a Hard Plastic Toy:

- Wash toy in warm, soapy water. Rinse in clean running water.
- Place toy in mild bleach solution made from 1 tablespoon of bleach and 1 gallon of water 10-20 minutes. This solution should be mixed fresh for each use as it loses its effectiveness after one day.
- Use a brush to get crevices clean.
- Rinse well and allow to air dry.
- Plastic toys may be washed in the dishwasher.

Cloth toys may be cleaned in hot water cycle of washing machine.

Children receiving oral motor of feeding therapy should have their own materials stored in clearly marked plastic bag before and after washing.

All Toys Used but not Mouthed:

- Non-porous toys should be wiped or sprayed with a child safe disinfectant wipe or spray after each use. These toys must be thoroughly disinfected at least weekly with a bleach solution, disinfectant spray or washed in a dishwasher.
- Do not use toys or items that cannot be washed or wiped down with a disinfectant (i.e. cloth toys, blankets, etc.)

On Site: Large Equipment not mouthed:

- All large equipment/mats/therapy must be sprayed/wiped down with a disinfectant after each use.
- A weekly cleaning schedule for disinfecting of equipment must be posted in motor room.
- Children in diapers are not allowed in ball pit.
- All children/staff must have covered feet on floors, equipment, mats
- No children with apparent illness (sneezing, running nose) are allowed mats, ball pit, climbing equipment.

On Site: Items requiring daily disinfecting:

- All toys in waiting area

- Diaper area
- Faucets and handles of all sinks
- Door knobs of rooms

X. Food Handling and Feeding Policy

A. Drinking Water:

Safe drinking water will be available to all children Drinking water will be dispensed by single-use paper cups.

B. Food Safety/Dishes, Utensils and Surfaces:

If ALL ABOUT KIDS personnel provide snacks to a child whether as part of his/her therapy program or as a reward, the following must be adhered to:

- Only provide snack with permission of the family.
- Check that the child does not have any food intake limitations because of allergies, medical, oral motor limitations, religious or cultural limitations.
- Any child that has a food allergy shall have a plan developed by the parent, primary care provider, EI provider and EIO, which includes identification and documentation of the allergy, prevention of exposure, and required plan to treat an allergic reaction.
- Children do not share drinking cups, even among siblings in the home setting.
- The provider's use of highchairs may only be used for feeding purposes or therapy and is consistent with the child's developmental status and cannot be used as a restraint.

Food Allergens: All providers regardless of location of therapy are to follow a non-specific child protocol and child specific protocol for the child regarding allergen prevention measures. All providers must know and have documentation of the specific allergens causing anaphylactic reactions for the child.

- Use only "safe" reinforcers, snack, or foods.
- Reinforce hand washing before and after eating of for yourself and child(ren).
- Avoid cross-contamination of foods by cleaning surfaces with soap and water before and after eating with designated cloth (not shared), and before and after each session.
- Antibacterial hand sanitizers have not shown to be sufficient at removing food allergens. Clean table thoroughly with a disposable cloth that is not placed in a solution with other cloths to avoid cross-contamination.
- Present any food to a child on a paper dish or napkin if placed on table.
- ALL ABOUT KIDS facility or child's daycare/school: have child eat in area that is allergen safe.
- Consider non-food treat when possible.
- Foods must be "healthy" or "nutritious ".
- Foods should be based on child's developmental abilities e.g. avoid popcorn and peanuts.

- Safe drinking water must be on site at ALL ABOUT KIDS and available to children if needed.
- Disposable cups and plates may be used if discarded after use. Plastic eating utensils may be used if such utensils are not easily broken by young children. Styrofoam cups may not be used for infants or toddlers. The use of common drinking cups or utensils is prohibited.
- Food contact surfaces must be clean and washed after every use.
- Gloves need to be worn at all times when working with food or having direct contact with a child's mouth.
- Adaptive utensils used in the provision of services must be sanitized after each use.
- Anyone with signs of illness (including vomiting, diarrhea, open infections skin sores) or who is known to be infected with bacteria or viruses that can be carried in food will not be responsible for food handling.
- Children will eat only when seated to decrease the possibility of choking.
- Adults will not eat or drink anything the children are not allowed to have while the adults are in view of the children.
- All food stored in the refrigerator except fresh, whole fruits and vegetables will be covered, wrapped, or protected from contamination.
- Foods that do not require refrigerated storage will be kept at least 6 inches above the floor in clean, dry, well-ventilated storerooms or other approved area. Storage will facilitate easy cleaning.

On Site: Staff Eating Area

- No common sponges, or cloth towels, paper toweling are to be used. A drain is to be available for air-drying. Liquid soap is to be available.
- Each person is to disinfect table after using it.
- All dishware must be washed immediately after use by person who used it.
- All guidelines for food safety, dishes, utensils, and surfaces to be followed as above.

XI. Smoking, Prohibited Substances, and Guns

A. Controlled Substances/Smoking:

Consumption of or being under the influence of alcohol or controlled substances by ALL ABOUT KIDS personnel is prohibited. Possession of illegal substances or unauthorized potentially toxic substances is prohibited. Providers, staff or other adults who are inebriated, intoxicated, or otherwise under the influence of mind altering or polluting substances will be required to leave the premises immediately.

Smoking in indoor or outdoor areas where children are treated (i.e. home, childcare, school) or while treating or in the presence of a child, his/her family is prohibited. ALL ABOUT KIDS Evaluations and Therapy Centers are smoke free and no smoking by anyone on site, including parents, is to be strictly enforced.

Policy Prohibiting Electronic Smoking Device (E-Cigarettes) To Be Used In Smoke-Free Places:

ALL ABOUT KIDS is committed to providing a safe, orderly, and productive environment for its employees and the public who enter the premises.

In addition to New York State's Smoke-Free Workplace and Public Places Law, it is the policy of ALL ABOUT KIDS that the use of electronic smoking devices (also known as electronic cigarettes or "e-cigarettes") is prohibited in any place where smoking of tobacco products is prohibited by law.

This directive applies to all employees, visitors, volunteers, students, contract workers, delivery personnel, etc., who enter the work setting or environment which includes all facilities and properties of ALL ABOUT KIDS.

The unrestricted use of electronic smoking devices is potentially hazardous to health and is disruptive to an orderly, productive environment. The use of unregulated electronic smoking devices in existing smoke-free locations threatens to undermine compliance with smoking regulations, confuses the public, and reverses the progress that has been made in establishing a social norm that smoking is not permitted in public places and places of employment.

By prohibiting the use of electronic smoking devices in places where smoking is prohibited, ALL ABOUT KIDS protects its employees and visitors from involuntary exposure to the second hand byproducts of electronic smoking devices such as "e-vapor" and reduces the likelihood that the public will associate the use of electronic smoking devices at ALL ABOUT KIDS with healthful behavior, reduces the likelihood of workplace disturbances, and enhances employee productivity.

<u>Definitions:</u>
Electronic smoking device: Any electronic product that can be used to simulate smoking in the delivery of nicotine or other substances to the person inhaling from the device, including but not limited to an electronic cigarette, electronic cigar, electronic cigarillo, or electronic pipe, and any cartridge or other component of the device or related product.

B. Guns/Lethal Weapons:

No guns or other lethal weapons will be in the ALL ABOUT KIDS the treatment center or brought to any other therapy location by the provider.

Distribution and training of ALL ABOUT KIDS' Health & Safety Plan is to occur upon hire of personnel and annually thereafter.

LDSS-2221A . 09 2016

APPENDIX A:

REPORT OF SUSPECTED CHILD ABUSE OR MALTREATMENT

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SUBJECTS OF REPORT

.	Sex (m, f, unk)	Birthday or Age mo/day/yr		only if			.
1.				☐			
2.				☐			
3.				☐			
4.				☐			
5.				☐			
6.				☐			
7.				☐			

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BASIS OF SUSPICIONS

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☐ **Additional sheet attached with more explanation.** **The Mandated Reporter Requests Finding of Investigation** ☐ ☐

CONFIDENTIAL		**SOURCE(S) OF REPORT**	*CONFIDENTIAL*

RELATIONSHIP

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___ ___ ___ ___ ___

For use by Physicians only		**X**	.
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LDSS-2221A . 09 2016 **APPENDIX A**:

TO ACCESS A COPY OF THE LDSS-2221A FORM: Via Internet: http://ocfs.ny.gov/main/documents/forms_keyword.asp OR

TO ORDER A SUPPLY OF FORMS ACCESS FORM (OCFS-4627) ***Request for Forms and Publications***
THE OFFICE OF CHILDREN AND FAMILY SERVICES, FORMS AND PUBLICATIONS UNIT, 52 WASHINGTON ST. ROOM 134 NORTH, RENSSELAER, NY 12144-2834. the Forms Order Line at 518-473-0971.

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES

RACE CODE	ETHNICITY CODE	RELATION CODES FAMILIAL REPORTS (Choose One)	ROLE CODE (Choose One)	LANGUAGE CODE (Choose One)
AA: Black or African-American **AL**: Alaskan Native **AS**: Asian **NA**: Native American **PI**: Native Hawaiian/Pacific Islander **WH**: White **XX**: Other **UNK**: Unknown	*(Check **Only If** Hispanic/ Latino)*	**AU**: Aunt/Uncle **XX**: Other **CH**: Child **PA**: Parent **GP**: Grandparent **PS**: Parent substitute **FM**: Other family member **UH**: Unrelated home member **FP**: Foster parent **UK**: Unknown **DC**: Daycare provider **IAB REPORTS ONLY** **AR**: Administrator **IN**: Instit. non-prof **CW**: Child care worker **IP**: Instit. pers/vol. **DO**: Director/operator **PI**: Psychiatric staff	**AB**: Abused child **MA**: Maltreated child **AS**: Alleged subject (perpetrator) **NO**: No role **UK**: Unknown	**CH**: Chinese **KR**: Korean **CR**: Creole **MU**: Multiple **EN**: English **PL**: Polish **FR**: French **RS**: Russian **GR**: German **SI**: Sign **HI**: Hindi **SP**: Spanish **HW**: Hebrew **VT**: Vietnamese **IT**: Italian **XX**: Other **JP**: Japanese

Abstract of Sections from Article 6, Title 6, Social Services Law
Section 412. Definitions

1. **Definition of Child Abuse,** . . . 1012

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3 .

2. **Definition of Child Maltreatment,** . . . 1012

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3

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6
7 .

Section 415. Reporting Procedure.
48 .

Submit the written paper copy of the LDSS-2221A form originally signed to: the Local County Department of Social Services (LDSS) where the abused/maltreated child resides.
To locate your Local Department of Social Services, visit this site _____

Residential institutional abuse reports: Call 1-855-373-2122 or go online to: _____

NYS CHILD ABUSE AND MALTREATMENT REGISTER: 1-800-635-1522 (FOR MANDATED REPORTERS ONLY)
1-800-342-3720 (FOR PUBLIC CALLERS)

Section 419. Immunity from Liability, 419

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Section 420. Penalties for Failure to Report.
1.

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2.

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2221 *(IF NEEDED)*

APPENDIX A:

REPORT OF SUSPECTED CHILD ABUSE OR MALTREATMENT

(Use only if the space on the LDSS-2221A under "Reasons for Suspicion" is not enough to accommodate your information)

☐ ☐		

PERSON MAKING THIS REPORT: _____

Print clearly if filling out hard copy.

Continued:	☐ ☐

NEW YORK STATE | Office of Children and Family Services

Summary Guide for Mandated Reporters in New York State

This material provides mandated reporters with an overview of their obligations and some basic information about the New York State Child Protective Services (CPS) system.

Who Are Mandated Reporters?

New York State recognizes that certain professionals are specially equipped to perform the important role of mandated reporter of child abuse or maltreatment. Those professionals include:

- Physician
- Registered physician's assistant
- Surgeon
- Medical examiner
- Coroner
- Dentist
- Dental hygienist
- Osteopath
- Optometrist
- Chiropractor
- Podiatrist
- Resident
- Intern
- Psychologist
- Registered nurse
- Social worker
- Emergency medical technician
- Licensed creative arts therapist
- Licensed marriage and family therapist
- Licensed mental health counselor
- Licensed psychoanalyst
- Licensed behavior analysts
- Certified behavior analyst assistants
- Hospital personnel engaged in the admission, examination, care or treatment of persons
- Christian science practitioner
- School official, including (but not limited to):
  - teacher
  - guidance counselor
  - psychologist
  - social worker
  - nurse
  - administrator or other school personnel required to hold a teaching or administrative license or certificate
- Social services worker
- Director of a
  - children's overnight camp,
  - summer day camp or
  - traveling summer day camp
- Day care center worker
- School age child care worker
- Provider of family or - group family day care
- Employee or volunteer in a residential care facility for children
- Any other child care or foster care worker
- Mental health professional
- Substance abuse counselor
- Alcoholism counselor
- All persons credentialed by the NYS Office of Alcoholism and Substance Abuse Services
- Peace officer
- Police officer
- District attorney or assistant district attorney
- Investigator employed in the office of the district attorney
- Any other law enforcement official

The entire current list can be found in Article 6, Title 6, and Section 413 of the New York Social Services Law. The website can be accessed online through the New York State Legislature's Website (http://public.leginfo.state.ny.us/menuf.cgi). Click on Laws of New York to access Social Services Law.

When Am I Mandated to Report?

Mandated reporters are required to report suspected child abuse or maltreatment when they are presented with a reasonable cause to suspect child abuse or maltreatment in a situation where a child, parent, or other person legally responsible for the child is before the mandated reporter when the mandated reporter is acting in his or her official or professional capacity. “Other person legally responsible” refers to a guardian, caretaker, or other person 18 years of age or older who is responsible for the care of the child.

Mandated reporters who are social services workers have expanded reporting requirements. Social services workers are required to report when, in their official or professional role, they are presented with a reasonable cause to suspect child abuse or maltreatment where any person is before the mandated reporter and the mandated reporter is acting in his or her official or professional capacity.

What is a Professional Role?

For example, a doctor examining a child in her practice who has a reasonable suspicion of abuse must report her concern. In contrast, the doctor who witnesses child abuse when riding her bike while off-duty is not mandated to report that abuse. The mandated reporter’s legal responsibility to report suspected child abuse or maltreatment ceases when the mandated reporter stops practicing his/her profession. Of course, anyone may report any suspected abuse or maltreatment at any time and is encouraged to do so.

Reasonable Cause to Suspect

Reasonable cause to suspect child abuse or maltreatment means that, based on your rational observations, professional training and experience, you have a suspicion that the parent or other person legally responsible for a child is responsible for harming that child or placing that child in imminent danger of harm. Your suspicion can be as simple as distrusting an explanation for an injury.

What Is Abuse and Maltreatment?

Abuse

Abuse encompasses the most serious injuries and/or risk of serious injuries to children by their caregivers. An abused child is one whose parent or other person legally responsible for his or her care inflicts serious physical injury upon the child, creates a substantial risk of serious physical injury, or commits a sex offense against the child. Abuse also includes situations where a parent or other person legally responsible knowingly allows someone else to inflict such harm on a child.

Maltreatment (Includes Neglect)

Maltreatment means that a child's physical, mental or emotional condition has been impaired, or placed in imminent danger of impairment, by the failure of the child's parent or other person legally responsible to exercise a minimum degree of care by:

- failing to provide sufficient food, clothing, shelter, education;

  or

- failing to provide proper supervision, guardianship, or medical care *(refers to all medical issues, including dental, optometric, or surgical care)*; or
- inflicting excessive corporal punishment, abandoning the child, or misusing alcohol or other drugs to the extent that the child was placed in imminent danger.

Poverty or other financial inability to provide the above is not maltreatment.

Note: *The definitions of abuse and maltreatment are different for children in residential facilities operated or licensed by the state.*

How Do I Recognize Child Abuse and Maltreatment?

The list that follows contains some common indicators of abuse or maltreatment. This list is not all-inclusive, and some abused or maltreated children may not show any of these symptoms.

Indicators of Physical Abuse Can Include:

- Injuries to the eyes or both sides of the head or body *(accidental injuries typically only affect one side of the body);*
- Frequent injuries of any kind *(bruises, cuts, and/or burns)*, especially if the child is unable to provide an adequate explanation of the cause. These may appear in distinctive patterns such as grab marks, human bite marks, cigarette burns, or impressions of other instruments;
- Destructive, aggressive, or disruptive behavior;
- Passive, withdrawn, or emotionless behavior;
- Fear of going home or fear of parent(s).

Indicators of Sexual Abuse Can Include:

- Symptoms of sexually transmitted diseases;
- Injury to genital area;
- Difficulty and/or pain when sitting or walking;
  Sexually suggestive, inappropriate, or promiscuous behavior or verbalization;
- Expressing age-inappropriate knowledge of sexual relations;
- Sexual victimization of other children.

Indicators of Maltreatment Can Include:

- Obvious malnourishment, listlessness, or fatigue;
- Stealing or begging for food;
- Lack of personal care—poor personal hygiene, torn and/or dirty clothes;
- Untreated need for glasses, dental care, or other medical attention;
- Frequent absence from or tardiness to school;
- Child inappropriately left unattended or without supervision.

NEW YORK STATE | Office of Children and Family Services

Summary Guide for Mandated Reporters in New York State

Where Do I Call to Make a Report?

As soon as you suspect abuse or maltreatment, you must report your concerns by telephone to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR). The SCR is open 24 hours a day, seven days a week, to receive your call. The timeliness of your call is vital to the timeliness of intervention by the local department of social services' Child Protective Services (CPS) unit. You are not required to notify the parents or other persons legally responsible either before or after your call to the SCR. In fact, in some cases, alerting the parent may hinder the local CPS investigation and adversely affect its ability to assess the safety of the children. The telephone numbers to report abuse or maltreatment by a parent, foster care or day care are:

Mandated Reporter (800) 635-1522
Public Hotline (800) 342-3720
For Abuse by Institutional Staff:
1-855-373-2122

Oral reports to the SCR from a mandated reporter must be followed within 48 hours by a written report to the local department of social services' CPS unit on form **LDSS-2221A**.

A copy of this form and the local mailing address can be obtained by contacting your local department of social services, or by visiting the New York State Office of Children and Family Services (OCFS) website at **ocfs.ny.gov**. Click on "Forms", then click on "Try a keyword search…", enter the form number in the box and click "Find".

To contact your local department of social services, click here: **http://ocfs.ny.gov/main/localdss.asp**

What Happens When I Call the SCR?

There may be times when you have very little information on which to base your suspicion of abuse or maltreatment, but this should not prevent you from calling the SCR. A trained specialist at the SCR will help to determine if the information you are providing can be registered as a report.

The **LDSS-2221A** *Mandated Reporter* form can be used to help you organize the identifying or demographic information you have at your disposal. Be sure to ask the SCR specialist for the "Call I.D." assigned to the report you have made.

If the SCR staff does not register the child abuse or maltreatment report, the reason for their decision should be clearly explained to you. You may also request to speak to a supervisor, who can help make determinations in difficult or unusual cases.

Local CPS Role and Responsibilities

When a report is registered at the SCR, the local department of social services is immediately notified for investigation and follow-up. A local CPS caseworker will initiate an investigation within 24 hours.

CPS intervention consists of an evaluation of the child and other children in the home and the development of a plan to meet the needs of the child and family. If there is an immediate threat to the child's life or health, CPS may remove the child from the home.

Upon request, CPS may obtain from the mandated reporter those records that are essential to a full investigation of alleged child abuse and maltreatment for any report made by the mandated reporter. The mandated reporter must determine which records are essential to the full investigation and provide those records to CPS when requested to do so.

Within 60 days of initiating the investigation, CPS will determine whether the report is indicated or unfounded. Mandated reporters may ask to be informed of the outcome of the report.

Law Enforcement Referrals

If a call to the SCR provides information about an immediate threat to a child or a crime committed against a child, but the perpetrator is not a parent or other person legally responsible for the child, the SCR staff will make a Law Enforcement Referral (LER). The relevant information will be recorded and transmitted to the New York State Police Information Network or to the New York City Special Victims Liaison Unit. This is not a CPS report, and local CPS will not be involved.

NEW YORK STATE | Office of Children and Family Services

Summary Guide for Mandated Reporters in New York State

What Protection or Liability Do I Have? Source Confidentiality

The Social Services Law provides confidentiality for mandated reporters and all sources of child abuse and maltreatment reports. OCFS and local CPS are not permitted to release to the subject of the report any data that would identify the source of a report unless the source has given written permission for them to do so. Information regarding the source of the report may be shared with court officials, police, and district attorneys, but only in certain circumstances.

Immunity from Liability

If a mandated reporter makes a report with earnest concern for the welfare of a child, he or she is immune from any criminal or civil liability that might result. This is referred to as making a report in "good faith."

Protection from Retaliatory Personnel Action

Section 413 of the Social Services Law specifies that no medical or other public or private institution, school, facility or agency shall take any retaliatory personnel action against an employee who made a report to the SCR. Furthermore, no school, school official, child care provider, foster care provider, or mental health facility provider shall impose any conditions, including prior approval or prior notification, upon a member of their staff mandated to report suspected child abuse or maltreatment.

Penalties for Failure to Report

Anyone who is mandated to report suspected child abuse or maltreatment—and fails to do so—could be charged with a Class A misdemeanor and subject to criminal penalties. Further, mandated reporters can be sued in a civil court for monetary damages for any harm caused by the mandated reporter's failure to make a report to the SCR.

Who Provides Training for Mandated Reporters?

The New York State Education Department (SED) Office of the Professions oversees the training requirements for mandated reporters. Some categories—including teachers, many medical professionals, and social workers—need this training as part of their licensing requirement. The training may be included in their formal education program.

The New York State Office of Children and Family Services (OCFS) is proud to be a certified provider authorized by SED to offer mandated reporter training, and has developed a comprehensive curriculum with content customized to medical professionals, educators, law enforcement personnel, day care providers, and human services staff.

OCFS has shared this well-received curriculum with other certified providers of mandated reporter training, as well as with colleges and universities across the state that provide educational programming in the fields covered by the mandated reporter statute.

OCFS provides mandated reporter training through a contractual agreement with the CUNY School of Professional Studies.

OCFS offers a Self-Directed Online Training for mandated reporters. This two-hour web-based online training course is available 24/7 and is accessible at:

www.nysmandatedreporter.org.

There is no cost to the participant.

Special Note: *Mandated Reporters who require licensure or certification through the New York State Department of Education (NYSED) are required to take mandated reporter training from a trainer who has been approved by the New York State Education Department. For more information, please go to* ***http://www.op.nysed.gov*** *or contact the New York State Education Department at:*

OPPLEUCA@mail.NYSSED.gov.

Conclusion

Protecting children and preventing child abuse and maltreatment does not begin or end with reporting. Efforts to prevent child abuse and maltreatment can only be effective when mandated reporters and other concerned citizens' work together to improve the safety net in their communities.

To be most effective, your local CPS needs strong partnerships within your community. By getting to know the staff in your local CPS unit, you will gain a better understanding of how your local program is structured, and CPS will better understand how to work more effectively with you.

By working together, we can better protect our vulnerable children.

New York State Office of Children & Family Services
Capital View Office Park, 52 Washington Street
Rensselaer, New York 12144

To report child abuse and neglect, call: **1-800-342-3720**

For information on the Abandoned Infant Protection Act, call: **1-866-505-SAFE (7233)**

Mandated Reporters Hotline for making child abuse and maltreatment reports: **1-800-635-1522**

Justice Center for Institutional Abuse: **1-855-373-2122**

For additional copies of this pamphlet visit our website at: ocfs.ny.gov and click on "Publications."

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Pub-1159 (Rev. 01/2019)

APPENDIX C:

EXCLUSION/READMISSION DUE TO ILLNESS

Disease	If a Child in Your Care Has Been Diagnosed With This Disease You Should	When to Allow Child to Return
Bacterial Meningitis	• Exclude the child from child care. (In most cases, the child will be hospitalized.) • Immediately contact your Health Department to report the case of meningitis. They will contact the child's physician and make recommendations about what to do to prevent the spread of infection. • Ask whether you need to contact the parents of the other children in your facility. The Health Department may recommend antibiotics for children and adults in the facility. • If so, in cooperation with the Health Department, contact the parents of the children in your facility and tell them: • that their child may have been exposed to meningitis. • that their child should see a physician IMMEDIATELY if fever, headache, rashes, spots, unusual behavior, or any other symptom that concerns them develops. • to follow any preventive measures the Health Department recommends. • Carefully follow group separation and good hygiene procedures. (See chapter on Protective Practices.)	When the Health Department tells you it is safe.
Chickenpox	• Temporarily exclude the sick child from the child care setting. • Notify parents, especially those whose child is • taking steroid medications. • being treated with cancer or leukemia drugs. • is immunosuppressed. (Chickenpox can be extremely dangerous to these children.) • You may contact your Health Department to find out what other preventive measures to take. • Carefully follow group separation, hand washing, and cleaning procedures. (See chapter on Protective Practices.)	6 days after the rash begins or when blisters have scabbed over.
Diarrheal Disease	• Temporarily exclude the sick child from the child care setting. • Carefully follow group separation, hand washing, and cleaning procedures. (See chapter on Protective Practices.) • If you know the diarrhea is caused by bacteria or a parasite such as shigella, campylobacter, *E. coli, Cryptosporidium,* salmonella, or giardia, ask the Health Department	When the child no longer has diarrhea. However, some of these diseases require negative stool cultures; allow the child to return when the Health Depart-ment tells you it is

	• Whether other ill and well children and adults should be tested. • when to allow the sick child to return to child care.	safe.
Diphtheria	• Temporarily exclude the sick child from the child care setting. • Immediately contact the Health Department to ask what additional preventive measures should be taken. • Observe all children and adults for sore throats for 7 days. • Anyone developing a sore throat should see a physician. • Advise parents that their child should see a physician if • the child develops a sore throat. • the child is incompletely immunized against diphtheria. • Carefully follow group separation and good hygiene procedures. (See chapter on "Protective Practices.")	When the Health Department tells you it is safe.
Epiglottitis	• A child diagnosed with this disease will probably be hospitalized. Contact your Health Department and ask what preventive measures to take. — The Health Department may tell you to contact all parents and tell them 1. that their children may have been exposed to a serious contagious disease, 2. that their children should immediately see a physician if they develop *fever, headache, symptoms of infection, or behavior that seems unusual* and 3. about any additional preventive measures the Health Department has recommended. • Carefully follow group separation and good hygiene procedures. IMPORTANT: *H-flu* is not the same germ as "flu" or influenza. *H-flu* can cause SERIOUS ILLNESS in young children. If a case of *H-flu* occurs in your facility, TAKE ALL ACTIONS ABOVE.	Not due to *H-flu*: When treating physician tells you it is safe. Due to *H-flu*: When the Health Department tells you it is safe.
Hand- Foot- and- Mouth Disease	• Exclude if child has open, draining lesion on hand or has lesions in the mouth AND is drooling.	When lesions heal or drooling ceases.
Head Lice	• Temporarily exclude the infested child from the child care setting. • Contact your Health Department or health consultant for advice about examining, treating, and readmitting exposed children and adults. • Check the other children for lice or nits (eggs of lice).	24 hours after treatment.
Hepatitis A	• Temporarily exclude the sick child from the child care setting. • Immediately notify your Health Department. (They may recommend immune globulin shots and possibly vaccination for children and adults and additional preventive measures.) Ask for specific recommendations on notifying parents and on exclusion policies. • Carefully follow group separation and good hygiene	1 week after illness begins (onset of jaundice or yellow appearance).

	procedures.	
Influenza	In the absence of an epidemic, influenza is difficult to diagnose and usually the diagnosis comes after the end of the infectious period, so exclusion will be impractical.	N/A
Measles	• Temporarily exclude the sick child from the child care setting. • Immediately notify your Health Department. • Identify unimmunized children and adults and make sure they get vaccinated and/or exclude them from the child care setting until 2 weeks after rash appears in the last child who had measles in the child care setting.	5 days after rash appears and Health Department says it is safe.
Mumps	• Temporarily exclude the sick child from the child care setting. • Carefully follow group separation and good hygiene practices. • Notify Health Department.	9 days after swelling begins.
Pertussis (Whooping Cough)	• Temporarily exclude the sick child from the child care setting. • Immediately notify your Health Department. • Exclude, until diagnosed by a physician, any child who develops a cough within 2 weeks of the case. • Carefully follow group separation and good hygiene procedures.	5 days after antibiotics are begun and Health Department says it is safe.
Pinworms	• Temporarily exclude the child from child care setting. • Notify parents.	24 hours after treatment and bathing.
Pneumonia	• A child diagnosed with this disease will probably be hospitalized. Contact your Health Department and ask what preventive measures to take. — The Health Department may tell you to contact all parents and tell them 1. that their children may have been exposed to a serious contagious disease, 2. that their children should immediately see a physician if they develop *fever, headache, symptoms of infection, or behavior that seems unusual,* and 3. about any additional preventive measures the Health Department has recommended. • Carefully follow group separation and good hygiene procedures. IMPORTANT: *H-flu* is not the same germ as "flu" or influenza. *H-flu* can cause SERIOUS ILLNESS in young children. If a case of *H-flu* occurs in your facility, TAKE ALL ACTIONS ABOVE.	Not due to *H-flu*: When treating physician tells you it is safe. Due to *H-flu*: When the Health Department tells you it is safe.
Ringworm	• Temporarily exclude the child if the lesion cannot be covered.	If unable to cover lesion, after treatment begins and the lesion starts to shrink.
Rubella (German or 3-day measles)	• Temporarily exclude the child from the child care setting. • Immediately notify your Health Department. • Advise any pregnant women in the facility who are not known to be immune to see their physicians. • Carefully follow group separation and good hygiene	6 days after rash appears and Health Department says it is safe.

	procedures.	
Scabies	• Temporarily exclude the child from the child care setting. • You may contact your Health Department for advice about identifying and treating exposed children and adults.	24 hours after treatment has begun.
Streptococcal sore throat (Strep throat)	• Temporarily exclude the child from the child care setting. • Contact your Health Department if 2 or more children are diagnosed with strep throat.	24 hours after antibiotics are begun.
Active Tuberculosis (See Fact Sheet on Tuberculosis for information on nonactive TB infection.)	• Immediately notify your Health Department. • Children with TB may usually remain in child care after treatment as long as they are receiving appropriate treatment.	When Health Department says it is safe.

Note: The term "adult" is used to refer to any adult in the facility (center or home) who may have come in contact with a sick child. This may include more that just those adults actually providing child care. In a home situation, for example, it may also include household occupants.

APPENDIX D:

Dear Parent or Legal Guardian:

Today at our child care facility, your child was observed to have one or more of the following signs or symptoms:

- o Diarrhea (more than one abnormally loose stool)
- o Difficult or rapid breathing
- o Earache
- o Fever (101° F or above orally)
- o Gray or white stool
- o Headache and stiff neck
- o Infected skin patches
- o Crusty, bright yellow, dry or gummy areas of skin
- o Loss of appetite
- o Pink eye
- o Tears, redness of eyelid lining
- o Irritation
- o Swelling and/or discharge of pus
- o Severe coughing
- o Child gets red or blue in the face
- o Child makes a high-pitched croupy or whooping sound after s/he coughs
- o Severe itching of body/scalp
- o Sore throat or trouble swallowing
- o Unusual behavior
- o Child cries more than usual
- o Child feels general discomfort
- o Cranky or less active
- o Just seems unwell
- o Unusual spots or rashes
- o Unusually dark, tea-colored urine
- o Vomiting
- o Yellow skin or eyes

<u>Contact your health care provider if there is</u>:

- o Persistent fever (over 100° F) without other symptoms
- o Breathing so hard he cannot play, talk, cry or drink
- o Severe coughing
- o Earache
- o Sore throat with fever
- o Thick nasal drainage
- o Rash accompanied by fever
- o Persistent diarrhea
- o Severe headache and stiff neck with fever
- o Yellow skin and/or eyes
- o Unusual confusion
- o Rash, hives or welts that appear quickly
- o Severe stomach ache that causes the child to double up and scream
- o No urination over an 8 hour period; the mouth and tongue look dry
- o Black stool or blood mixed with the stool
- o Any child who looks or acts very ill or seems to be getting worse quickly

We are excluding your child from attendance at our program until (possible options):

- o The signs or symptoms are gone
- o The child can comfortably participate in the program
- o We can provide the level of care your child needs
- o Other: _____

APPENDIX E:

18.2

Like children, adults are also capable of transmitting communicable diseases. A child care provider should be temporarily excluded from providing care to children if she or he has one or more of the following conditions:

Condition	Exclude from Child Care Setting
Chickenpox	Until six days after the start of rash or when sores have dried/crusted.
Shingles	Only if sores cannot be covered by clothing or a dressing; if not, exclude until sores have crusted and are dry. A person with active shingles should not care for immune-suppressed children, or work with immune-suppressed staff or parents.
Rash with fever or joint pain	Until diagnosed not to be measles or rubella.
Measles and Rubella	Until six days after rash starts.
Vomiting	If two or more episodes of vomiting during the previous 24 hours, or if accompanied by a fever, until vomiting resolves or is determined to be due to such noninfectious conditions as pregnancy or a digestive disorder.
Pertussis (whooping cough)	Until after five days of prescribed antibiotic therapy.
Mumps	Until nine days after glands begin to swell.
Diarrhea illness	If three or more episodes of loose stools during previous 24 hours, or if diarrhea is accompanied by fever, until diarrhea resolves.
Hepatitis A	For one week after jaundice appears or as directed by health department, especially when no symptoms are present.
Impetigo (a skin infection)	Until 24 hours after prescribed antibiotic treatment begins and lesions are not draining.
Active Tuberculosis (TB) [not a positive skin test only]	Until the local health department approves return to the setting.
Strep throat (or other streptococcal infection)	Until 24 hours after initial antibiotic treatment, and fever has ended.
Scabies/head lice/etc.	Until after the first treatment; scabies until treatment has been completed.
Purulent Conjunctivitis	Until 24 hours after prescribed treatment has begun.
Haemophilus Influenza Type b (Hib)	Until the prescribed antibiotic treatment has begun.
Meningococal Infection	As specified in specific disease section of this manual.
Respiratory Illness	If the illness limits the staff member's ability to provide an acceptable level of child care and compromises the health and safety of children or other staff.
Herpes cold sores	Should cover and not touch their lesions, carefully observe hand washing policies and must not kiss or nuzzle infants and children, especially those with dermatitis.
Other conditions mandated by State public health law	As required by law (consult your local health department).

Appedix F.

NEW YORK STATE DEPARTMENT OF HEALTH

Communicable Disease Reporting Requirements

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR 2.10,2.14). The primary responsibility for reporting rests with the physician; moreover, laboratories (PHL 2102), school nurses (10NYCRR 2.12), day care center directors, nursing homes/hospitals (10NYCRR 405.3d) and state institutions (10NYCRR 2.10a) or other locations providing health services (10NYCRR 2.12) are also required to report the diseases listed below.

Anaplasmosis
Amebiasis
Animal bites for which rabies prophylaxis is given[1]
Anthrax[2]
Arboviral infection[3]
Babesiosis
Botulism[2]
Brucellosis[2]
Campylobacteriosis
Chancroid
Chlamydia trachomatis infection
Cholera
Cryptosporidiosis
Cyclosporiasis
Diphtheria
E.coli O157:H7 infection[4]
Ehrlichiosis
Encephalitis
Foodborne Illness
Giardiasis
Glanders[2]
Gonococcal infection
Haemophilus influenzae[5] (invasive disease)
Hantavirus disease
Hemolytic uremic syndrome
Hepatitis A
Hepatitis A in a food handler
Hepatitis B (specify acute or chronic)
Hepatitis C (specify acute or chronic)
Pregnant hepatitis B carrier
Herpes infection, infants aged 60 days or younger
Hospital associated infections (as defined in section 2.2 10NYCRR)
Influenza, laboratory-confirmed
Legionellosis
Listeriosis
Lyme disease
Lymphogranuloma venereum
Malaria
Measles
Melioidosis[2]
Meningitis
Aseptic or viral
Haemophilus
Meningococcal
Other (specify type)
Meningococcemia
Monkeypox
Mumps
Pertussis
Plague[2]
Poliomyelitis
Psittacosis
Q Fever[2]
Rabies[1]
Rocky Mountain spotted fever
Rubella (including congenital rubella syndrome)
Salmonellosis
Severe Acute Respiratory Syndrome (SARS)
Shigatoxin-producing E.coli[4] (STEC)
Shigellosis[4]
Smallpox[2]
Staphylococcus aureus[6] (due to strains showing reduced susceptibility or resistance to vancomycin)
Staphylococcal enterotoxin B poisoning[2]
Streptococcal infection (invasive disease)[5]
Group A beta-hemolytic strep
Group B strep
Streptococcus pneumoniae
Syphilis, specify stage[7]
Tetanus
Toxic shock syndrome
Transmissable spongiform encephalopathies[8] (TSE)
Trichinosis
Tuberculosis current disease (specify site)
Tularemia[2]
Typhoid
Vaccinia disease[9]
Vibriosis[6]
Viral hemorrhagic fever[2]
Yersiniosis

WHO SHOULD REPORT?

Physicians, nurses, laboratory directors, infection control practitioners, health care facilities, state institutions, schools.

WHERE SHOULD REPORT BE MADE?

Report to local health department where patient resides.

Contact Person _____

Name _____

Address _____

_____

Phone _____ Fax _____

WHEN SHOULD REPORT BE MADE?

Within 24 hours of diagnosis:

- Phone diseases in bold type,
- Mail case report, DOH-389, for all other diseases.
- In New York City use form PD-16.

SPECIAL NOTES

- Diseases listed in **bold type** warrant prompt action and should be reported **immediately** to local health departments by phone followed by submission of the confidential case report form (DOH-389). In NYC use case report form PD-16.
- In addition to the diseases listed above, any unusual disease (defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) is reportable.
- Outbreaks: while individual cases of some diseases (e.g., streptococcal sore throat, head lice, impetigo, scabies and pneumonia) are not reportable, a cluster or outbreak of cases of any communicable disease is a reportable event.
- **Cases of HIV infection, HIV-related illness and AIDS are reportable on form DOH-4189 which may be obtained by contacting:**

  Division of Epidemiology, Evaluation and Research
  P.O. Box 2073, ESP Station
  Albany, NY 12220-2073
  (518) 474-4284

  In NYC: New York City Department of Health and Mental Hygiene
  For HIV/AIDS reporting, call:
  (212) 442-3388

1. Local health department must be notified prior to initiating rabies prophylaxis.
2. Diseases that are possible indicators of bioterrorism.
3. Including, but not limited to, infections caused by eastern equine encephalitis virus, western equine encephalitis virus, West Nile virus, St. Louis encephalitis virus, La Crosse virus, Powassan virus, Jamestown Canyon virus, dengue and yellow fever.
4. Positive shigatoxin test results should be reported as presumptive evidence of disease.
5. Only report cases with positive cultures from blood, CSF, joint, peritoneal or pleural fluid. Do not report cases with positive cultures from skin, saliva, sputum or throat.
6. Proposed addition to list.
7. Any non-treponemal test ≥1:16 or any positive prenatal or delivery test regardless of titer or any primary or secondary stage disease, should be reported by phone; all others may be reported by mail.
8. Including Creutzfeldt-Jakob disease. Cases should be reported directly to the New York State Department of Health Alzheimer's Disease and Other Dementias Registry at (518) 473-7817 upon suspicion of disease. In NYC, cases should also be reported to the NYCDOHMH.
9. Persons with vaccinia infection due to contact transmission and persons with the following complications from vaccination; eczema vaccinatum, erythema multiforme major or Stevens-Johnson syndrome, fetal vaccinia, generalized vaccinia, inadvertent inoculation, ocular vaccinia, post-vaccinial encephalitis or encephalomyelitis, progressive vaccinia, pyogenic infection of the infection site, and any other serious adverse events.

ADDITIONAL INFORMATION

For more information on disease reporting,
call your local health department or the
New York State Department of Health
Bureau of Communicable Disease Control at
(518) 473-4439
or (866) 881-2809 after hours.
In New York City, 1 (866) NYC-DOH1.
To obtain reporting forms (DOH-389), call (518) 474-0548.

PLEASE POST THIS CONSPICUOUSLY

APPENDIX G:

Name of Child Care Program: _____

Address of Child Care Program: _____

Telephone Number of Child Care Program: _____

Date: _____

Dear Parent or Legal Guardian:

A child in our program has or is suspected of having: _____

Information about this disease:

The disease is spread by: _____

The symptoms are: _____

The disease can be prevented by: _____

What the program is doing:

_____

a doctor, or ask other parents for names of their children's doctors. If you have any

(Caregiver's name) _____

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Appendix H.

Incident Report Form

Child's Name_____ **D.O.B** _____

Incident Type: □ Non-Injury □ Injury

Date of Incident____/____/_____ **Duration of Incident**___:___am / pm **to** ___:___am / pm

1) **Setting/Location of Incident (Be Specific):** _____

2) **List All Participants/Witnesses involved (other than the child) - Provide names, addresses and phone numbers:**

Name:	**Sex:** □ **M** □ **F**	**Phone (Mobile):**
Address:	**Relationship to Child:** □ Staff Member (Position):_____	
City: **St:** **Zip:**	□ Student/Child □ Parent/Guardian □ Other:	

Name:	**Sex:** □ **M** □ **F**	**Phone (Mobile):**
Address:	**Relationship to Child:** □ Staff Member (Position):_____	
City: **St:** **Zip:**	□ Student/Child □ Parent/Guardian □ Other:	

3) **Description of the Incident: (Provide EXACT details of the incident, who was involved, injured body part(s), specify any equipment, tools, or consumer products being used at the time. If unsafe condition-describe the condition.)**

_____

_____

_____

_____

4) **Details of Injury**

Nature of injury *(i.e. burn, cut, sprain, etc.)*:		**Location on body** *(i.e. right cheek, left forearm, etc.)*:
Cause of injury *(i.e. fall, grabbed by person, etc.)*:		
First Aid Given? □ Yes □ No	**First Aid Administered by:**	**Phone (Mobile):**
Type of Aid Administered:		**List Any Universal Precautions Followed:**
Was EMS/911 Called? □ Yes □ No	**Outcome:**	

5) **Does the student have a Behavioral Intervention Plan?** □ Yes □ No
Was Emergency Intervention Required? □ Yes □ No
If Yes, describe intervention strategies utilized:

_____

_____

_____

_____

Were these the strategies listed on the Behavior Intervention Plan? □ Yes □ No
If the strategies were not on the BIP, was parental consent obtained to use alternative strategies? □ Yes □ No

6) **Was the Parent/Caregiver notified of this incident?** □ Yes, Date_____Time_____am/pm □ No, Reason_____

_____

7) **Who was the Child's Parent, Guardian, or Caregiver Onsite at the time of the incident?**
Name:_____Relationship to Child: □ Parent □ Legal Guardian □ Caregiver
Other_____

***Person completing this report (print name):** _____

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

***Parent/Caregiver reviewing this report (print name):** _____

***Signature**_____**Relationship to Child:**_____**Date:** _____

Service Child was receiving during incident:

EI___CPSE___CSE___PP___ST___
OT___PT___SW/PSY___SEIT___
Other_____

Appendix H.a

Accident/Incident/ Emergency Intervention Follow up Report

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

Details of Incident:

Date:___/___/____ Type: _____
(accident, illness, etc.)

Time:_____AM / PM Location:_____
(Child's home, waiting room, etc.)

Details of Follow-up:

Date:___/___/____ Person following up:_____
(Name/Title)

Time:_____AM/PM Caregiver consulted:_____

Follow up comments on accident/incident:

_____

_____

_____

_____

_____

Medical Services provided: _____

_____

Additional Comments:_____

_____

Parent/Guardian instructed to see physician or take child to emergency room:_____Yes/No

Name of person who reported incident:_____

Name of person filling out the report:_____

Signature of person filling out the report:_____

Supervisor's s name:_____Signature:_____Date:____/____/____

Date incident reported to supervisor:_____/_____/_____

Appendix H.1

Behavior Emergency Intervention Incident Report

A Behavior Emergency Intervention Report shall immediately be completed and forwarded to the designated administrator. A copy shall be maintained in the student's IEP file. The Behavior Emergency Intervention Report must be completed by the staff member who initiated the emergency behavior intervention with the student.

Child's Name_____ **D.O.B**_____

Date of Incident____/____/_____ **Duration of Incident**___:___AM / PM **to** ___:___AM / PM

1) Setting/Location of Incident (Be Specific): _____

2) Description of the Incident

a. Precipitating events; Child's behavior which created imminent threat of serious injury to child or Another person:

_____

_____

b. Description of the Emergency Intervention(s) Used and Persons Involved:

_____

_____

c. Describe the child's resulting behaviors/response to the interventions:

_____

_____

3) Does the student currently have a Behavioral Intervention Plan (BIP)? □ Yes □No

4) Details of any injuries sustained by child or others (including staff) as a result of the incident. State names of all and indicate nature of injury, location of injury, cause of injury:

_____

_____

5) Indicate if first aid was provided. Who provided the aid and who was the aid administered to? What kind of aid was provided?

_____

_____

Date parent/guardian was notified: _____

Date of review of documentation by school nurse (or other medical personnel), as necessary: _____

If incident occurred in a preschool setting – Name of medical personnel notified onsite: _____

Were pictures of injury taken if parent not available (must obtain parental consent before taking pictures)? Yes_____**No** _____

Person completing this report (print name): _____

Signature_____**Title:**_____**Date:** _____

Sent to AAK Owners and Designated Administrators via □ Email □ Fax □ Personally Delivered

Staff member must confirm Owners and Designated Administrator confirms and acknowledges receipt of this report

Owner	**Date**
Owner	**Date**
Program Manager	**Date**
ABA Supervisor	**Date**

All BEIRs must be forwarded immediately to, and reviewed by the designated administrator. Any time a BEIR is written regarding a student who does not have a behavioral intervention plan (BIP), the administrator shall, within two (2) days schedule an internal IEP Team meeting. In addition, the school district will be notified to request a CPSE/CSE meeting.

Appendix H.2

Post Behavior Emergency Intervention Analysis and Debriefing

WITHIN TWO (2) DAYS: SCHEDULE AN IEP TEAM MEETING TO REVIEW THE EMERGENCY REPORT AND DETERMINE THE NEED FOR A FUNCTIONAL BEHAVIORAL ASSESSMENT (FBA) AND/OR NEED FOR AN INTERIM PLAN.

ATTACH A COPY OF THE ORIGINAL INCIDENT REPORT TO THIS FORM.

CHILD'S NAME_____ **D.O.B** _____ **DATE OF INCIDENT**____/____/_____

1) PARTICIPANTS IN THE MEETING - PROVIDE NAMES, ADDRESSES AND PHONE NUMBERS:

NAME:	**RELATIONSHIP TO CHILD:** □ STAFF MEMBER (POSITION):_____ □ PARENT/GUARDIAN □ OTHER:
NAME:	**RELATIONSHIP TO CHILD:** □ STAFF MEMBER (POSITION):_____ □ PARENT/GUARDIAN □ OTHER:
NAME:	**RELATIONSHIP TO CHILD:** □ STAFF MEMBER (POSITION):_____ □ PARENT/GUARDIAN □ OTHER:

2) SUMMARY OF THE INCIDENT:

_____

_____

_____

3) WHAT LED TO THE INCIDENT (IDENTIFY PRECIPITATING FACTORS):

_____

_____

_____

4) IF RESTRAINTS OR SECLUSION WERE UTILIZED - WAS THIS THE LEAST RESTRICTIVE TYPE? WAS IT EFFECTIVE AND APPROPRIATE UNDER THE CIRCUMSTANCES?

_____

_____

_____

5) WERE THERE ANY TRENDS OR PATTERNS RELATED TO STAFF APPROACHES OR THE ENVIRONMENT?

_____

_____

_____

6) ALTERNATIVE STRATEGIES FOR MANAGING SIMILAR SITUATIONS IN THE FUTURE:

_____

_____

_____

7) SUMMARY OF TEAM RECOMMENDATIONS FOR (COMPLETE ALL THAT APPLY):

POLICY DEVELOPMENT:_____

ENVIRONMENTAL CHANGES:_____

IMPROVE PROFESSIONAL DEVELOPMENT PRACTICES FOR STAFF: _____

CHILD'S IEP:_____

OTHER: _____

STAFF MEMBER COMPLETING THIS REPORT (PRINT NAME): _____

SIGNATURE_____ **TITLE:**_____ **DATE:** _____

AAK ADMINISTRATOR (PRINT NAME): _____

SIGNATURE_____ **TITLE:**_____ **DATE:** _____

All BEIRs must be forwarded immediately to, and reviewed by the designated administrator. Any time a BEIR is written regarding a student who does not have a behavioral intervention plan (BIP), the administrator/case manager shall, within two (2) days schedule an IEP Team meeting.

Appendix J:

NOTIFICATION OF AUTHOROTIES

Executives:

Cathy Grossfeld - *Executive Director*

Michael Grossfeld - *Division Director*

Long Island:

Patricia Sales - *Finance Director*

Erika Zelaya – *Human Resources Manager*

Eileen Lombardo-Young - *Long Island Office Manager*

Robert Heuthe - *Assistant Director*

Queens:

Maureen Tablan - *Educational Supervisor*

Westchester:

Robert Heuthe - *Assistant Director*

Bronx:

Ingri Dejesus - *NYC EI Staffing Manager*

Brooklyn:

Shyamal Barot - *Service Coordination Supervisor*

Washingtonville:

Delilah Morales – *Program Manager*

APPENDIX K:

Section 1: Understanding the Spread of Disease

***Through Air or Respiratory Transmission*:**

- Breathing germs in the air
- Contact with infected saliva and mucus
- Coughing or sneezing into the air
- Kissing on the mouth
- Sharing mouthed toys
- Wiping noses without thorough hand washing
- Poor ventilation
- Cold
- Flu
- Measles
- Pink eye
- Chickenpox
- Tuberculosis (TB)
- Coughing
- Fever
- Rash
- Runny nose
- Sore throat
- Earache

***Through Stool or Fecal-Oral Transmission*:**

- Mouth contact with items and hands contaminated by infected stool
- Diapering and toileting or food preparation without thorough hand washing
- Sharing mouthed toys
- Unsafe food preparation
- Not disinfecting diapering areas
- Salmonella
- Shigella
- Giardia
- Pinworms
- Hand, foot and mouth disease
- Hepatitis A
- Polio
- *E. coli*
- Stomach ache
- Nausea
- Vomiting
- Diarrhea

Through Direct Contact:

- Contact with infected hair, skin and objects
- Touching skin or hair which is infected
- Sharing clothing, hats and brushes which are infected
- Herpes
- Ringworm
- Scabies
- Head lice
- Impetigo
- Chickenpox
- Rash
- Oozing sores
- Itching
- Visible nits or eggs

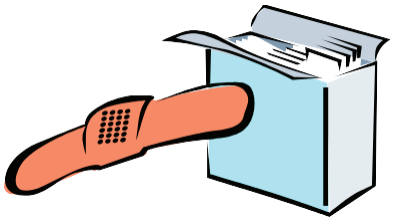
Through Contact with Blood and Bodily Fluids:

- Contact with infected blood and sometimes other body fluids
- Sexual contact
- Changing bloody diapers without gloves
- Providing first aid without gloves
- Getting infected blood or body fluids into broken skin, eyes or mouth
- HIV/AIDS
- Hepatitis B & C
- Cytomegalovirus (CMV)
- Herpes
- Fatigue
- Weight loss
- Yellow skin
- Weakened immune system

APPENDIX L:

Gloving

1. .



2. .

3. .

.

.

4.

.

5.

. .

6.

. .

Instructions: If the service type listed in the left column, "Section" is provided by you/your agency, the indicator may apply to your practice. If the item is marked "N/A" (Not Applicable), written policy, documentation or observation will not apply to the monitoring review.

Key: ISC – Initial Service Coordinator
OSC – Ongoing Service Coordinator
All – Indicator applies to all provider types.
MDE – Multidisciplinary Evaluator
Supplemental – Supplemental Evaluator
Service Provider – Provides services such as Special Instruction, OT, PT, etc.

Section	Indicator	Practice/ Procedures are in Place	Written Policy is in Place	Documentation Found in Child Records	Other Documentation	Observation
ISC	**PI-4** At the initial contact with the parent, the initial service coordinator ensures that the parent has a copy of "The Early Intervention Program: A Parent's Guide," reviews this guide with the parent, and documents this review in the child's record.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
ISC	**PI-5** The initial service coordinator assists the parent in identifying and applying for benefit programs for which the family may be eligible.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
ISC	**PI-6** The initial service coordinator (ISC) reviews all options for evaluations and screenings from the list of approved evaluators. The ISC assists the family in selecting an evaluator or screener by providing objective information regarding all options including location, types of evaluations performed, and settings for evaluations.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
ISC	**PI-7** The initial service coordinator provides parents with information regarding the funding of EIP services including services at no cost to parent, required use of Medicaid/third party insurance, and protections when Medicaid and/or NYS regulated third party insurance are used.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
ISC	**PI-8A** The initial service coordinator collects insurance policy information from the family.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
OSC	**PI-8B** The ongoing service coordinator collects insurance policy information from the family.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
MDE	**PI-13** The multidisciplinary evaluation team includes at least two qualified personnel from different disciplines with at least one specialist in the area of suspected delay or disability.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
MDE	**PI-15A** The multidisciplinary evaluation includes an evaluation of the child's functioning in all five developmental domains using informed clinical opinion and age appropriate instruments and procedures.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
Supplemental	**PI-15B** Tests and other supplemental evaluation materials shall be administered in the dominant language or other mode of communication of the child unless clearly not feasible to do so.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
MDE	**PI-16** The multidisciplinary evaluation includes a health assessment, including a physical examination, vision and hearing screening.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	☐ YES ☐ NO	N/A

Section	Indicator	Practice/ Procedures are in Place	Written Policy is in Place	Documentation Found in Child Records	Other Documentation	Observation
MDE	**PI-19A** The multidisciplinary evaluation report includes a statement of the child's eligibility based on regulatory criteria.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
Supplemental	**PI-19B** The supplemental evaluation report includes Diagnosis code.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
MDE	**PI-20A** The evaluation report and summary are written in accordance with EIP regulations.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
Supplemental	**PI-20B** The supplemental evaluation report is written in accordance with EIP regulations.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
MDE	**PI-21A** The results of the evaluation are discussed with parents by the evaluator.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
Supplemental	**PI-21B** The results of the supplemental evaluation are discussed with parents by the evaluator.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
OSC	**PI-25** The ongoing service coordinator coordinates and monitors the delivery of services.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
OSC	**PI-27** The ongoing service coordinator completes required transition activities.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
Service Provider	**PI-29** Prescriptions/orders for all services are obtained.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
Service Provider	**PI-31** The provider delivers services that are family-centered.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
ISC, OSC, Service Provider	**PI-32** The provider maintains original session/service coordination notes that include minimum content requirements.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
ISC	**PI-36A** Service coordinators assist parents and children to receive the rights, procedural safeguards and services that are authorized to be provided under State and federal law.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
OSC	**PI-36B** Service coordinators assist parents and children to receive the rights, procedural safeguards and services that are authorized to be provided under State and federal law.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
All	**PI-38** The provider maintains documentation for each service provided.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
ISC and OSC	**PI-39** Service coordinators bill for reimbursable activities according to EIP regulations.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A

Section	Indicator	Practice/ Procedures are in Place	Written Policy is in Place	Documentation Found in Child Records	Other Documentation	Observation
Service Provider	**PI-41** The provider delivers services as authorized in the IFSP.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
All	**PI-42** Requirements of Title 34 of the Code of Federal Regulations and other applicable legal requirements for confidentiality are followed.	☐ YES ☐ NO	N/A	N/A	N/A	N/A
All	**PI-42B** All records containing personally identifiable information are maintained in secure locations and disposed of appropriately.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	☐ YES ☐ NO
All	**PI-42C** All records containing personally identifiable information are maintained securely when stored off-site.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-42E** Confidentiality of electronic records that are stored on computer is maintained.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-42F** Confidentiality is maintained when e-mail is used.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A
All	**PI-42G** Confidentiality of faxed information is maintained.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-42I** A record is kept of any individual, other than authorized individuals, who access a child's record, along with the date and purpose for which the record was accessed.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A
All	**PI-42J** Parents are notified of the process that they must follow to inspect and review all records pertaining to their child.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A
All	**PI-42K** Parental access to their child's record is ensured including review, and upon request an explanation and interpretation of material and copies of records.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-42M** The procedure to address amendment of their child's records, or to request a hearing, protects the parent's rights.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-42O** Written parental consent is obtained before any disclosure of personally identifiable information is disclosed to anyone other than authorized individuals.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A
All	**PI-42Q** Provider adheres to all legal requirements that protect records containing sensitive information.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-42S** When electronic records are used documentation is maintained in a manner that demonstrates the provider's right to receive payment under the Medicaid program.	☐ YES ☐ NO	☐ YES ☐ NO	NA	NA	NA
(Agencies Only)	**PI-42T** Provider assures that all employees, independent contractors, consultants, and volunteers with access to personally identifiable information are informed of and are required to adhere to all confidentiality requirements related to this information.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A

Section	Indicator	Practice/ Procedures are in Place	Written Policy is in Place	Documentation Found in Child Records	Other Documentation	Observation
All	**PI-43** Providers have New York State Department of Health Bureau of Early Intervention approval. Individual and Agency Providers have an agreement in place (Basic or Appendix) to deliver early intervention (EI) services.	☐ YES ☐ NO	N/A	N/A	☐ YES ☐ NO	N/A
(Individual Providers Only)	**PI-44** Individual provider licensure, certification, or registration is current and are qualified to deliver EIP services.	☐ YES ☐ NO	N/A	N/A	☐ YES ☐ NO	N/A
(Agencies Only)	**PI-45** Agency providers ensure their employees and contractors have current licensure, certification, or registration, as appropriate, and are qualified to deliver EIP services, including service coordination.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A
(Agencies Only)	**PI-46** Agency providers maintain policies/procedures to screen employees and subcontracted individuals through the New York State (NYS) Central Register of Child Abuse and Maltreatment (SCR) and the NYS Justice Center for the Protection of People with Special Needs (NYSJC), as appropriate.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A
All	**PI-47** All providers have procedures in place to report suspected child abuse and maltreatment, including notification either directly to the New York State (NYS) Central Register of Child Abuse and Maltreatment (SCR) or to an appropriate authority.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-49** Standard precautions are utilized when EI services are delivered.	☐ YES ☐ NO	N/A	N/A	N/A	N/A
All	**PI-50** Appropriate procedures are in place to address behavior which is injurious to the child or others. Corporal punishment, abuse, and the use of aversive interventions in any form are prohibited when providing EIP services.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A
All	**PI-52** Providers have policies and procedures to address child and provider illness and emergencies.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	☐ YES ☐ NO
All	**PI-53** The provider's equipment, materials, and toys are in good condition, cleaned regularly, and free of lead and other known safety issues.	☐ YES ☐ NO	N/A	N/A	N/A	☐ YES ☐ NO
All	**PI-57** Providers ensure that the physical environment is maintained in a manner that protects the health and safety of children receiving EI services with respect to location.	☐ YES ☐ NO	N/A	N/A	☐ YES ☐ NO	☐ YES ☐ NO
All	**PI-73** Prescription and over-the-counter medications are stored and administered in a safe manner in accordance with law and applicable State standards.	☐ YES ☐ NO	N/A	N/A	☐ YES ☐ NO	☐ YES ☐ NO
All	**PI-78** Providers ensure that any child with a food or other allergy has a plan in place.	☐ YES ☐ NO	N/A	N/A	☐ YES ☐ NO	☐ YES ☐ NO
All	**PI-80** Providers protect the general health and safety of children with respect to illness, injury, and emergencies while receiving EI services in a community setting.	☐ YES ☐ NO	N/A	N/A	☐ YES ☐ NO	N/A

Section	Indicator	Practice/ Procedures are in Place	Written Policy is in Place	Documentation Found in Child Records	Other Documentation	Observation
All	**PI-81** The provider has procedures in place to address unsafe conditions encountered in the home environment.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-82** Providers adhere to requirements as outlined in the provider agreement and regulation.	☐ YES ☐ NO	N/A	N/A	☐ YES ☐ NO	N/A
(Agencies Only)	**PI-83** The agency implements a quality assurance plan for each type of service offered by the agency, including evaluations and service coordination.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A

Instructions: If the service type listed in the left column, "Section" is provided by you/your agency, the indicator may apply to your practice. If the item is marked "N/A" (Not Applicable), written policy, documentation or observation will not apply to the monitoring review.

Key: ISC – Initial Service Coordinator
OSC – Ongoing Service Coordinator
All – Indicator applies to all provider types.
MDE – Multidisciplinary Evaluator
Supplemental – Supplemental Evaluator
Service Provider – Provides services such as Special Instruction, OT, PT, etc.

Section	Indicator	Practice/ Procedures are in Place	Written Policy is in Place	Documentation Found in Child Records	Other Documentation	Observation
ISC	**PI-4** At the initial contact with the parent, the initial service coordinator ensures that the parent has a copy of "The Early Intervention Program: A Parent's Guide," reviews this guide with the parent, and documents this review in the child's record.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
ISC	**PI-5** The initial service coordinator assists the parent in identifying and applying for benefit programs for which the family may be eligible.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
ISC	**PI-6** The initial service coordinator (ISC) reviews all options for evaluations and screenings from the list of approved evaluators. The ISC assists the family in selecting an evaluator or screener by providing objective information regarding all options including location, types of evaluations performed, and settings for evaluations.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
ISC	**PI-7** The initial service coordinator provides parents with information regarding the funding of EIP services including services at no cost to parent, required use of Medicaid/third party insurance, and protections when Medicaid and/or NYS regulated third party insurance are used.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
ISC	**PI-8A** The initial service coordinator collects insurance policy information from family using the Department Collection of Insurance Information form.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
OSC	**PI-8B** The ongoing service coordinator collects insurance policy information from family using the Department Collection of Insurance Information form.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
ISC and OSC	**PI-8C** The service coordinator obtains and enters third party insurance information in NYEIS.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
MDE	**PI-13** The multidisciplinary evaluation team includes at least two qualified personnel from different disciplines with at least one specialist in the area of suspected delay or disability.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
MDE	**PI-15A** The multidisciplinary evaluation includes an evaluation of the child's functioning in all five developmental domains using informed clinical opinion and age appropriate instruments and procedures.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
Supplemental	**PI-15B** Tests and other supplemental evaluation materials shall be administered in the dominant language or other mode of communication of the child unless clearly not feasible to do so.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A

Section	Indicator	Practice/ Procedures are in Place	Written Policy is in Place	Documentation Found in Child Records	Other Documentation	Observation
MDE	**PI-16** The multidisciplinary evaluation includes a health assessment, including a physical examination, vision and hearing screening.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	☐ YES ☐ NO	N/A
MDE	**PI-19A** The multidisciplinary evaluation report includes a statement of the child's eligibility based on regulatory criteria.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
Supplemental	**PI-19B** The supplemental evaluation report includes Diagnosis code or ICD code.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
MDE	**PI-20A** The evaluation report and summary are written in accordance with EIP regulations.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
Supplemental	**PI-20B** The supplemental evaluation report is written in accordance with EIP regulations.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
MDE	**PI-21A** The results of the evaluation are discussed with parents by the evaluator.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
Supplemental	**PI-21B** The results of the supplemental evaluation are discussed with parents by the evaluator.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
OSC	**PI-25** The ongoing service coordinator coordinates and monitors the delivery of services.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
OSC	**PI-27** The ongoing service coordinator completes required transition activities.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
Service Provider	**PI-29** Prescriptions/orders for all services are obtained.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
Service Provider	**PI-31** The provider delivers services that are family-centered.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
ISC, OSC, Service Provider	**PI-32** The provider maintains original session/service coordination notes that include minimum content requirements.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
ISC	**PI-36A** Service coordinators assist parents and children to receive the rights, procedural safeguards and services that are authorized to be provided under State and federal law.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
OSC	**PI-36B** Service coordinators assist parents and children to receive the rights, procedural safeguards and services that are authorized to be provided under State and federal law.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
All	**PI-38** The provider maintains documentation for each service provided.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A

Section	Indicator	Practice/ Procedures are in Place	Written Policy is in Place	Documentation Found in Child Records	Other Documentation	Observation
ISC and OSC	**PI-39** Service coordinators bill for reimbursable activities according to EIP regulations.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
Service Provider	**PI-41** The provider delivers services as authorized in the IFSP.	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A	N/A
All	**PI-42** Requirements of Title 34 of the Code of Federal Regulations and other applicable legal requirements for confidentiality are followed.	☐ YES ☐ NO	N/A	N/A	N/A	N/A
All	**PI-42B** All records containing personally identifiable information are maintained in secure locations and disposed of appropriately.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	☐ YES ☐ NO
All	**PI-42C** All records containing personally identifiable information are maintained securely when stored off-site.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-42E** Confidentiality of electronic records that are stored on computer is maintained.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-42F** Confidentiality is maintained when e-mail and texting is used.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A
All	**PI-42G** Confidentiality of faxed information is maintained.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-42I** A record is kept of any individual, other than authorized individuals, who access a child's record, along with the date and purpose for which the record was accessed.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A
All	**PI-42J** Parents are notified of the process that they must follow to inspect and review all records pertaining to their child.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A
All	**PI-42K** Parental access to their child's record is ensured including review, and upon request an explanation and interpretation of material and copies of records.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-42M** The procedure to address amendment of their child's records, or to request a hearing, protects the parent's rights.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-42O** Written parental consent is obtained before any disclosure of personally identifiable information is disclosed to anyone other than authorized individuals.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A
All	**PI-42Q** Provider adheres to all legal requirements that protect records containing sensitive information.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-42S** When electronic records are used documentation is maintained in a manner that demonstrates the provider's right to receive payment under the Medicaid program.	☐ YES ☐ NO	☐ YES ☐ NO	NA	NA	NA

Section	Indicator	Practice/ Procedures are in Place	Written Policy is in Place	Documentation Found in Child Records	Other Documentation	Observation
All (Agencies Only)	**PI-42T** Provider assures that all employees, independent contractors, consultants, and volunteers with access to personally identifiable information are informed of and are required to adhere to all confidentiality requirements related to this information.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A
All	**PI-43** The provider has State approval status and a Basic or Appendix agreement for services delivered.	☐ YES ☐ NO	N/A	N/A	☐ YES ☐ NO	N/A
All (Individual Providers Only)	**PI-44** Individual providers maintain documentation of current licensure, certification, or registration, as appropriate, and are qualified to deliver EIP services, including service coordination.	☐ YES ☐ NO	N/A	N/A	☐ YES ☐ NO	N/A
All (Agencies Only)	**PI-45** Agency provider employees and contractors have current licensure, certification, or registration, as appropriate, and are qualified to deliver EIP services, including service coordination.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A
All (Agencies Only)	**PI-46** Agency providers maintain policies/procedures to screen employee and subcontracted individuals through the New York State (NYS) Central Register of Child Abuse and Maltreatment (SCR) and the NYS Justice Center for the Protection of People with Special Needs, as appropriate.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A
All	**PI-47** All providers have procedures in place to report suspected child abuse and maltreatment, including notification either directly to the SCR or to an appropriate authority.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-49** Standard precautions are utilized when EI services are delivered.	☐ YES ☐ NO	N/A	N/A	N/A	N/A
All	**PI-50** Appropriate procedures are in place to address behavior which is injurious to the child or others. Corporal punishment, abuse, and the use of aversive interventions in any form are prohibited when providing EIP services.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A
All	**PI-52** Providers have policies and procedures to address child and provider illness and emergencies.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	☐ YES ☐ NO
All (Agency only)	**PI-53** The provider's equipment, materials, and/or toys are in good condition, cleaned regularly and free of lead.	☐ YES ☐ NO	N/A	N/A	N/A	☐ YES ☐ NO
All	**PI-80** Providers protect the general health and safety of children with respect to illness, injury, and emergencies while receiving EI services in a community setting.	☐ YES ☐ NO	N/A	N/A	☐ YES ☐ NO	N/A
All	**PI-81** The provider has procedures in place to address unsafe conditions encountered in the home environment.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	N/A	N/A
All	**PI-82** Providers adhere to requirements as outlined in the provider agreement and regulation.	☐ YES ☐ NO	N/A	N/A	☐ YES ☐ NO	N/A

Section	Indicator	Practice/ Procedures are in Place	Written Policy is in Place	Documentation Found in Child Records	Other Documentation	Observation
All (Agencies Only)	**PI-83** The agency implements a quality assurance plan for each type of profession/service offered by the agency, including evaluations and service coordination.	☐ YES ☐ NO	☐ YES ☐ NO	N/A	☐ YES ☐ NO	N/A

Appendix O:

Name of Site:_____ **Date of Survey Completion:** _____

Child's Name:_____ **Child's D/O/B:** _____

Community Health and Safety Survey-Indoor Areas

- ❑ The environment where El services are provided is safe from chemicals, contaminants, toxic materials, and other hazards.
- ❑ The environment is free of potential lire, construction, and other structural hazards.
- ❑ Public restrooms are available/accessible, clean, and adequately supplied.
- ❑ Hallways and/or exits are not obstructed and are free from clutter.
- ❑ Stairs are lighted.
- ❑ Stairs, walkways, porches, and ramps are free of ice, snow, and other hazards, and have railings or other barriers to prevent children from falling.
- ❑ Pets on premises do not pose a potential threat to children.
- ❑ Areas where El children are receiving services have entrances and exits that prevent children from wandering out of the immediate area.
- ❑ There are no other physical conditions that are potentially hazardous to children during the deliver^{y} of services.
- ❑ Evacuation procedures and routes are prominently posted.
- ❑ Providers are aware of the current emergency evacuation plan and evacuation routes in the community-based setting, location of telephones on premises and up-to-date emergency telephone numbers.
- ❑ Public swimming pools used are only those subject to the oversight of Chapter I. Subpart 6-1 of NY Sanitary Code and do not pose a health risk to children.

Comments:_____

_____

_____.

I_____**(parent/guardian), was present and participated in the assessment of the Community location where my child will receive El services, along with my child's service provider on**_____**(date of completed survey) and I agree that my child receive services at this location.**

Appendix P:

Name of Site:_____ **Date of Survey Completion:** _____

Child's Name:_____ **Child's D/O/B:**_____

Community Health and Safety Survey-Outdoor Areas

- ❑ Site is free of obstacles that could cause injuries such as overhanging tree branches, wires, tree stumps, and/or roots, rocks, bricks/concrete.
- ❑ Play equipment is clean and in good condition (no broken pieces, sharp edges, choking hazards, splinters, cracks, rusted areas, screws, etc..).
- ❑ Walkways should be clear of trash and clutter to prevent tripping.
- ❑ Play areas are clear of debris and small or potentially harmful object
- ❑ Play equipment is developmentally appropriate.
- ❑ Play equipment is securely anchored.
- ❑ There is adequate protective surfacing under/around playground equipment to help absorb the shock if a child falls.
- ❑ There are no openings in equipment that can trap a child's head or neck, such as openings in guardrails or ladders.
- ❑ Elevated surfaces such as platforms and ramps have guardrails to prevent falls.
- ❑ Slides have large decks and hand rails at the top.
- ❑ Merry-go-rounds have solid, .[fat riding surfaces and handholds.
- ❑ Sandboxes are clean and void of organic, toxic, or harmful material.
- ❑ Public restrooms are available/accessible, clean, and are adequately supplied.
- ❑ Public swimming pools used are only those subject to the oversight of Chapter 1, Subpart 6-1 of NY Sanitary Code and do not pose a health risk to children.
- ❑ There are no other physical conditions that are potentially hazardous to children during • the delivery of services.

Comments:

I_____**(parent/guardian), was present and participated in the assessment of the Community location where my child will receive El services, along with my child's service provider on**_____**(date of completed survey) and I agree that my child receive services at this location.**

Appendix Q:

Allergy and Anaphylaxis Overview

MYItXt>MfIN14n –rt'WaLne—MWf– J'.fLwi–vT: r-- ~l+nrM n X.: ~ev1.YfJ WifM. Mtm..CmAY.I+,..-KAA.I.t» :lci1W+RR :(H.m [tirnnc[:fM+t. n'D–:.iiJV.n.'JIML .>..ww..r/w.—~1.W.•MM.r}b^.N7a.1–+MR'Y~J[tLRIfJ..v~s[iNfx%RHKItEC YN•Y.

Pathophysiology and Treatment Overview

Food Allergies

It is known that the incidence of severe allergic reactions has been rising at an alarming rate, especially food allergies, and research suggests that the prevalence has yet to peak. Any health issues in the general pediatric population, become health concerns for the school setting. Approximately five to six percent of the pediatric population has had an occurrence of food allergy, with eight foods accounting for 90°/ of allergic reactions. The most common foods that students are allergic to include peanuts, shellfish, fish, tree nuts (i.e. walnuts, cashews, pecans, etc.), eggs, milk, soy, and wheat (NASN, 2001). However, any food can cause a severe reaction. Currently there is no cure for food allergies and strict avoidance is the only way to prevent a reaction.

An allergic reaction begins with a predisposed individual ingesting a food (by eating, inhaling, or through contact with mucous membranes), causing the body to produce an antibody that initially attaches to the surfaces of cells. This initial process yields no symptoms and will go unnoticed. However, the next time the food is ingested, the proteins in the food attach to these antibodies and cause the cells to primarily release histamine which leads to the allergic reaction (Formanek, 200)1). A reaction can occur within minutes to hours after ingestion. Symptoms can be mild to life-threatening. The specific symptoms that the student will experience depend on the location in the body in which the histamine is released. If the allergic reaction becomes severe it is then known as anaphylaxis, a life-threatening event. (Smith, 2005) Food allergies are the leading cause for anaphylaxis outside of the hospital setting. Other common causes of anaphylaxis include allergies to latex, medications, and insect stings.

Insect Sting Allergies

Insect allergy is an under reported event that occurs every year to many adults and children. Most stings are caused by yellow jackets, paper wasps, and hornets. For most, complications include pain and redness at the bite site. However, some people have true allergy to insect stings that can lead to life-threatening systemic reactions. in these cases, prompt identification of the insect and management of the reaction are needed in a timely manner.

(New York State Resource Guide)

Appendix Q:

Allergy and Anaphylaxis Overview

YN.IN.VaWl7|.J41SEM.'i~R'A01~✓'!Ta!'⁵4.:.. :WdlFNl .0.A31Rl ~~. ~FJ1:1u'~J~.Fr'Y.11+'NM1C+'iYftiUf7'A we.4"Cpl:'L<2~~4iY.~YMdYC'Yl^~✓n:'YLWYS.iWAf'f.'filY>.1.'irl~s1141M,+Tl.}>tMSlM'~.0.1• ~UAG'FQ~'~' :l-S:~CflGG•:JIiO[F+Ki6.~OMIMW,.I~i 4..+•9L'NM.:~

Insect avoidance is advised for students and staff at risk for anaphylaxis. Some precautions schools should follow include: 1) insect nests should be removed on or near school property, 2) garbage should be properly stored in well-covered containers, and 3) eating areas should be restricted to inside school buildings for students
and staff at risk.

Latex Allergies

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Latex products area common source of allergic type reactions. Two common types of reactions include contact dermatitis and immediate allergic reactions, Contact dermatitis can occur on any part of the body that has contact with latex products, usually after 12-36 hours. Immediate allergic reactions however, are potentially the most serious form of allergic reactions to latex products. Rarely, exposure can. lead to anaphylaxis depending on the amount of latex allergen that they are exposed to and their degree of sensitivity.

Latex exposure should be avoided by students and staff at risk for anaphylaxis. Since the reactions caused by latex var, each student at risk should be evaluated by a trained
medical provider, preferably an allergist.

Signs and Symptoms

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Allergies can affect almost any part of the body and cause various symptoms. Anaphylaxis includes the most dangerous symptoms; including but not limited to breathing difficulties, a drop in blood pressure, or shock, which are potentially fatal. Common signs and symptoms of allergic/anaphylactic reactions may include:

- Hives
- Cough
- Itching (of any part of the body)
- Swelling (of any body parts)
- Red, watery eyes
- Runny nose
- Vomiting
- Wheezing
- Throat tightness or closing

- Difficulty swallowing
- Difficulty breathing
- Sense of doom
- Diarrhea
- Dizziness
- Stomach Cramps
- Fainting or loss of consciousness
- Change of voice
- Change of skin color

(Source: Position Statement- *American Academy* of Asthma Allergy and *Immunology)*

Accessed from ▸ http://www.aaaai.org/!medi/lresources/acruter_ statements/position_statements/ps34.asp on 6/10/08

Appendix R

Hands on Home Safety Checklist

Based on "Home Safety Council, 2011"

Falls Prevention

- Use bright lights at the top and bottom of stairs and make sure hallways and dark areas in the home are well-lit at night with nightlights.
- Install grab bars in the tub, shower and near toilets.
- Use a rubber bath mat or non-slip strips in the tub.
- Wipe up spills and splashed bathwater promptly.
- All stairs and steps need handrails along both sides, secured along the full length of the stairway.
- Keep stairs and pathways clear of clutter.
- In homes with babies and toddlers, use baby gates at the top and bottom of stairs

Fire & Burn Prevention

- Check the setting of your water heater and make sure it's set no higher than 120 degrees F.
- Install smoke alarms on each level of your home—especially in or near sleeping areas.
- Test each smoke alarm every month by pushing the test button until you hear a loud noise.
- Replace smoke alarm batteries with new ones at least once each year.
- Know how to escape a fire. Find two exits out of every room – the door and possibly a window. Choose an outside meeting place in front of the home. Practice your plan twice a year with all members of the family.
- Stay in the kitchen while food is cooking on the stove.
- Make sure an adult is in the room constantly while a candle is burning.
- Be sure to lock matches and lighters away from children

Prevent Choking and Suffocation

- Keep coins, latex balloons and hard round foods, such as peanuts and hard candy where children cannot see or touch them.
- Place babies to sleep on their backs, alone in their crib. Don't put pillows, blankets, comforters or toys in cribs. These things can sometimes keep a baby from breathing.
- Tell children to sit down when they eat and to take small bites
- When your children are in or near water, watch them very carefully. Stay close enough to reach out and touch them. This includes bathtubs, toilets, pools and spas – even buckets of water.

Be smart Around Water

- Stay within an arm's length of children in and around the water. This includes bathtubs, toilets, pools and spas – even buckets of eater.
- Put a high fence all the way around your pool or spa. Always keep the gate closed and locked.
- Make sure the children always swim with adult(s).

XV. HEALTH AND SAFETY

The following appears in the Nassau County Department of Health contract with providers:

Recommended NYS Day Care Regulations Minimum Staff/Child Ratio Based on Group Size for Infants, Toddlers and Preschoolers

Age of Children	Staff/Child Ratio*	Maximum **
6 wks to 18 months	1:4	8
18 months to 36 months	1:5	12
3 years	1:7	18
4 years	1:8	21
5 years	1:9	24

* Staff/Child ratio refers to the maximum number of children per staff person
** Group size refers to the number of children cared for together as a unit

General Indoor Areas

Yes	No	
		Floors are smooth and have nonskid surfaces. Rugs are skid-proof
		Doors to places that children can enter, such as bathrooms, can be easily opened from the outside by a child or by an adult.
		Doors in children's areas have see-through panes so children are visible to anyone opening the door.
		Doors have slow closing devices and/or rubber gaskets on the edges to prevent finger pinching.
		Glass doors and full-length windows have decals on them that are at the eye levels of both children and adults
		Windows cannot be opened more than 6 inches from the bottom or have window guards
		All windows have closed, permanent screens
		Bottom windows are lockable
		Walls and ceilings have no peeling paint and no cracked or falling plaster
		The child care setting is free of toxic or lead paint and of crumbly asbestos
		Safety covers are on all electrical outlets
		Electrical cords are out of children's reach. Electrical cords are placed away from doorways and traffic paths
		Covers or guards for fans have openings small enough to keep children's fingers out
		Free-standing space heaters are not used
		Pipes, radiators, fireplaces, wood burning stoves, and other hot surfaces cannot be reached by children or are covered to prevent burns
		Nobody smokes or has lighted cigarettes, matches, or lighters around children
		Trash is covered at all times and is stored away from heaters or other heaters or other heat sources
		Drawers are closed to prevent tripping or bumps. Drawer locks are present
		Sharp furniture edges are cushioned with cotton and masking tape or with commercial corner guards
		There is an operable flashlight or battery powered lantern on premises
		Regular lighting is bright enough for good visibility in each room
		All adults can easily view all areas used by children
		Enough staff members are always present to exit with children safely and quickly in an emergency
		Poisonous plants are not present either indoors or outdoors in the child care areas
		All adult handbags are stored out of children's reach

		All poisons and other dangerous items are stored in locked cabinets out of children's reach. This includes medicines, paints, cleansers, mothballs, etc. Material Safety Data Sheets (MSDS) are on site/
		Cleansers and other poisonous products are stored in their original containers, away from food, and out of children's reach

		Cots are placed in such a way that walkways are clear for emergencies
		Children are never left alone in infant seats on tables or other high surfaces
		A well-stocked first aid kit is accessible to all caregivers
		Non-porous gloves are readily available for caregivers in all areas where child care is provided
		Heavy equipment or furniture that may tip over is anchored

Toys and Equipment

Yes	No	
		Toys and play equipment have no sharp edges or points, small parts, pinch points, chipped paint, splinters, or loose nuts or bolts
		All painted toys are free of lead
		Toys are put away when not in use
		Toys that are mouthed are washed after each use
		Toys are too large to fit completely into a child's mouth and have no small, detachable parts to cause choking. No coins, safety pins, or marbles for children under 4 years of age
		Toy chests have air holes and a lid support or have no lid. A lid that slams shut can cause pinching, head injuries or suffocation
		Shooting or projectile toys are not present
		Commercial art materials are stored in their original containers out of children's reach.
		Rugs, curtains, pillows, blankets, and cloth toys are flame-resistant
		Hinges and joints are covered to prevent small fingers from being pinched or caught
		Cribs, playpens, and highchairs are away from drapery cords and electrical cords
		Infant walkers are not used without supervision
		Five-gallon buckets are not accessible to infants and toddlers

Hallways and Stairs

Yes	No	
		Handrails are securely mounted at child height
		Handrails are attached to walls for right-hand descent, but preferably are attached to the walls on both right and left sides
		Stairway gates are locked in place when infants or toddlers are nearby. Gates should have openings small enough to prevent a child's head from fitting through. No accordion-type gates are used
		Doorways to unsupervised or unsafe areas are closed and locked unless the doors are used for emergency exits
		Emergency exit doors have easy-open latches
		Safety glass is used in all areas of potential impact
		Caregivers can easily monitor all entrances and exits to keep out strangers
		Stairways and hallways are clear of objects that can cause a fall

Serving of Snacks/Meals

Yes	No	
		Infants and toddlers are not permitted to eat small objects and foods that may easily cause choking, such as hot dogs, hard candy, seeds, nuts, popcorn, and uncut round foods such as whole grapes and olives
		Caregivers always wash hands before handling food and wear gloves when serving food
		Caregivers always wash children's hands before mealtimes
		Trash is always stored away from food preparation and storage areas
		Cleansers and other poisonous products are stored in their original containers, away from food, and out of children's reach
		Food preparation surfaces are clean and are free of cracks and chips
		Eating utensils and dishes are clean, free of cracks, chips and lead

		Appliances and sharp or hazardous cooking utensils are stored out of children's reach
		Trash is stored away from the furnace, and hot water heater
		Hot foods and liquids are kept out of children's reach
		Stable step stools are used to reach high places

Bathrooms

Yes	No	
		Toilet facilities are age appropriate, clean and are supplied with toilet paper, soap, disposable towels, and tissues accessible to children
		Stable step stools are available where needed
		Electrical outlets have safety covers or are modified to prevent shock
		Electrical equipment is stored away from water and not accessible to children
		Cleaning products and disinfectants are locked in a cabinet out of children's reach
		If potty chairs are used, they are easy to clean with a solution that follows the green laws in a utility sink used only for that purpose, if possible
		Potty chairs are not used in the food preparation or dining areas, and potty chairs cannot be reached by children when they are not in use
		Caregivers and children always wash hands after toileting and diaper changing
		The changing of diapers or soiled underwear is done in a special, separate area away from food and play
		The diapering and changing table has rails to keep the child from rolling off
		Trash cans for diapers, tissues, and other materials that come in contact with body fluids can be opened with a step pedal and are lined with a plastic bag, emptied daily, and kept clean
		Paper towels and liquid soap are readily available at the sink
		Diaper changing area are washed and disinfected with a germicidal solution after each use
		Children are never left alone on a changing table, bed, or any other elevated surface
		Children are never left unsupervised in or near water

Active Play Areas Including Playgrounds

Yes	No	
		Surfaces underneath indoor and outdoor play equipment are covered with impact absorbing materials in accordance with the U.S. Consumer Product Safety Commission standards.
		Playground area is fenced in
		The active play area offers a wide range of parallel and interactive activities and are developmentally appropriate
		Water for drinking and first aid is available near the play area
		A well-stocked first aid kit is accessible to all caregivers during outdoor play

Surfacing

Yes	No	
		The following surfacing materials are not in use underneath indoor and outdoor play equipment that children can climb: asphalt, concrete, soil or hard-packed dirt, grass, turf, linoleum, or carpeting
		There are no toys or objects (including surfacing material) with a diameter less than 1 ¼ inch accessible to children who are still placing objects in their mouths

Protrusion & Entanglement

Yes	No	
		All metal edges are rolled
		Any exposed bolts do not protrude more than two threads beyond the face of the nut; exposed bolts have no burrs or sharp edges

Entrapment

Yes	No	
		There are no openings in any pieces of active play equipment between 3 ½ and 9 inches that could cause head entrapment
		All spaces are too big or too small to entrap a child's finger.

Equipment Spacing

Yes	No	
		There are at least 6 feet of open space on all sides of each piece of equipment
		Play equipment pieces are spaced at least 12 feet apart from each other (each has its own 6-foot use space)

Trip Hazards

Yes	No	
		All anchoring devices, such as footings and bars at the bottom of climbers, are below the playing surface
		There are no exposed tree/plant roots
		Changes in elevation are made obvious by the use of brightly colored visual or other barriers

Appropriate Activities & Equipment

Yes	No	
		Age-specific play areas are separated by distance or physical barrier

Maintenance

Yes	No	
		Daily checks include: broken glass and/or equipment, trash, displaced surfacing, puddles of water, etc.
		All hardware fasteners, permanent coverings, or connecting devices are tight and cannot be removed without tools
		All surfaces are intact
		All structures are sturdy enough that they will not move or tip over when the weight of an adult is put against them
		There is no peeling paint. (Lead in peeling paint on play equipment is a common hazard.)
		All ropes are tight and strands cannot be pulled apart

Supervision

Yes	No	
		All areas where children can play are in view of an adult at all times
		Every child is accounted for at all times by a supervising adult. Some method of assuring that no child is hidden or missing from the group must be used
		When children must leave the play area to use the toilet, to get first aid, or for any other reason, supervision of the child who leaves and the children who remain in the play area is secure and consistent with staff/child ratio requirements
		Children are prevented from playing in a way that challenges them beyond their abilities or that puts others at risk of significant injury

Sand

Yes	No	
		Sand digging areas are in the shade

		Sand digging areas are contained by smooth frames
		Sand is covered when not in use to prevent infectious disease and injury risk when animals and insects get into it

Pinch, Crush, & Shearing Points

Yes	No	
		All spaces are too big or too small to entrap a child's finger
		All wooden parts are smooth and without splinters
		All corners are rounded, especially at exit ends and sides along a slide bed
		Exposed ends of tubing have caps that cannot be removed without tools

Other Hazards

Yes	No	
		Play area is checked daily for litter, animals, animal feces or other hazards that may attract insects, hide hazards, and harbor infectious disease agents
		There are no attractive climbing hazards (such as trees) that are accessible from an object placed underneath them
		There are no toxic or thorny plants present
		If classroom animals are kept, only an adult should clean cages, etc. Materials and sinks used for this purpose separate from feeding and changing areas. If children are handling animals, it should be under supervision and followed by hand washing afterwards.

Emergency Preparedness

Yes	No	
		A working telephone is readily available as well as an operable flashlight or battery powered lantern
		Emergency plan is available, staff are aware of plan and procedures include the following: • How to phone emergency medical services (EMS) system • Transportation to an emergency facility • Notification of parents • Where to meet if the child care setting is evacuated • Plans for an adult to care for the children while a caregiver stays with injured children. This includes escorting children to emergency medical care Alternate location for care is known to staff and parents, and is stocked with essential supplies (formula, diapers, toys, first aid supplies)
		Children's emergency phone numbers are posted near the phone and can be easily taken along in case of an emergency evacuation. Office has alternate emergency phone numbers in the event a parent cannot be reached. Alternate emergency phone numbers are updated on a routine basis
		Emergency procedures and telephone numbers are clearly posted near each phone
		Each room and hallway has a fire escape route clearly posted
		One or more caregivers certified in infant and child first aid and where children swim or children with disabilities are in care, one or more caregivers certified in infant and child CPR are always present
		Caregivers always take a first aid kit on trips
		Smoke detectors and other alarms are tested monthly
		All exits are clearly marked and free of clutter
		Doors and gates all open out for easy exit
		Information on children with allergies or other special needs is kept in each room and clearly posted in the event the regular caregiver is not there.

First Aid Kit Inventory

ITEM	DATE CHECKED (Restock after each use and inventory monthly)				
Disposable, nonporous gloves (use to protect hands from contact with blood or body fluids)					
Sealed packages of antiseptic (use for cleaning)					
Scissors (use for cutting tape or dressings)					
Tweezers (use to remove splinters)					
Thermometer (use for taking temperature)					
Bandage tape (hold gauze pads or splint in place)					
Sterile gauze pads (cleaning injured area and covering cuts and scrapes)					
Flexible roller gauze (hold gauze pad, eye pad, or splint in place)					
Triangular bandage (supporting injured arm or hold a splint in place)					
Safety pins (pin triangular bandage)					
Eye dressings (cover both eyes if foreign body is present and cannot be removed)					
Pen/pencil and note pad (writing down information and instructions)					
Syrup of ipecac (to be used only with instruction from or poison control center – check expiration date)					
Current American Academy of Pediatrics or American Red Cross Infant/Child first aid resource or equivalent guide (instructions)					
Coins (for use in pay phone)					
Poison control telephone number					
Water (bottle or a water source for cleaning injured areas and hand washing)					
Small plastic metal splint (to immobilize an injured finger)					
Soap (washing hands or injured area)					
Bee/insect sting kit (if child with severe allergy is in care). Be sure to keep written instructions for use with the medication					
INITIALS OF PERSON WHO CHECKED					

KEEP OUT OF THE REACH OF CHILDREN

Adapted from American Academy of Pediatrics, American Public Health Association. (1992) *Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of –Home Child Care Programs*. Washing, DC: AAP and APHA.

Get Medical Help Immediately*

For some conditions, you need to get medical help immediately. If the caregiver can reach the parent, the parent must come right away. Parents should let the child's doctor know that the caregiver has the parent's permission to call for advice in an urgent situation. In situations that require immediate medical evaluation, if the parent or the child's doctor is not available, the caregiver should contact the facility's health consultant or emergency medical services (EMS)/911system for help.

Get help immediately for a child with any of the following conditions: (Please note that this is <u>not</u> a comprehensive list; when in doubt, call 911!)

- Specific fevers:
  - A baby less than 4 months of age has a temperature of 101 degrees F. rectally or 100 degrees F. axillary (armpit)
  - A temperature of 105 degrees F. or higher in a child of any age
- For infants under 4 months, forceful vomiting more than once
- Looking or acting very ill or getting worse quickly
- Neck pain when the child's head is moved or touched
- A stiff neck or severe headache and looking very sick
- A seizure for the first time
- Acting unusually confused
- Unequal pupils (black centers of the eyes)
- A blood-red or purple rash made up of pinhead-sized spots or bruises that are not associated with injury
- A rash of hives or welts that appears and spreads quickly
- Breathing so fast or so hard that the child cannot play, talk, cry, or drink
- A severe stomachache that causes the child to double up and scream
- A stomachache without vomiting or diarrhea after a recent injury, blow to the abdomen, or hard fall
- Stools that are black or have blood mixed through them
- Not urinating at least once in 8 hours, a dry mouth, no tears or sunken eyes
- Continuous clear drainage from the nose after a hard blow to the head

Note for programs that provide care for sick children:

If any of the conditions listed above appear after the child's care has been planned, medical advice must be obtained before continuing child care can be provided.

(List modified from the American Red Cross Child Care Course, 1990. For information about the course, contact the local chapter of the American Red Cross or write to the American Red Cross, National Headquarters, Health and Safety, 8111 Gatehouse Road, Falls Church, VA 22042)

Footnote: Recommendations are based on NYS Day Care Regulations and American Academy of Pediatrics Health and Safety Checklist

APPENDIX T:

DAILY ATTENDANCE RECORD

Name _____ **Phone** ( )

Address _____ **Report Month** _____

School Day/Time **Year**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
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APPENDIX T2:

RECORD OF FIRE DRILLS FOR CHILD DAY CARE

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DATE (Check Day)	TIME		NUMBER OF CHILDREN	NAME OF PERSONS CONDUCTING DRILL	EXIT ROUTE FOLLOWED P=Primary S=Secondary O=Other (Please Specify)			COMMENTS (Include any special conditions)
	Start	End			P	S	O	
1. ☐ M ☐ T ☐ W ☐ TH ☐ F					☐	☐	☐	
2. ☐ M ☐ T ☐ W ☐ TH ☐ F					☐	☐	☐	
3. ☐ M ☐ T ☐ W ☐ TH ☐ F					☐	☐	☐	
4. ☐ M ☐ T ☐ W ☐ TH ☐ F					☐	☐	☐	
5. ☐ M ☐ T ☐ W ☐ TH ☐ F					☐	☐	☐	
6. ☐ M ☐ T ☐ W ☐ TH ☐ F					☐	☐	☐	
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8. ☐ M ☐ T ☐ W ☐ TH ☐ F					☐	☐	☐	
9. ☐ M ☐ T ☐ W ☐ TH ☐ F					☐	☐	☐	