1. **Communicable Diseases**
   a. Temporary Exclusion Due to Short-Term Illness or Injury Policy and Procedure  
      *(Also Includes Reportable Communicable Diseases) (Revised 07/18)*
   b. Head Lice Information and Policy (English/Spanish) *(Revised 08/02)*
   c. Head Lice Parent/Guardian Letter (English/Spanish) *(Revised 06/14)*
   d. Daily Health Checks & Observations *(Revised 07/18)*
   e. Communicable Disease Board List *(Revised 06/14)*
   f. Exposures and Exposure Notices Procedure *(Revised 06/13)*

2. **Emergency Procedures & Classroom Postings**
   a. Child Health and Safety Policy and Procedure *(Revised 05/10)*
   b. Emergency Procedures for Accidents or Critically Ill Children *(Revised 08/18)*
   c. Emergency Care In Case of a Seizure *(Revised 05/10)*
   d. Reference & Handout for When a Child has Experienced a Bump to the Head  
      *(English/Spanish) *(Revised 05/10)*
   e. Health/Nutrition Postings Procedure *(Revised 08/18)*
   f. Classroom Emergency Supplies & Postings Proc. (LCC East & West Ctrs.) *(R: 08/02)*
   g. Bee Sting Allergy Procedure *(Revised 06/14)*
   h. Earthquake Preparedness Procedure *(Revised 01/13)*
   i. Fire Drill Preparedness Procedure *(Revised 07/18)*
   j. Fire/Earthquake/Lockdown Drill Record *(Revised 10/16)*

3. **First Aid Kits**
   a. First Aid Kits Policy *(Revised 07/18)*
   b. First Aid Supplies List *(Revised 06/14)*
   c. Care of a Human Bite Procedure *(Revised 06/14)*

4. **Hygiene**
   a. Hygiene Policy and Hand Washing/Hygiene Procedure *(Revised 07/18)*
   b. Handling of Body Fluids Procedure *(Revised 08/15)*
   c. Diaper/Pull-Up Changing Procedure *(Revised 07/18)*
   d. Bleach Solution Ratios *(Created: 08/15)*
   e. Monthly Bleach Log – Food Prep/Surface Sanitizing *(Revised: 08/15)*
   f. EHS Cleaning and Sanitizing Record – Teen Center *(Created 12/17)*

5. **Medication Administration**
   a. Medication Policy and Procedure *(Revised 07/18)*
   b. Medication Checklist *(Revised 11/15)*
   c. Medication Authorization Form *(Revised 08/15)*
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6. **Parent/Guardian Assistance for Student Health Services**
   a. Parent/Guardian Assistance for Student Health Services Policy *(Revised 07/18)*
   b. Determination Instructions for Program Pay of Student Physical Examinations or Medical  
      Services *(Revised 06/14)*
   c. Determination Instructions for Program Pay of Student Dental Exams *(Revised 06/14)*
   d. Procedure for FREE Vision Care for Qualifying Children *(Revised 02/17)*
7. Posted Emergency Evacuation Routes
   a. Emergency Evacuation and Safety Policy (Revised 07/18)
   a1. Disaster and Emergency Preparedness Training Acknowledgement (Created 08/16)
   b. Barnes Center Fire Drill – Evacuation Procedure (Revised 07/18)
   bb. Emergency Evacuation Procedure – Memorial Park Center (Revised 01/17)
   c. Barnes Center Diagram for Emergency Evacuation (Revised 07/18)
   cc. Memorial Park Center Diagram for Emergency Evacuation (Revised 01/17)
   d. Broadway Center – Room #11 Fire Drill – Evacuation Procedure (Revised 06/16)
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   x. Broadway Center – Room #16 Fire Drill – Evacuation Procedure (Revised 05/10)
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   z. Broadway Center – Room #15 Fire Drill – Evacuation Procedure (Created 04/10)
   z1. Broadway Center Diagram for Emergency Evacuation Room #15 (Created 04/10)

8. Special Health Care Needs of Students
   a. Special Health Care Needs of Students Policy (Revised 05/10)
   b. Acquired Immune Deficiency Syndrome (AIDS) and Hepatitis C Special Procedures (Revised 06/13)

9. Student Accident Prevention and Reporting
   a. Injury Prevention Policy (Revised 07/18)
   b. Procedure for Completing an Accident Report (Revised 03/18)
   c. Child Accident Report Form (English/Spanish) (Revised 06/16)
   d. Bicycle Helmets Outdoors Procedure (Revised 07/18)
   e. Safe Infant Sleep Procedure (Revised 08/17)
   e1. Nap and Quiet Rest Period Procedure for Toddlers (not in a crib) and Preschoolers (Revised 08/17)

10. Student Health Examinations
    a. Child Health and Developmental Services Policy (Revised 07/18)
        (See Developmental Screening Procedure in FS/PI/ERSEA Handbook)
    b. Physical Exam Form Cover Letter (Revised 06/13)
    c. Physical Exam Form (Revised 06/14)
d. Denial of Consent for Medical Services (English/Spanish) (Revised 06/13)
e. Dental Exam Form Cover Letter (Revised 06/14)
f. Dental Exam Form (Revised 07/13)
g. Denial of Consent for Dental Services (English/Spanish) (Revised 06/13)
h. Well Child and Dental Exams Process (Revised 06/14)
i. Spring Conference/End-of-Year Home Visit/Close-Out PIR Health Questionnaire (English/Spanish) (Revised 03/17)
j. End-of-Year Child Health Summary (English/Spanish) (Revised 01/18)

11. Student Health Follow-Up, Referrals and Treatment
   a. Health Referral for New or Recurring Concerns Policy and Procedure (Revised 07/18)
d. Request for Child Developmental and/or Health Records Procedure (Revised 08/18)
e1. Health Record Request Letter (Revised 10/18)
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12. Student Hearing & Vision Screenings
   a. Hearing Screening Policy and Procedure (Revised 07/18)
b. Vision Screening Policy and Procedure (Revised 07/18)
c. Hearing, Vision & Strabismus Screening Form (Revised 06/18)
d. Hearing Referral Form (English/Spanish) (Revised 11/13)
e. Vision Referral Form (English/Spanish) (Revised 11/13)
f. Record of Vision Exam (Revised 11/13)
g. Screening for Vision & Hearing Concerns in Infants & Toddlers Procedure (R: 06/18)
g1. EHS Three-Pronged Approach I. Parent Interview Questions (R: 07/18)
g2. EHS Three-Pronged Approach II. Developmental Skills Checklist (Revised 07/18)
g3. EHS Three-Pronged Approach III. Observations (R: 07/18)
h. EHS Screenings Summary Form (Revised 10/17)
i. Otoacoustic Emission (OEA) Screening Procedure (Created 06/17)
j. EHS SPOT Vision and OAE Hearing Screening Form (Revised 06/18)

13. Student Immunizations
   a. Immunization Agreement Procedure (Revised 08/18)
b. Vacant
c. Immunization Agreement Form (English/Spanish) (Revised 06/14)
d. Immunization Records Requirements (Created 08/18)

14. Head Start Oral Health Initiative
   a. Caries Risk Assessment Form (Revised 05/16)
b. Dental Screening & Fluoride Services (English/Spanish) (Revised 10/17)
c. Prenatal Dental History Questionnaire (Revised 09/11)
h. Prenatal Dental Services Form (Revised 11/13)

15. Early Head Start
   a. Well Child Exam Forms (EPSDT)
b. All About My Day – EHS (Created 04/10)
c. EHS Home Safety Checklist (Created 06/12)
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Temporary Exclusion Due to Short-Term Illness or Injury

POLICY: Our program must temporarily exclude a child with a short-term injury or an acute or short-term contagious illness, that cannot be readily accommodated, from program participation in center-based activities or group experiences, but only for that generally short-term period when keeping the child in care poses a significant risk to the health or safety of the child or anyone in contact with the child.

CONTAGIOUS ILLNESS PROCEDURE:
1. Ill children will be separated from others and cared for in a separate area of the classroom.

2. The parent will be notified to pick up the child as soon as possible, and is expected within the hour.

3. Illness incidents will be recorded in ChildPlus/Family Services.

4. The following communicable diseases will be reported to the Health Specialist by the classroom teacher: Head Lice, Chicken Pox, Scarlet Fever/Strep Throat, Impetigo, Pin Worms, Pink Eye, etc... If in doubt, the illness should be reported.

   The Health Specialist is responsible for providing an informational sheet on the diagnosed disease to staff, parents and volunteers of the classroom.

5. The informational sheet will state whether or not a note from the child's health provider is needed prior to re-admittance. Some communicable disease must be reported to the local health department. The following partial list of reportable communicable diseases includes those sometimes found in child care settings.

Reportable Communicable Diseases:

Diseases Preventable by Vaccination - Call the Health Department whenever the diseases are suspected:
*Chicken Pox
*Diphtheria
*Hemophilus Influenza Type B (HIB)
*Measles (Rubeola, 10-day measles, hard measles)
*Mumps
*Pertussis (Whooping Cough)
*Poliomyelitis (Polio)
*Rubella (German Measles, 3-day measles)
*Tetanus

Uncommon Illnesses Causing Severe Symptoms
*Acquired Immune Deficiency Syndrome (AIDS)
*E. Coli
*Foodborne or Waterborne Illnesses
*Gonorrhea (G.C.)
*Hepatitis, Viral (Please report all instances of illness in children and their families, and teachers)
*Kawasaki Syndrome
*Meningococcal Disease
*Meningitis
*Reye Syndrome
*Rheumatic Fever
*Salmonellosis
*Shigellosis
*Tuberculosis (T.B.)
*Typhoid Fever
*Viral Encephalitis

Common Illnesses Causing Severe Symptoms
*Campylobacteriosis ("Campy")
*Giardiasis
*Influenza (Call if more than 10% of day care group -- teachers & students -- out ill.)

The classroom teacher/EHS staff will notify the Health Specialist whenever these diseases are suspected. The Health Specialist will then notify the Health Department. At this time, the Health Specialist will provide in informational sheet on the suspected disease to staff, parents and volunteers of the classroom. As a preventative and management measure for the classroom, the information sheet will include information on prevention and reporting of the disease.

6. Infections
During the winter months there are many different kinds of infections in our community. If children eat the right foods and get plenty of rest, they are more able to resist infection and/or to recover more quickly when infection occurs.

The following can indicate an infection:
1. Poor appetite - child may pick at solid foods, eat lightly, want only certain foods, and/or prefer liquids.
2. Child may be irritable and have a bad temper; play activities may diminish; child may be hard to please.
3. Fever - if a child's fever is over 100.2 degrees, he/she needs to stay at home. Call the doctor or nurse:
   • If baby is younger than 2 months and has a fever of 100.2 degrees F or higher;
   • If baby is between 2 and 6 months old and has a fever of 101 degrees F or higher;
   • If child is older than 6 months and has a fever of 103 degrees F or higher.
A child should see a doctor if the fever is high (105 degrees); when fever lasts longer than 24 hours without an obvious indication of infection; when the fever lasts longer than 72 hours with any illness; when child has a serious underlying disease. Taking aspirin should be avoided because of the association of aspirin with Reyes Syndrome. Acetaminophine (Tylenol) may be okay to give to children (read warning on label).
4. Fatigue - children coming down with an illness show greater fatigue and may require more sleep. When this is a change from a child's normal pattern, it may indicate an illness.
5. Sore throat - this can be minor or could possibly be a streptococcal infection. A child may need to see a doctor, as he/she will need medication to clear up a "strep" infection.
6. Earache and/or discharge from the ear - when there is an earache and/or when blood or pus is seen running from the ear, the child needs medical attention.
7. Other indicators are skin color, a rash, itching, change in bowel habit, nasal discharge and obstruction, cough, pain (back, limbs, neck, stomach).

7. Keeping Your Ill Child Home
Children with symptoms of communicable disease are likely to spread the disease to others. If your child has been diagnosed with an illness by a health care provider, a note from the provider will be needed upon the child’s return to school. Keep your child home if any of the following symptoms are present:

**Fever** - No child with a fever should be sent to school. If a child has been ill he/she shouldn't be sent back until he/she has been fever free for 24 hours.

**Cold** - If your child has a bad cold, he/she belongs at home in bed. Chronic greenish nose discharge should probably be evaluated by your child's primary health care provider. (Runny noses with no fever may be a little uncomfortable but would be okay. Good personal hygiene is needed--lots of tissue and avoid close contact with others.)

**Rash** - You should find out what it is. If it's localized and he/she has no temperature and no other symptoms, it's most likely an allergic reaction. A generalized rash, particularly with fever, probably indicates a viral or bacterial illness.

**Headache** - If it is "splitting" enough to hamper functioning or is accompanied by a fever, child should stay home. (Without other symptoms, may be okay.)

**Stomach Ache** - Stay home if it's severe enough to limit activity and contact your child’s health care provider.

**Vomiting** - If there's more than one episode with no apparent explanation -- better check with your child's primary health care provider. Child may return to school after being symptom free for 24 hours.

**Sore Throat** - Keep an eye on their symptoms for 24 hours. If white spots are seen or they develop a fever it may indicate a strep infection and should be checked by a health care provider. If strep is diagnosed, the child cannot return for 24 hours after beginning medication. (If your child's throat is slightly red but they do not have a fever or swollen glands they will probably be okay in school.)

**Ear Ache** - Sharp pain may indicate an infection--discharge of fluid in the ear definitely means an infection. See a health care provider, since hearing loss may result.

**Sores** – Open or oozing sores, unless properly covered with cloths or with bandages.

**Eyes** - Thick mucus or pus draining from the eye or pink eye. See a health care provider. The child may not return until the eyes are clear of infection.
Communicable Skin Infections – Impetigo and scabies: The child may return 24-hours after starting antibiotic treatment.

Diarrhea - 3 or more watery stools in a 24-hour period, especially if the child acts or looks ill. Child may return to school after being symptom free for 24 hours.

Children with mild cold symptoms who do not have any symptoms described above probably do not need to be excluded from school. Chronic greenish nose discharge should probably be evaluated by your health care provider.

8. Scabies Procedure
If scabies is suspected, the child must be seen by their Primary Health Care Provider for diagnosis. If scabies is diagnosed, the health care provider may prescribe medication. Before returning to school, the child must have a note from the health care provider stating that he/she may return to school.

If you have any questions regarding this information or whether or not your child needs to stay home, please call your child's health care provider or Head Start/EHS/ECEAP.

9. Short Term Injury
A child with a short-term injury, that cannot be readily accommodated, must be temporarily excluded but only for that generally short-term period when keeping the injured child in care poses a significant risk to the health or safety of the child or anyone in contact with the child. If a temporary exclusion is necessary, the Direct Service Team/EHS staff will develop an action plan with the child’s parent/guardian, their supervisor, the Health Specialist and the child’s health care provider.

10. Parent/Guardians Being Prepared
Parents need to have an alternative plan for the care of their ill child, so other children won't be exposed to the illness and so the ill child can get the needed rest. If a child has been exposed to a communicable disease, or has an illness, the parent/guardian is to let the child's teacher know. For more detailed information on control of communicable disease in children, contact the Head Start Health Specialist at 442-2807 or the Cowlitz County Health Department at 414-5599.
LOWER COLUMBIA COLLEGE HEAD START/ECEAP
Head Lice Information and Policy

THE HEAD LOUSE
The fertilized female louse lays her eggs at the base of the hair shaft close to the scalp. The egg is attached firmly to the hair shaft with a cement-like substance, and is called a nit. The egg hatches within one week (7 to 10 days), and reaches maturity in ten days. The mature female can lay 50 to 150 eggs during her lifetime of 30 days.

HEAD LOUSE FACTS
1. Head lice do not fly or jump; they fall and crawl.
2. Head lice are a species specific to people. They do not live on dogs, gerbils, other pets or animals.
3. Head lice do not transmit disease.
4. Head lice are NOT dislodged by water or regular shampooing.
5. Head lice do not like heat or direct sunlight.
6. Head lice are sensitive to cold.

TRANSMITTING THE HEAD LOUSE
The head louse is spread from person to person by shared combs, hair brushes, barrettes, scarves, hats, helmets, coats and bedding (including sleeping bags and pillows).

TREATMENT
Once head lice and/or nits are found, your health care provider may prescribe a LiceMeister comb, medicated lice shampoo or lice cream rinse. When you use a lice shampoo, FOLLOW DIRECTIONS CAREFULLY. Remember these products are chemicals, not just hair care products. Some shampoos may require repeated applications. Examine and treat all household members (including adults) who have lice or nits. Children cannot return to school until lice have been treated and nits have been removed.

Your child must be cleared by a program staff member (teacher, family advocate or assistant teacher) before returning to class.

OTHER WAYS OF KILLING LICE, i.e. on hats, clothing, bedding, combs, hairbrushes, etc.
1. Clean clothes and bedding by machine washing or drying on the hot cycle.
2. Vacuum floors, carpets, furniture (sofas, chairs, mattresses) and the inside of your car. Dispose of vacuum bag after use.
3. Dry clean items that cannot be laundered - inform cleaners so clothing can be handled separately. Take items to cleaners in plastic bags.
4. Soak combs and brushes in very hot water for 10 minutes. Wash in soap and water, rinse and air dry.
5. Bag clothing that cannot be washed in a plastic bag and place in freezer for 48 hours or seal in a bag for 10 days.
6. Clean smooth surfaces with disinfectant solution to wipe away nits or lice. Put cleaning cloths etc. into disinfectant solution until they can be washed.

(C:05/00;R:08/02
Approved by Policy Council 06/19/00)
**Head Lice Policy & Information**

**LOWER COLUMBIA COLLEGE HEAD START/ECEAP**

**Información y Política acerca de los Piojos**

**EL PIOJO**
El piojo hembra deposita los huevecillos en la raíz del cabello cerca del cuero cabelludo. Los huevecillos están pegados firmemente en la raíz del cabello con una sustancia como-cemento y se llaman liendres. El huevecillo revienta como en una semana (7 a 10 días), y maduran en diez días. La hembra madura puede llegar a poner entre 50 y 150 huevecillos durante su período de vida de 30 días.

**INFORMACION SOBRE LOS PIOJOS**
1. Los piojos no vuelan o brincan; se caen y caminan.
2. Los piojos son especies específicas de las personas. Ellos no viven en los perros, gerbos, en mascotas o cualquier otro animal.
3. Los piojos no transmiten enfermedades.
4. Los piojos NO se pueden caer con el agua o con lavarse el cabello con champú.
5. A los piojos no les gusta el calor o luz directa del sol.
6. Los piojos son sensibles a lo frió.

**COMO SE TRANSMITEN LOS PIOJOS**
Los piojos se transmiten de persona a persona cuando comparten peines, cepillos para el cabello, pasadores, bufandas, sombreros, cascos, abrigos y cosas de la cama (incluyendo sleeping bags y almohadas).

**TRATAMIENTO**
Una vez que se aya encontrado piojos y/o liendres, su doctor le puede recetar un peine, champú o crema de enjuague para los piojos. Cuando usted use champú para los piojos, **SIGA CUIDADOSAMENTE LAS INSTRUCCIONES.** Recuerde éstos productos son químicos, no son solamente productos para el cabello. Algunos champús pudieran requerir mas de un tratamiento. Examine y trate a todos los miembros de su familia (incluyendo a los adultos) que tengan piojos o liendres. **Los niños no podrán regresar a la escuela hasta que no se hayan tratado los piojos y se les haya quitado las liendres.**

A su niño lo tendrá que revisar un miembro del personal (maestra, trabajadora social o la asistente de la maestro) antes de regresar a clases.

**OTRAS MANERA DE MATAR A LOS PIOJOS, i.e. en los sombreros, ropa, cosas para la cama, peines, cepillos para el cabello, etc.**
1. Lave su ropa y las cosas de la cama en lo más caliente de la lavadora y secadora.
2. Aspire los pisos, alfombras, muebles (sofás, sillas, colchones) y adentro de su carro. Deseche la bolsa de la aspiradora después de usarla.
3. Limpie en seco las cosas que no se puedan lavar. LLévese la ropa a la tintorería en una bolsa de plástico e infórmelas a ellos para que se puedan encargar de su ropa por separado.
4. Remoje los peines y cepillos en agua bien caliente por 10 minutos. Lave con agua y jabón, enjuague y seque al aire libre.
5. Ponga en bolsas de plástico ropa y objetos que no se puedan lavar y congélelos por 48 horas o selle bien las bolsas por 10 días.
6. Limpie bien las superficies con desinfectantes para remover los piojos y las liendres. Ponga los trapos de la limpieza en desinfectantes hasta que los pueda lavar.
Date: ________________________________

Dear Parent/Guardian:

_________________________ is being sent home today because we found head lice and/or nits. Lower Columbia College Head Start/EHS/ECEAP requires that students found with head lice and/or nits be removed from school until the hair has been treated and ALL NITS have been removed. Once head lice and/or nits are found, your primary health care provider may prescribe a LiceMeister comb, medicated lice shampoo or lice cream rinse. When you use a lice shampoo, FOLLOW DIRECTIONS CAREFULLY. Remember these products are chemicals, not just hair care products. Some shampoos may require repeated applications. Examine and treat all household members (including adults) who have lice or nits. We recommend you contact your own primary health care provider for proper treatment.

Children returning to school after having been sent home with head lice are to be accompanied by a parent/guardian and checked by their school teacher before re-entering the classroom.

Anyone can get lice, no matter the cleanliness of an individual or family. Enclosed is information that may be beneficial in recognition and treatment of head lice.

If you have any further questions, please call me at: ________________________________.

Sincerely,

Teacher

Cut Here and Return Bottom Portion to Head Start

I certify that my child: ________________________________

(Print Student's Name)

has been treated for head lice according to the policy given to me by my child's teacher.

I used: ________________________________ on: ________________________________ for this treatment.

(Product Name) (Date)

_________________________ Signature of Parent/Guardian

_________________________ Telephone Number

(C: 11/97; R: 06/14)
Fecha: ____________________________

Estimado Padre/Guardián:

Ha sido mandado a la casa hoy porque encontramos piojos y/o liendres. College Head Start/EHS/ECEAP sugiere que los niños con piojos y/o liendres sean removidos de la Escuela hasta que su cabello sea tratado y todas LAS LIENDRES hayan sido removidas. Una vez que los piojos y/o liendres han sido encontrados, su proveedor de cuidado de salud quizás recete un peine LiceMeister, shampoo medicado para los piojos o crema de lavado para los piojos. Cuando use el shampoo para los piojos, SIGA LAS INSIDICACIONES CUIDADOSAMENTE. Recuerde estos productos son químicos, no productos para el cuidado del cabello. Algunos shampoos quizás requieran aplicaciones repetidas. Le recomendamos que contacte a su propio proveedor del cuidado de la salud para el tratamiento.

Los niños que regresen a la Escuela después de que hayan sido mandados a la casa con piojos tienen que ser acompañado(a) por el Padre/Guardián y ser resisado por la maestro(o) de la escuela antes de que entre al salon de clases.

Cualquiera puede adquirir los piojos, no importa la limpieza del individuo o familia. En este sobre esta una información que quizás sea beneficial en el reconocimiento y tratamiento de los piojos.

Si usted tiene cualquier pregunta, por favor llámeme al teléfono: ____________________________.

Sinceramente,

Maestra(o)

Corte aquí y regrese la porción de abajo a el Head Start

Yo certifico que mi niño(a): ____________________________ (Escriba el nombre del estudiante)

ha sido tratado con respecto a los piojos de acuerdo a la póliza que me dio la maestro(o) de mi niño(a).

Yo use: ____________________________ el: ____________________________ para est tratamiento.

(Nombre del producto) (Fecha)

Firma del Padre ____________________________  Numero Teléfono ____________________________

(C: 07/02; R: 06/14)
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP

Daily Health Checks & Observations

Policy
Direct Service Team/EHS staff members will observe each child daily to identify any new or recurring medical, dental, or developmental concerns so that they may quickly make appropriate referrals.

Procedure
Direct Service Team/EHS staff members will conduct daily health checks on the children as they arrive and again prior to leaving the program for the day. (See Keeping Your Ill Child Home and Contagious Illness Procedures HLTH 1a) Children are also observed throughout the day. These checks and observations are a general overview of the child’s appearance and health status and include the following:

- **HEAD**: lice and/or nits; sores/cuts; bumps/bruises;
- **EYES**: dull/circles under; red, runny, itchy, discharge-clear; discharge-pus, lids swollen and/or red;
- **EARS**: ear ache, discharge-pus(clear), pulling at/digging in, discharge-wax;
- **NOSE**: discharge-clear, discharge-yellow-green, swollen-red nostrils, sneezing;
- **MOUTH**: blisters/bumps/sores, white coating, teeth decayed, missing, appear loose, swelling-lips and/or tongue;
- **BREATHING**: noisy/wheezing, fast, cough/hoarseness, labored (difficulty);
- **SKIN**: dry, chapped, swollen, red skin, rash, burns, bruised/discolored, scratches, feels feverish/temperature, bug/insect bites, teeth bite marks;
- **STOMACH**: vomiting or nausea;
- **BOWEL MOVEMENTS**: diarrhea-watery or soft stools, constipated-firm stools, diaper rash, or body itch;
- **BEHAVIOR**: frequent mood changes, restless/irritable, fearful, angry, seldom smiles or laughs, inactive/sluggish, clumsy/sits poorly, fussy/cries often;
- **COMPLAINTS**: headache, body itch or suspect communicable disease.
<table>
<thead>
<tr>
<th>Your child has been exposed to</th>
<th>Su niño ha estado expuesto a</th>
</tr>
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<tbody>
<tr>
<td>Chickenpox</td>
<td>Varicela</td>
</tr>
<tr>
<td>Fifth Disease (Parvovirus B19)</td>
<td>Infección con el parvovirus B19 (Quinta Enfermedad)</td>
</tr>
<tr>
<td>Hand, Foot &amp; Mouth Disease</td>
<td>Enfermedad de mano, pié y boca (MPB)</td>
</tr>
<tr>
<td>Head Lice (Pediculosis)</td>
<td>Infestación por piojos de la cabeza</td>
</tr>
<tr>
<td>Impetigo</td>
<td>Impétigo</td>
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<tr>
<td>Influenza (Flu)</td>
<td>La Gripe (Flu)</td>
</tr>
<tr>
<td>Meningitis</td>
<td>Menigitis</td>
</tr>
<tr>
<td>Pink Eye (Conjunctivitis)</td>
<td>Ojo Rosado (Conjuntivitis)</td>
</tr>
<tr>
<td>Ringworm</td>
<td>Culebrilla</td>
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<tr>
<td>Roseola Infantum</td>
<td>Roseola Infantum</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>El Rotavirus</td>
</tr>
<tr>
<td>Scabies</td>
<td>Sarna (Scabies)</td>
</tr>
</tbody>
</table>

When a child in your classroom has been diagnosed with one of the above, state both the English and Spanish sentences underlined above with the name of the disease (in the appropriate language) on your classroom Communicable Disease board. Also provide parent/guardian handouts in the appropriate languages.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP

Exposures and Exposure Notices Procedure

EXPOSURE NOTICES

When a child has been diagnosed by a medical professional as having an infectious illness and has been at the center during the period when the illness is contagious, an exposure notice will be sent home to all exposed children. The notice will alert parents of the exposure and give them information about signs and symptoms to watch for that may indicate their child has contracted the illness.

Also post communicable disease information on the Communicable Disease Board.

Exposure notices have been developed for the most common childhood illnesses. **At least one copy of every exposure notice should be kept on file in the classroom to facilitate easy access for copying and distributing.**

TEMPORARY EXCLUSION DUE TO ILLNESS

Children who have an infectious illness are excluded from classroom participation until the contagious phase of the illness has passed. This period of time will vary depending on the illness. Parents receive guidance from their primary care provider as to when to return to the program. Staff consults with the Health Specialist as needed.

REPORTABLE ILLNESSES

LCC Head Start/EHS/ECEAP is required to report some illnesses to the Health Department. They keep track of potential outbreaks in the community. If an enrolled child has a “reportable” illness, the Health Specialist, staff, a school nurse, or the child’s health care provider reports the illness to the Health Department according to school/agency procedures. Refer to Temporary Exclusion Due to Short-Term Illness or Injury policy and procedure (HLTH 1a).
Lower Columbia College Head Start/EHS/ECEAP
Child Health and Safety

POLICY
In order to maintain and promote child health and safety, our program has established and implemented procedures to respond to medical and dental health emergencies with which all staff members are familiar and trained.

Approved by HSAC March 4, 2002

PROCEDURE
Procedures include but are not limited to:

- Posted plans of action for emergencies
- Posted locations and telephone numbers of emergency response systems
- Up-to-date family contact information and authorization for emergency care for each child
- Posted emergency evacuation procedures and routes
- Methods of notifying parents in the event of an emergency involving their child
- Emergency Response Procedure notebook which also includes the above stated procedures.
- Established methods for handling cases of suspected or known child abuse and neglect that are in compliance with applicable Federal and Washington State laws.

The Health Services Advisory Committee (HSAC) will review procedures, which are applicable to this policy, annually.
I. SEVERE EMERGENCIES

A. Assess the situation for danger and mechanism of injury and then proceed accordingly. In the case of very serious emergencies, such as unconsciousness, severe bleeding, broken bones, severe burns, head injuries or if stops or has difficulty breathing, give IMMEDIATE first aid as spelled out in the first aid guide and call 911 (Castle Rock Center and EHS Teen Center call 9-911) and request an ambulance.

<table>
<thead>
<tr>
<th>AMBULANCE</th>
<th>Barnes, Broadway, LCC Campus &amp; Memorial Park</th>
<th>Castle Rock &amp; EHS Teen</th>
</tr>
</thead>
<tbody>
<tr>
<td>911</td>
<td>9-911</td>
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</tr>
</tbody>
</table>

B. For emergencies needing police, ambulance, fire department or poison control, call:

<table>
<thead>
<tr>
<th>Barnes, Broadway</th>
<th>Castle Rock &amp; EHS Teen</th>
</tr>
</thead>
<tbody>
<tr>
<td>LCC Campus &amp; Memorial Park</td>
<td>9-911</td>
</tr>
</tbody>
</table>

C. The Lead Teacher/Child & Family Development Specialist staff member will remain with the child before and during transporting child to the hospital emergency department bringing the child's Family Information form with them.

Assistant teacher/remaining EHS staff member is responsible for:
- Taking charge of remaining children in class.
- Call 360-442-2800 or appoint another adult to contact staff person in main Head Start office of the emergency. (At that time, request a second staff member to come to classroom if needed.)

Office staff will:
- Notify the responsible parent/guardian of the emergency situation and plan of action.
- Ensure the hospital emergency department has the Family Information Form.
- If emergency at LCC East or West Centers, office staff member will also call Campus Services at extension 2911.
- Assist, as needed, with placing a second staff member in classroom.

II. SUSPECTED POISONING

If a child swallows poison, call the Poison Control Center, 1-800-222-1222. Give the following information immediately:
1. Child’s AGE
2. Child’s SEX
3. Approximate **WEIGHT** (usually between 35-40 lbs.)
4. **WHAT** he/she swallowed and **WHEN**
5. Have **SAMPLE** of substance or bottle
6. **QUANTITY** of substance ingested
7. **HISTORY** of events and present physical condition

**THEY WILL TELL YOU WHAT ACTION TO TAKE**

### III. PROCEDURES FOR MINOR INJURIES

A. Staff trained in first aid will take appropriate steps.
C. Report the incident to the parent the day it occurs.
D. Complete an Accident Report form.

### IV. DENTAL EMERGENCY PROCEDURES

In the event of an accident to the tongue, cheeks or teeth:

A. Attempt to calm the child: All incidents should be handled calmly and quietly; an upset child is likely to create problems for treatment and may cause further trauma.
B. Check for bleeding.
C. If child’s tongue, cheeks and/or teeth are bleeding:
   - Put on gloves.
   - Apply direct pressure to the area or have child, if able to do so, bite firmly down onto a clean cloth towel too large to swallow.
   - Have the child stand or sit over a basin to allow blood to fall into it.
   - Contact parent or Alternate Care Provider to take child to their primary health care provider or the hospital Emergency Department.
D. If tooth is fractured or broken:
   - Staff can do little for a fractured tooth except calm the child
   - Contact parent or Alternate Care Provider to take child to their primary health care provider or the hospital Emergency Department. Child should be checked for other head, neck and facial trauma.
E. If tooth is knocked out:
   - Place tooth in a clean and moistened cloth/paper towel and then into a new, clean plastic bag.
   - Contact parent or Alternate Care Provider to take child to dentist for immediate treatment. It is most important that the tooth be replanted immediately.
F. If a tooth is knocked into the gums:
   - Do not attempt to free or pull on the tooth.
   - Contact parent or Alternate Care Provider to take child to a dentist for treatment. (If the child does not have a dentist, also contact the Health Specialist or Disabilities/Health Coordinator to arrange for the child to see a dentist.)

### V. REPORTING AND DOCUMENTING

All accidents involving students, parents or staff are to be reported to a Leadership Team member by the end of the same working day.

A. The form titled: Lower Columbia College Head Start/EHS/ECEAP Student Accident Report Form is completed when a preschool student or childcare participant has had an accident.
1. An Accident Report is to be completed and submitted online at
https://cm.maxient.com/reportingform.php?LowerColumbiaCollege&layout_id=1
when an employee, work-study student, volunteer or other adult has had an accident.

B. The staff member administering first aid is to use their best judgement when determining
if an Accident Report needs to be completed. If in doubt about completing a form, the
staff member needs to contact the Health Specialist or another Leadership Team member. As a guide-line, an Accident Report is to be completed anytime outside medical attention
is considered to be warranted. Regardless if an Accident Report is completed or not, the
parent/guardian of any child involved in an accident is to be notified of any injuries or
potential injuries. (*Reference Instructions for Completing an Accident Form HLTH 9b)

VI. BUS/VAN ACCIDENT PROCEDURES
In case of accident, follow the suggestions below:

a. Children are your major priority! If needed, evacuate the bus/van. (When evacuating and if possible, take the cell phone, first aid kit and Family Information forms with you.) Take the children to a secure location that is a safe distance from the bus/van. Whether on the bus/van or at a secure location, check for injuries and apply first aid, if indicated. If there are serious injuries, use emergency first aid and try to get help without leaving the children unattended by using the cell phone to call 911, etc.

b. Complete a police report.

c. If another vehicle is involved, be sure to get appropriate information, such as:
license number, make and color of vehicles, name of driver, and name of insurance company.

d. As soon as able, call the main Head Start office at 360-442-2800, request any
needed assistance and report the accident.

All accidents/vehicle damage are to be reported in WRITING to the Director by the end of
the same working day.
Lower Columbia College Head Start/EHS/ECEAP
Emergency Care in Case of a Seizure

Should a seizure occur the following protocol should be followed:

- **If this is a first-time seizure, first call 911.** If an individual emergency plan has been developed with the family of the child, that plan should be followed.

1. The staff member witnessing the onset of the seizure should immediately note the time.
2. Allow the person to lie down to provide ample room for convulsive movements.
   a. The Lead Teacher/EHS staff member stays with the person having the seizure.
   b. The Assistant Teacher/other EHS staff member removes other children from the room or vicinity of the child and sends additional staff member to assist, if possible.
   c. The Assistant Teacher documents the symptoms and duration of the seizure to provide to the paramedics and/or parents.
3. Loosen tight clothing, especially around the neck and waist.
4. Turn body to the side, if possible, to allow saliva to drain.
5. Do not put anything between the teeth. Do not attempt to give anything to drink.
6. Keep the person from hurting themselves: Move chairs, etc., that may be close by.
7. Protect the head, arms, and legs, but do not restrain. A coat, sweater, or pillow under the head may be helpful.

- **The seizure may last 2-5 minutes.** Should a seizure be followed by another major seizure or last more than 3 minutes, call 911. At any time, if this is a first-time seizure, 911 is to be called.

9. Allow the person the opportunity to rest after a seizure.
   a. Tiredness and drowsiness will occur.
   b. Have the child rest on their side.
   c. Loss of bowel or bladder control may also have occurred.
10. Note the time the seizure ended.
11. Contact the person’s parent/guardian.

**Information:**

The word “epilepsy” means “seizure.” A seizure occurs when groups of brain cells release too much electrical energy (an electrical storm). This abnormal release of electrical disturbance causes a sudden loss of consciousness and, during severe forms of attack, is accompanied by muscle spasms and convulsions. A seizure may also occur when blood glucose (blood sugar) drops to dangerous levels.

**Two Main Types of seizures:**

- **Petit Mal:** A rapid onset of loss of awareness and surroundings of brief duration followed by a rapid return to full awareness and the person will resume his/her activity. This “blanking out” may not be noticed or remembered by the person.
- **Grand Mal:** Occurs suddenly, with or without a warning signal. A cry is often heard as air is forced out of the lungs. The person falls, stiffens, arches body, stops breathing temporarily, and lies rigid. Then contractions change to rhythmic ones and breathing starts again. The tongue may be accidentally bitten and urination and defecation may occur. Sleep follows the seizure for minutes and sometimes an hour or longer. Upon awakening, the person will not remember what happened and should not be expected to know he/she had a seizure. They may complain of aching, fatigue, and/or a headache.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Reference & Handout for When a Child has Experienced a Bump to the Head

Head Injuries:
- Fall into two categories
  - External (usually scalp)
  - Internal (may involve the skull, the blood vessels within the skull, or the brain.)
- Fortunately, most childhood falls or blows to the head result in injury to the scalp only, which is usually more frightening than threatening. An internal head injury has more serious possible implications since the skull serves as a protective helmet for the delicate brain.

External (scalp) Injuries of the Head:
The scalp is rich with blood vessels, so even a minor cut to the scalp can bleed profusely. The "goose egg" or swelling that may appear on the scalp after a head blow results from the scalp's veins leaking fluid or blood into (and under) the scalp. It may take days or weeks to disappear.

What to do:
If the child is unconscious, even briefly, or is an infant call 911. If the child is conscious and not an infant, call the child's parent or alternate care individual (responsible adult). The responsible adult with a staff member's assistance is to determine if their child requires their immediate care. However, a staff member can require that the responsible adult pick-up the child and determine if a medical assessment is needed.
- If the child has not lost consciousness and is alert and behaving normally after the fall or blow, apply an ice pack or instant cold pack to the injured areas for 20 minutes. (If you use ice, always wrap it in a washcloth or clean cloth; ice applied directly to bare skin can cause frostbite damage.)

At School or Home:
- Observe the child carefully for the next 24 hours. If the child shows any of the signs of internal injury (see below), call 911 immediately.
- If the incident has occurred close to bedtime or naptime and the child falls asleep soon afterward, check him every two hours for disturbances in color or breathing, or twitching limbs.
  - If color and breathing are normal, and you observe or sense no other abnormalities, let the child sleep (unless the doctor has advised otherwise).
  - If color and/or breathing are abnormal, or if you are not comfortable with the child's appearance (trust your instincts), arouse him partially by sitting him up. The child should fuss a bit and attempt to resettte. If he does not protest, try to awaken him fully. If he cannot be awakened, or shows any signs of internal injury (see below), call 911 immediately.
Internal Injury to the Head
The brain is cushioned by cerebrospinal fluid, but a severe blow to the head may knock the brain into the side of the skull or tear blood vessels. Any internal head injury – fractured skull, torn blood vessels, or damage to the brain itself – can be serious and may even be life-threatening.

What to do:

• Call an ambulance (911) if the child shows any of the following symptoms:
  ➢ Unconsciousness
  ➢ Abnormal breathing
  ➢ Obvious wound or fracture
  ➢ Bleeding from the nose, ear, or mouth or clear drainage from the ear or nose.
  ➢ Disturbance of speech or vision
  ➢ Pupils of unequal size
  ➢ Weakness or paralysis
  ➢ Dizziness
  ➢ Neck pain or stiffness
  ➢ Seizure
  ➢ Vomiting
  ➢ Loss of bladder or bowel control

• Until help arrives, do not move the child unless absolutely necessary.
  ➢ **If the child is unconscious or dazed, or there is any paralysis**, do not move him/her at all – there may be injury to the spine.
    1. If child is not breathing, administer mouth-to-mouth resuscitation.
    2. If child vomits, roll child to the side keeping his/her head and neck immobile.
    3. Place your hands on either side of child’s head and keep child in the position in which you found him/her.
  ➢ **If the child is conscious**, do your best to keep him/her calm and still. If he/she vomits, sit child up slightly and help child lean forward, unless you suspect a neck injury. In that case, keep head and neck immobile and roll child on to his/her side.

• If he has a seizure, keep his airway clear.
• If there is swelling, apply an ice pack or cold pack.
• If there is bleeding, apply a sterile dressing (bandage).
  ➢ **Do not** attempt to cleanse the wound, which may aggravate bleeding and/or cause serious complications if the skull is fractured.
  ➢ **Do not** apply direct pressure to the wound if you suspect the skull is fractured.
  ➢ **Do not** remove any objects stuck in the wound.

Adapted from the American Medical Association and the Nemours Foundation "Emergencies and First Aid" Web Page (12/00)
Lesiones en la cabeza:
- Se dividen en dos categorías
  - Externas (comúnmente en el cuero cabelludo)
  - Internas (podría implicar el cráneo, los vasos sanguíneos del cráneo, o el cerebro.)
- Afortunadamente, la mayoría de los niños que sufren caídas o se dan golpes en la cabeza solamente se lesionan el cuero cabelludo que suele ser más espantoso que serio. Una lesión interna en la cabeza pudiera tener implicaciones posiblemente más serias ya que el cráneo actúa a modo de casco protector del delicado tejido cerebral.

Lesiones Externas (cuero cabelludo) en la Cabeza:
El cuero cabelludo contiene muchos vasos sanguíneos, así que por más pequeña que sea la cortada al cuero cabelludo pudiera sangrar significativamente. El chichón o inflamación que aparezca en el cuero cabelludo después de un golpe en la cabeza es porque las venas están filtrando un líquido o sangre adentro (y por fuera) del cuero cabelludo. Pudiera tomarse días o semanas antes de desaparecer.

Que puede hacer:
Si el niño está inconciente a un que sólo sea brevemente o si es un bebé llame al 911. Si el niño esta conciente y no es un bebé, llame a los padres del niño o tutor (adulto responsable). El adulto responsable con la ayuda de un miembro del personal determinará si el niño requiere cuidados inmediatos. Sin embargo, el miembro del personal pueda pedir que el adulto responsable venga a recoger al niño y determinar si una evaluación médica sea necesaria.
- Si el niño no a perdido el conocimiento y esta alerta y se esta comportando de manera normal después de la caída o golpe, aplíquele una bolsa con hielo o compresa fría a la herida por 20 minutos. (Si utiliza hielo, siempre envuélvalo en una franela o trapo limpio; si se aplica directamente el hielo a la herida pudiera causar daños de congelación).

En la Escuela o en su Casa:
- Observe al niño cuidadosamente durante las próximas 24 horas. Si el niño muestra cualquiera de los síntomas de lesiones internas (vea más adelante) llame al 911 inmediatamente.
- Si el incidente ocurre cerca de la hora de irse a la cama o la siesta y el niño se duerme, revíselo cada dos horas por si pudiera tener cambios de color, manera de respirar o que le tiemble alguna parte de su cuerpo.
  - Si su color y respiración son normales, y usted siente que no hay ninguna anormalidad, deje al niño dormir (a menos que el doctor le hay aconsejado diferente).
  - Si su color y/o respiración son anormales, o si no se siente conforme con la apariencia del niño (confié en su instinto), enderécelo poquito para que despierte. Pueda ser que el niño se moleste un poco y se forcejeé. Si no protesta, intente despertarlo completamente. Si no despierta, o muestra señales de lesiones internas (vea mas adelante), llame al 911 inmediatamente.
Lesiones internas en la Cabeza
El cerebro está acojinado por un líquido cerebroespinal, pero un severo golpe en la cabeza podría causar que el cerebro choque con el cráneo y rompa vasos sanguíneos. Cualquier lesión interna en la cabeza – podría fracturar el cráneo, romper vasos sanguíneos, o dañar el cerebro – puede ser serio y poner la vida en peligro.

Que puede hacer:
- Llamar a una ambulancia (911) si el niño muestra los siguientes síntomas:
  - Inconciente
  - Respiración anormal
  - Heridas o fracturas evidentes
  - Si esta sangrando de la nariz, oídos o boca o si arroja algo claro de los oídos o nariz.
  - Si tiene dificultad para hablar o de su visión
  - Si sus pupilas son de tamaño diferente
  - Debilidad o parálisis
  - Mareos
  - Dolor o entumecimiento en el cuello
  - Ataques
  - Vomito
  - Perdida del control de la vejiga o del intestino
- Mientras la ayuda llega, no mueve al niño a menos que sea absolutamente necesario
  - Si el niño esta inconciente, aturdido o tiene una parálisis, no lo mueva a él/ella para nada – podría tener lesionada la espina dorsal.
    1. Si el niño no esta respirando, adminístrele resurrección de boca a boca.
    2. Si el niño vomita, voltéelo de lado manteniendo su cabeza y cuello inmóvil.
    3. Póngale sus manos a lado de la cabeza para detenerla y manténgalo en la posición que lo encontró.
  - Si el niño esta consciente, haga lo mejor que pueda para mantenerlo calmado y quieto. Si él/ella vomita, ayúdelo a enderezarse y sentarse despacio, a menos que sospeche de una lesión en el cuello. En ese caso, mantenga la cabeza y el cuello inmóvil y voltéelo de lado.
- Si le da un ataque, mantenga el flujo del aire despejado.
- Si hay inflamación, aplique una compresa fría o una bolsa de hielo.
- Si esta sangrando, póngale un vendaje esterilizado (venda).
  - No intente limpiar la herida, porque el sangrado podría empeorarse y/o causar complicaciones serias si el cráneo esta fracturado.
  - No le aplique presión a la herida si es que sospeche que el cráneo esta fracturado.
  - No remueva ningún objeto que pueda estar atorado en la herida.

Adaptado de la Asociación Medica Americana y la Fundación Nemours "Emergencias y Primeros Auxilios" Web Page (12/00)
LOC ID Number(s) ________________________________ Date ____________________________

Classroom staff is to complete this check-off list each September and at the time a new classroom is being set-up for operation.

The following documents are to be posted in your classroom prior to the first day of school:

- Emergency Medical/Dental Procedures \textit{HLTH 2b}, \textit{Emergency Care for Seizure HLTH 2c} & Bump to the Head Handout \textit{HLTH 2d} – All on a “Ring” together.
- Classroom Fire Drill/Evacuation Plan for Specific Classroom/Center
- Exit signs by each Exit Door
- Fire/Earthquake/Lockdown Drill Record Form \textit{HLTH 2j}
- Emergency Phone Numbers for Police, etc. \textit{(Post by your telephone.)}
- Phone Location Sign
- Germ Buster Poster \textit{(Handwashing Poster)}
- Justice for All Poster
- Dental Health Poster(s)
- First Aid Kit Location Sign
- Emergency Light Source Location Sign
- First Aid Poster \textit{(Layperson CPR & First Aid for Choking)}
- Food Health & Sanitation Checklist for Staff & Volunteers \textit{NUTR 2c}
- Diaper/Pull-Ups Changing Procedure \textit{HLTH 4c} \textit{(Post by changing table or in bathroom.)}
- Toothbrushing Procedure \textit{EDUC 7f}
- Bathroom Procedure \textit{EDUC 7a} \textit{(HS/ECEAP only)}
- Toileting Procedure \textit{EDUC 7a1} \textit{(EHS only)}
- Bleach Solutions & Three-Step Process \textit{HLTH 4e}
- Dietary Restrictions List \textit{(ChildPlus Health Report)}

You will receive a Classroom Allergy/Medical Concerns List \textit{(ChildPlus Health Report)} to place in your Emergency Response Procedures Notebook.

The following documents are to be posted at your Center prior to the first day of school:

- Smoke Free Environment Policy \textit{FACI 1g}
- Annual Fire Inspection \textit{(If questions, please see Area Manager.)}
- Annual Fire Alarm / Smoke Detector Sensitivity Testing \textit{(If questions, please see Area Manager.)}
- Health Department Food Program Permit \textit{(Posted in Center Kitchen or Kitchen Area. See Kitchen Manager if Needed or Expired)}
- Building for the Future \textit{(USDA)}
- WIC Poster

Turn in completed forms to the Health Coordinator.
LOWER COLUMBIA COLLEGE HEAD START/ECEAP
Classroom Emergency Supplies and Postings Procedure
LCC East and West Centers

Uniform placement, at the LCC East and West Centers, of the following items is in effect:

1. First Aid Kits are to be stored in the cupboard above the sink in each classroom
2. Emergency Procedures Notebook is to be stored in the tall locking cabinet in each classroom.
3. Fire Drill/Evacuation Plans are to be posted on or next to the primary fire exit door.
4. Emergency Medical/Dental Procedures are to be posted above the paper towel dispenser.
5. Emergency telephone numbers are to be posted next to the telephone.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP

Bee Sting Allergy Procedure

GOAL: Clarification and follow-up when a parent states their child has a bee sting allergy.

Clarify the Situation
The following questions may be useful:

1. Tell me about it.
2. Was there swelling? How much? Most people have some swelling after a bee sting. Swelling two joints past the sting site is considered a severe reaction that requires investigation.
3. Were there other symptoms like shortness of breath, difficulty breathing, and swelling around the eyes or mouth?
4. What was the treatment (e.g. cold packs, meat tenderizer, aid car)?
5. What was the response to the treatment?
6. Did the child receive medication (e.g. Benadryl, antihistamine, epinephrine)?
7. Did the child see a physician or health care provider? What treatment was prescribed?
8. “Do you keep a bee sting kit?” (Epi-Pen Junior or ANAKIT) at home?

Does the Child Have An Allergy?
Contact the child’s physician or health care provider (with parental consent) if any of the following are true:

1. The swelling was more than two joints past the sting site.
2. The child required treatment by a health care provider, emergency room, or aid car.
3. The child required medication to control the reaction.
4. There has been a bonafide allergy to bee stings diagnosed by a physician or health care provider.
5. There is a history of a systemic reaction to a bee sting in the past (hives, shortness of breath, difficulty breathing, swelling of the lips or face).

Plan
1. Work with the physician and parent to establish a treatment plan for the child in the program and on field trips. Post a copy of the treatment plan in the classroom.
2. Review the plan with the parent and center staff.
3. If using Epi-Pen Jr. is part of the plan, remember to:
   a. Complete medication forms.
   b. Assure proper training of staff in use of the Epi-Pen.
   c. Check expiration date on Epi-Pen Jr., and assure proper storage in the center.
   d. Replace yearly and return to parent when no longer needed.
   e. Carry Epi-Pen for activities outside of the building, including field trips and playground.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Earthquake Preparedness Procedure

Teachers instruct children:

1. On what to expect during an earthquake. This will help them to avoid panic and/or injury.

2. Not to run.

3. To remain where they are, indoors or outdoors.

4. To be alert for falling objects and try to avoid them. Particularly, to keep away from fallen wires.

5. Earthquake preparedness drills will be conducted monthly and recorded on the Fire/Earthquake/Lockdown Drill Record Form.

If an earthquake should occur while class is in session, teachers are to instruct children:

1. To crawl under a table or chair. The child should grab the leg of the table or chair they are under and place their other hand over their lowered head. If that’s not possible, the child should take a position against a weight bearing wall (usually corridor walls and outside walls), and protect their head and neck with their arms. Avoid crouching near windows, heavy pictures, mirrors, all bookcases or other tall movable objects. (Adults will protect infants and toddlers and may adjust positioning, as appropriate, to accommodate.)

2. To pay particular attention to keeping the head covered.

   (Teachers should also identify and discuss local hazards with their children.)

An easy phrase for your children to remember in the event of an earthquake:

STOP                  DROP                  GRAB-ON

*See Emergency Response Procedures Notebook.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Fire Drill Preparedness Procedure

Teacher instructs children:

1. On what to expect during a fire drill. This will help them to avoid panic and/or injury.

2. Upon hearing the building fire alarm or discovering fire or smoke, to line up calmly to evacuate the building. (EHS staff will utilize evacuation cribs as appropriate.)

3. To walk, not run to the nearest exit.

4. To be alert and to follow the Teacher’s instructions.

5. To stay with classroom staff members at all times and to assemble in the designated area (as stated on the posted classroom / center evacuation procedure).

6. That everyone must follow the orders of the fire and/or police departments when they arrive.

Additional Staff Responsibilities
Direct Service Team/EHS members are to ensure that all children are out of the classroom and accounted for. Teaching staff members are to bring their class roster, classroom Emergency Response Procedures notebook and Emergency Preparedness Supplies container.

Practice and Record Required Monthly Drills
Teachers, with the support of their supervisor, are to ensure that their classroom children participate in an unannounced Fire Drill, at varying times of the day at least once a month. All Fire Drills conducted are to be recorded, by the Lead Teacher or Assistant Teacher/EHS staff, on their classroom’s posted Fire/Earthquake/Lockdown Drill Record (EDUC 7c). (This record can be visibly posted in the classroom.)
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP  
Fire/Earthquake/Lockdown Drill Record

<table>
<thead>
<tr>
<th>Teacher</th>
<th>Asst. Teacher</th>
<th>Center</th>
<th>Classroom #</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>Type of Drill</th>
<th>Drill Took Place</th>
<th>Number of People Involved in Drill</th>
<th>Fire Drill ONLY: Time Taken to Clear Building</th>
<th>Staff Initials of Response Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire, Earthquake or Lockdown</td>
<td>Date</td>
<td>Time</td>
<td>Children Adults Minutes Seconds</td>
<td>Staff Initials</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>of Response Adult</td>
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</table>

1. Fire and Earthquake drills should be conducted a minimum of once per month.
2. Post in classroom visible to parents.
3. Lockdown drills to be conducted each fall and spring.
4. At end of program year, please place in front pocket of Emergency Response Notebook.

(C: 08/93; R: 10/16)
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
First Aid Kits Policy

Policy: Our program maintains readily available, well-supplied and appropriate first aid kits at each of our program centers. First aid supplies are also available on outings away from the center. The First Aid kits are restocked after use, and monthly classroom inventories conducted utilizing the Health Supply Request form.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
First Aid Supplies List

Teacher(s): ___________________________  Center: ______________  Rm. # _____

Classroom first aid supplies should always be monitored and fully stocked. The following items are to be included in your First Aid Supply box or accessible to your classroom. To order first aid supplies, use the Health Supplies Request Form.

- Disposable Gown
- Radio with Batteries (in building)
- Ice Pack (located in bldg. freezer or an instant ice pack)
- Biohazard Bag
- Blanket
- CPR Pocket Mask
- Thermometer Covers (digital/thermoscan)
- Soap
- Thermometer (digital/thermoscan)
- First Aid Tape
- Triangular Bandage
- Gloves
- Butterfly Bandages
- Syrup of Ipecac
- Gauze Pads
- Scissors
- Absorbent Gauze Bandages
- First Aid Chart
- Assorted Bandages
- Cot or Stretcher (in building)
- Large Bandages
- Flashlight (if needed, with batteries)
- N95 Respirator Mask
- Fire Extinguisher
- Eye Wash Kit (expires?) ____________
- Pop-Up Light(s)
- Emergency Response Procedures Notebooks
- Batteries for Pop-Up Light(s) (if needed)
- Tweezers (ECEAP)
- Safety Glasses
- First Aid Manual

Please note: Materials for use as splints need to be available (i.e., blanket and adhesive tape). Some type of plastic wrap should be available on site (i.e., sucking chest wounds).

Reference First Aid Training Materials.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Care of a Human Bite Procedure

- Attend to and comfort the bitten child.

- Apply first aid as needed. Whether the skin is broken or not, use Universal Precautions. Wash with warm water and soap for 10 minutes. Apply ice pack or cool cloth to reduce bruising and swelling.

- If skin is broken, contact bitten child’s parent/guardian and recommend that the child’s medical provider be contacted for further direction.

- Check to be sure that the tetanus immunization is current.

- Observe bitten child for indicators of infection, fever and swelling or redness of wound. If any occur, contact parent to take the child to be seen by medical provider. (Bite wounds can become infected by bacteria from ordinary mouth germs.)

- Have the biter rinse his/her mouth with warm water and spit it out in the sink.

- Complete an Accident Report form for the bitten child.

- If the biter is known to be HIV positive or a carrier of Hepatitis B, Health Specialist calls the local health department for current recommendations regarding this situation.

- A staff person discusses the biting incident separately with the parent/guardian of both children involved encouraging them to contact their child’s medical provider for advice and possible evaluation as their child may be at risk for any exchange of body fluids.

- **Staff is not to discuss confidential health information regarding other child with parent/guardian.**
Hygiene Policy

Our program is committed to the effective implementation of hygiene, sanitation, and disinfection procedures that significantly reduce health risks to children and adults by limiting the spread of germs.

Hand Washing/Hygiene Procedure

Post Department of Health procedure in all building bathrooms and at each sink in the classrooms. Hand washing is the single best way to reduce or stop the spread of bacteria (germs) that cause a child to be ill, e.g. diarrhea. Our staff washes their hands and teaches or assists children (if help is needed) to wash their hands.

Staff and volunteers wash their hands:

a. Upon arrival at the child care center.
b. Before putting on food service gloves.
c. Before and after handling foods, cooking activities, eating and serving food.
d. After touching/handling raw meat, poultry, fish, or eggs.
e. After personal toileting.
f. After assisting child with toileting.
g. Before and after diaper/pull-up changing.
h. After handling or coming in contact with body fluids such as mucus, blood, saliva, urine or vomit.
i. After touching any unclean item.
j. After attending to an ill child.
k. Before and after administering first aid.
l. Before and after giving medication.
m. After handling, feeding or cleaning-up pets or other animals.
n. After smoking.
o. After being outdoors or involved in outdoor play.

Children will be directed or assisted in hand washing:

a. Upon arrival at the center.
b. Before food and meal preparations, eating meals or cooking activities.
c. After toileting.
d. After outdoor play.
e. After coming in contact with body fluids.
f. After handling pets or other animals.

How Hand Washing is Done at Our Center:

a. Soap, warm running water and individual towels are available for staff and children.
b. Turn on water and adjust temperature.
c. Wet hands and apply a liberal amount of soap.
d. Rub hands in a wringing motion from wrists to fingertips for a period of not less than 20 seconds. (As a general rule, hands should be washed for 30 seconds.)
e. Rinse hands thoroughly.
f. Dry hands, using an individual towel.
g. Use hand-drying towel to turn off water faucet(s).
CONTROL METHODS
METHODS OF COMPLIANCE

There are a number of areas that must be addressed in order to effectively eliminate or minimize exposure to bloodborne pathogens. The five areas of concern are addressed in the plan.

1. The use of Universal Precautions.
2. Establishing appropriate Central Safety Controls.
3. Implementing appropriate Work Practice Controls.
5. Implementing appropriate Housekeeping Procedures.

Each of these areas are reviewed during the bloodborne pathogens related training. By rigorously following the requirements of OSHA's Bloodborne Pathogens Standard in these five areas, employees' occupational exposure to bloodborne pathogens will be eliminated or minimized as much as possible.

A. UNIVERSAL PRECAUTIONS
We will observe the practice of "Universal Precautions" to prevent contact with blood and other potentially infectious materials. As a result, we treat all human blood, blood components and products made from human blood and any body fluid as if they are known to be infectious for HBV, HIV and other bloodborne pathogens.

These universal precautions include staff taking responsibility for preventing transmission from self to others. (i.e. Bandaging own cuts, etc. before and during work.)

B. CENTRAL SAFETY CONTROLS
One of the key aspects to our Exposure Control Plan is the use of Central Safety Controls to eliminate or minimize employee exposure to bloodborne pathogens. As a result, our facility employs equipment such as disposal containers where appropriate.

C. WORK PRACTICE CONTROLS
In addition to Central Safety controls, our facility used a number of safe work practices, which will be referred to as Work Practice Controls to help eliminate or minimize employee exposure to bloodborne pathogens.

Our facility has adopted the following Work Practice Controls as part of our Bloodborne Pathogens Compliance Program:

1. Employees wash their hands immediately, or as soon as feasible, after removal of gloves or other personal protective equipment.
2. Following any contact of body areas with blood or any other infectious materials, employees wash their hands and any other exposed skin with soap and water as soon as possible. They also flush exposed mucous membranes with water.
3. Eating, drinking, applying cosmetics or lip balm and handling contact lenses is prohibited in work areas where there is potential for exposure to infectious agents.
4. All procedures involving blood or other infectious materials minimize splashing, spraying or other actions generating droplets of these materials.
5. Blood or other contaminated materials are placed in designated leak-proof containers, appropriately labeled, for handling and storage.
6. If outside contamination of a primary container occurs, that container is placed within a second leak-proof container, appropriately labeled, for handling and storage.

When a new employee comes to our facility, or an employee changes jobs within the facility, the employee receives trainings as arranged by the Heath Specialist in any work practice controls of which the employee is not experienced.

D. PERSONAL PROTECTIVE EQUIPMENT

Personal Protective Equipment is our employees’ last line of defense against bloodborne pathogens. Because of this, our facility provides (at no cost to our employees) the Personal Protective Equipment that they need to protect themselves against such exposure. Personal protective equipment will be considered to be appropriate only if it does not permit blood or other potentially infectious materials to pass through or to reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used. Appropriate protective equipment or clothing shall be worn while the employee has a potential for occupational exposure. This equipment includes, but is not limited to:

1. Gloves
2. Protective Gowns (disposable)
3. Disposable Mouthpieces or Resuscitation Bags
4. Safety Eyewear

The Health Specialist is responsible for ensuring that all classrooms have appropriate personal protective equipment available to employees.

Our employees are trained regarding the use of the appropriate personal protective equipment for their job classifications and procedures they perform. Initial training or the proper use of personal protective equipment and additional training is provided, when necessary, if an employee takes a new position or if new job functions are added to their current responsibilities.

To ensure that personal protective equipment is not contaminated and is in the appropriate condition to protect employees from potential exposure, our facility adheres to the following practices:

1. All personal protective equipment is replaced as needed.
2. All personal protective equipment is removed prior to leaving a work area.
3. Gloves are worn in the following circumstances:
   a. Whenever employees anticipate hand contact with potentially infectious materials.
   b. When handling or touching contaminated items or surfaces.
4. Disposable gloves are replaced as soon as practical after contamination or if they are torn, punctured or otherwise lose their ability to function as an "exposure barrier".

E. HOUSEKEEPING

Maintaining the facility in a clean and sanitary condition is an important part of the Bloodborne Pathogens Compliance Program.
1. All equipment, environmental and work surfaces shall be cleaned and decontaminated after contact with blood or potentially infectious materials.
   a. Contaminated work surfaces shall be decontaminated with an appropriate disinfectant or an absorbent agent.
      1. Whenever surfaces are overtly contaminated or after any spill of blood or other potentially infectious materials.
      2. After completion of procedures.
      3. At the end of the work shift (if the surface may have become contaminated since the last cleaning).
2. All pails and similar receptacles intended for reuse and for which have a reasonable likelihood of becoming contaminated with blood or other potentially infectious materials shall be inspected on a regular basis and shall be cleaned and decontaminated as soon as feasible upon visible contamination.
3. Broken glassware and other sharp objects shall be picked up using a broom and dustpan.
4. Regulated waste:
   a. Contaminated sharp items, i.e. broken glass, shall be discarded into containers that are:
      1. Closable
      2. Puncture resistant
      3. Leak-proof on sides and bottom
      4. Labeled with biohazard label. Containers shall be easily accessible and located as close as is feasible to the area. The source of waste shall be maintained upright, replaced as needed and not allowed to overfill.
5. Center staff, placing waste in the container, will contact the Health Specialist and Disabilities/Health Coordinator if the container is full/close to full and/or waste smells/has the potential of smelling. The Health Specialist or Disabilities/Health Coordinator (using appropriate procedures) will pick-up this biohazard waste and take it to the lined biohazard waste box in the Annex building. The Health Specialist or Disabilities/Health Coordinator will notify Campus Services when this box needs to be picked up and replaced with a new box. Campus Services will pick-up the filled box, provide a new box with a liner and then contact LCC’s biohazard waste contractor to pick up the filled box for incineration.
6. Approved Disinfectants:
   a. Routine decontamination of work surfaces may be carried out using an approved intermediate or low-level disinfectant.
   b. Decontamination of spills or overt contamination of blood or potentially infectious materials shall be disinfected as specified.
7. Chlorine bleach disinfection solution: 1 ¾ teaspoons + 24 ounces of water.
8. Laundry: Contaminated laundry is handled as little as possible: Gloves and other appropriate personal protective equipment are used. The laundry is not sorted or rinsed where it is used. It is placed directly into leak proof bags labeled with biohazard label and disposed of according to site policy.

For additional information, see the Exposure Control Plan. A copy of the plan is located in the Health Specialist's office.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Diaper/Pull-Up Offer Form

This form is completed during the enrollment process.

Center Location:  □ Longview Teen Program Center  □ Play & Learn Social Groups  
□ Broadway Learning Center  
(Combination Model)

LOC ID: ___________________________

Child’s Name: ___________________________  Date of Birth: _____________

Parent Name: ___________________________  Phone: _______________

The center indicated above provides diapers and/or pull-ups for children participating in the Early Head Start Program while your child is in our care. The diapers used are unscented for allergy purposes. Parents may choose to supply their own diapers/pull-ups due to allergies, etc. Please mark one of the options listed below:

□ I accept the diapers provided by LCC Head Start/EHS/ECEAP  Size: _____________

□ I accept “Pull Ups” provided by LCC Head Start/EHS/ECEAP  Size: _____________

□ I decline the offered diapers/pull-ups and will supply my own.  
Name of Diaper/pull-up I am providing: ___________________________

□ My child is no longer in diapers/pull-ups and I will provide his/her underwear and extra clothes.

________________________________________  __________________________________
Signature of Parent/Guardian  Date

________________________________________  __________________________________
Signature of Staff Member  Date
Our program has adopted sanitation and hygiene procedures for diapering and the changing of pull-ups that adequately protect the health and safety of our program children. These procedures protect against the spread of bacteria, viruses, and parasites that are present in the feces and/or urine of sick and healthy people.

Diapering is done on an elevated, nonporous surface used only for diapering. The surface is washable, made of wipeable plastic or equipped with removable paper covers. Pull-ups may be changed in the child bathroom. Designated diapering and pull-ups changing areas are located close to a water source and away from food preparation and service areas.

1. Wash hands with soap and warm running water. (As described in the Hygiene Procedure.)

2. Gather necessary materials.

3. Put disposable gloves on.

4. Change diaper/pull-up – Make certain that the child is safely secured at all times. Do not leave the child unattended. Talk to the child while diapering.
   a. Take off the child’s dirty diaper/pull-up.
   b. The child’s diaper (peri-anal) area is cleaned from front to back with wet wipes. Use a clean wipe for each stroke.
   c. At end of this procedure, note anything unusual in the child’s diaper/pull-up.

5. Dispose of diaper/pull-up, gloves and wipes used – Disposables: Place in a covered and hands free container lined with a plastic bag and designated specifically for disposable diapers. At the end of the day, place the closed plastic bag with contents into another plastic bag and then into the classroom garbage can for daily removal from the facility.

6. Clean your hands. Use soap and warm running water only if you can maintain contact with the child. Use disposable wipes otherwise.

7. Slide a clean diaper under the baby. Fasten the diaper securely, making sure it is not too tight. Child is dressed.

8. Wash child’s hands with soap and warm running water. Return child to a safe area.

9. Clean and rinse the diapering area, equipment and supplies touched with soap, warm water and a disposable towel. Also, disinfect with chlorine bleach solution of 1 ¾ teaspoons + 24 ounces of water. Solution must be mixed daily by staff member, labeled with date and stored out of children’s reach.

10. Wash hands with soap and warm running water.
### Monthly Bleach Log

**Diapering/Bloodborne/Disinfecting for Head Start/EHS/ECEAP Centers**

**Month of:**

<table>
<thead>
<tr>
<th>Week of:</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
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Solution is changed on a daily basis. Bleach water consists of 1 ¾ teaspoons to 24 ounces of water. *(The above solution meets the ratio necessary for disinfecting surfaces.)*
Lower Columbia College Head Start/EHS/ECEAP
Monthly Bleach Log
Food Prep/Surface Sanitizing for Head Start/EHS/ECEAP Centers

Month of: ________________

<table>
<thead>
<tr>
<th>Week of:</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
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Solution is changed on a daily basis. Bleach water consists of ½ teaspoon to 24 ounces of water. *(The above solution meets the ratio necessary for sanitizing surfaces.)*
Lower Columbia College Head Start/EHS/ECEAP
Bleach Solutions for Cleaning, Rinsing, Disinfecting/Sanitizing

Basic Tips

Bleach solutions must be made fresh daily, kept away from heat, and any unused solution must be discarded at the end of the day.

Bleach must be added to cool water rather than adding water to bleach.

Wear gloves and eye protection when mixing bleach and use a funnel.

Cleaning/disinfecting/sanitizing products must not be used in close proximity to children, and adequate ventilation should be maintained during the procedure to prevent children and caregivers/teachers from inhaling potentially toxic fumes.

Solution 1: Disinfecting
For use on diaper changing tables, hand washing sinks, bathrooms, door and cabinet handles

<table>
<thead>
<tr>
<th>Water</th>
<th>Bleach – 6%</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 ounces (spray bottle)</td>
<td>1 ¾ teaspoons</td>
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</tbody>
</table>

Solution 2: Sanitizing
For use on eating utensils, food use contact surfaces, mixed use tables, high chair trays, plastic mouthed toys and pacifiers

<table>
<thead>
<tr>
<th>Water</th>
<th>Bleach – 6%</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 ounces (spray bottle)</td>
<td>½ teaspoon</td>
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</table>

Important: If using an EPA-registered product, follow the manufacturer’s instructions on the label for diluting the product for sanitizing or disinfecting, as well as for the contact time. Instructions on how to determine this for the EPA-registered product you are using can be found here: http://cfoc.nrckids.org/Bleach/FindingEPARegInfo.cfm

Three-Step Process for disinfecting and sanitizing non-porous surfaces

1. Clean the surface with soap solution first using 2 drops of liquid detergent to 24 ounces of water. *Soap solutions must be made fresh weekly.*

2. Rinse with clean water and dry with paper towel.

3. Spray bleach solution and allow to air dry for 2 minutes before wiping dry with a paper towel.
# Lower Columbia College Early Head Start – Teen Center
## Cleaning and Sanitizing Record

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>CODE: Section # Mouthed Toys</th>
<th>Classroom</th>
<th>Initials</th>
</tr>
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<tbody>
<tr>
<td>11/11/2017</td>
<td>2:45pm</td>
<td>S1</td>
<td>Infant/Toddler</td>
<td>MS</td>
</tr>
<tr>
<td>11/11/2017</td>
<td>10:30am</td>
<td>MT</td>
<td>Infant</td>
<td>MS</td>
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<tr>
<td>11/11/2017</td>
<td>1:00pm</td>
<td>B</td>
<td>Toddler</td>
<td>MS</td>
</tr>
<tr>
<td>12/06/2017</td>
<td>8:00am</td>
<td>MRW/MRS</td>
<td>MR</td>
<td>MS</td>
</tr>
</tbody>
</table>

**Cleaning Codes:**

**Sections:** S1, S2, S3, S4, S5, MR - One section per class, per day – Wash and sanitize corresponding equipment

**Mouthed Toys:** MT - Washed daily

**Laundry:** B - Bedding washed weekly or as needed when soiled, Soft toys washed as part of sections

**Motor Room mats/equipment:** MRW - Washed weekly, MRS - Sanitized daily

(C: 12/17)
Medication Policy and Procedure

Policy
The Head Start/EHS/ECEA Program’s Medication Policy is not to administer medication to a child. However, medication will be administered to a child in circumstances where the child’s physician/licensed health care provider has advised and authorized such administration of medication by our staff.

Approved by HSAC 11/30/00

Procedure
A Medication Policy and Procedure training is held annually for staff members. The classroom teacher/Child and Family Development Specialist (CFDS) is designated as the individual responsible for the administration of medications. In the absence of the teacher/CFDS, the assistant teacher/other EHS staff member will take on this responsibility. In the instances where there is more than one assistant teacher per classroom, the teacher will delegate the responsibility of medication administration to one assistant teacher.

1. Medication Authorization
The child’s health care provider and the child’s parent/guardian must authorize the administration of all medications:

- Medication Authorization forms for prescription medications must be completed by the child’s health care provider or by the child’s parent and a Direct Service Team/EHS staff member referencing the original prescription label on the original prescription bottle.
- Medication Authorization forms or legible instructions on a prescription pad for nonprescription medications must be completed and signed by the child’s health care provider. If the health care provider provides instructions on a prescription pad, the child’s parent and a Direct Service Team/EHS staff member will reference this when completing the Medication Authorization form and when completing a label for the manufacturer’s container.
- All Medication Authorization forms must be reviewed and signed by the child’s parent/guardian.

The Medication Authorization form must specify the length of time that parental consent is granted:

- For a specified period of time during a period of illness.
- For the duration of the prescription
- Blanket authorization – This is allowed only for certain chronic or life-threatening conditions requiring medication. These authorizations must come with a signed statement from the child’s health provider or a prescription indicating that the treatment is on-going.

2. Medication Containers:
All medications must be in child-resistant containers:

- Prescription medications must be in the original prescription bottle. The label qualifies as a physician’s or health care provider’s authorization to give the medication.
- Nonprescription medications must be authorized by a physician or health care provider and be in the manufacturer’s container with a label. Parents should provide
instructions and information on the label, including: the child's first and last names; specific, legible instructions for administration and storage authorized by the health care provider; and the name of the health care provider who recommended the medication for the child.

3. Medicines and Home:
If the child’s parents do not want to take medicine home every night and bring it back the next morning, they can:
- Request that the pharmacist prepare two containers when they fill the prescription.
- Send the container with the pharmacist or manufacturer’s label to the center and keep a supply in a self-labeled container at home.

4. Medication and School Bus
- Medications will not be transported to or from home on the bus.
- On field trips, needed Emergency medications will be placed in the fanny pack that the Lead Teacher/CFDS is wearing.
- The classroom Emergency Response Procedures notebook is taken on field trips and contains completed medication forms for all authorized medications.
- Health care provider and parent authorized Emergency medications can be appropriately stored on the bus if medication storage/stability requirements are met. (The Health Specialist, Transportation Manager and Area Manager/EHS Supervisor must be contacted prior to Direct Service/EHS staff completing Medication forms and accepting medication from a parent/guardian for placement on a bus.)

5. Medication Storage Area
Only staff can put medicines in the storage area or take them out:
- Medications, (other than emergency medication (i.e., Epi-pen, Jr., etc.) will be kept in locked cabinets. Medication storage cabinets will be labeled, child-resistant, and out of reach of children. However, medications requiring refrigeration will be refrigerated. Again, all medications are to be in child-resistant containers.
- Emergency medication will be stored in a labeled cabinet out of reach of children.
- Medications for the skin must be kept separate from medications that children swallow.
- Medication of any kind needs to be stored away from food and cleaning products or chemical compounds.
- Unused medication is to be returned to the parents or if expired appropriately disposed of by the Health Specialist.
- Medication required by staff and volunteers is clearly labeled with their first and last names.

6. Medication Records:
- A physician or other health care provider legally authorized to prescribe medication provides instructions for the dose, frequency, and method to be used and duration of administration in writing by: 1) completing and signing the Medication Authorization form or 2) by providing signed legible instructions on a prescription pad or 3) by a prescription label. A completed Medication Authorization form will be signed by the child's parent/guardian.
The Medication Authorization form is a triplicate NCR form.

- The original is to be kept in the child’s classroom Emergency Response Procedures notebook with the Medication Administration form. Upon completion of medication administration, the original is to be given to the EHS Manager/Health Specialist and subsequently filed in the child’s site file.
- Upon completion and parent/guardian signing, the yellow copy is to be placed in the student’s site file.
- Upon completion and parent/guardian signing, the pink copy is to be given to the Health Specialist or Disabilities/Health Coordinator. (The Health Specialist or Disabilities/Health Coordinator will provide copies of common side effects (SE) or adverse reactions (AR) for child’s prescription drug(s) to Direct Service Team/EHS staff member and child’s site file. DST/EHS staff member to refer to container on Over The Counter (OTC) medications for SE or AR.)

- The Medication Administration form is to be filled out by the staff member administering the medication. Each time medication is administered, the date, time, amount (dose), how administered and staff signature are to be noted.
  - Prior to each administration of medication, the staff member is to compare the medication label with the Medication Authorization form to assure proper medication and dosage.
  - Upon completion of medication administration, the Medication Administration form is to be given to the Health Specialist and subsequently filed in the child’s site file.

- Ongoing Communication with Parent/Guardian
  - Medication error, problem and/or reaction are to be recorded on the Medication Administration form. This information is to be shared with the child’s parent/guardian, the Health Specialist, other appropriate staff members and the child’s health care provider.
  - The teacher/CFDS and/or assistant teacher are to record changes in a child’s behavior or physical symptoms, which have implications for drug dosage or type. This information is to be shared with the child’s parent/guardian, the Health Specialist, other appropriate staff members and the child’s health care provider.
  - If changes are noted at any time during medication administration, they are recorded and immediately brought to the attention of the child’s parent. The parent must then contact the child’s health care provider and provide documentation of the contact.
  - Communication, regarding the child’s medication usage and changes in behavior or physical symptoms, is ongoing between the child’s parent/guardian and program staff.

7. Emergency Procedures:
- A child’s reaction to medication may occasionally be extreme enough to initiate emergency procedures.
- Refer to emergency procedures.
8. **Medication Return or Disposal**

- **Unexpired Medication Return:** Upon medication completion, discontinued used and/or when a child will be leaving the program *(withdrawn or at the end of the program year)*, unused medication is to be returned to the child’s parent/guardian. Count amount of medication being returned to parent/guardian and write amount (e.g. number of pills) on Medication Administration form.

- **Expired Medication Disposal:** Expired medications are to be given to the Health Specialist for appropriate disposal. The parent/guardian of a currently enrolled child will be notified by the Family Advocate, Lead Teacher or EHS staff member that the medication has expired and been given to the Health Specialist for disposal. Count amount of medication being given to the Health Specialist and write amount (e.g. number of pills) on Medication Administration form. *(The Family Advocate, Lead Teacher or CFDS should discuss impending expiration of medication in advance with the parent/guardian to potentially renew the prescription.)*

- **Turning-In Medication Forms to the Health Specialist:** The Family Advocate, Lead Teacher or EHS staff member is to note the following on the Medication Administration form:
  - Medication status *(done, unexpired, expired)*;
  - If medication remaining - Medication returned to parent/guardian or Health Specialist and amount (e.g. number of pills);
  - Date and sign.

- The Family Advocate, Lead Teacher or EHS staff member is then to remove the medication forms from the Emergency Procedures Notebook, staple the forms together with the Medication Administration form on top and then forward to the Health Specialist. The Health Specialist or the Disabilities/Health Assistant will then enter medication close out information onto the ChildPlus Student Health Database.
LOWE COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Medication Check-List

Instructions: At the time a program parent requests medication be administered to their child at school and a Direct Service Team /EHS staff member accepts this responsibility, the staff member must address and check-off each item on this list.

____  Discussed alternatives to giving medication at school with child’s parent/guardian.

____  Obtained written Health Care Provider Authorization with legible medication administration instructions. (Prescription Medication Authorization = Original Prescription Bottle with Original Prescription Label; Non-Prescription Medication Authorization = A Medication Authorization form completed, signed and dated by the Health Care Provider or Legible Instructions on a document (Health Care Provider form, etc.), completed, signed and dated by the Health Care Provider.)

____  Obtained written Parent/Guardian Authorization. (Assisted parent in completing, signing, dating and reviewing a Medication Authorization form.)

____  Reviewed appropriate medication administration, for child’s specific medication, with parent/guardian.

____  Completed heading on a Medication Administration form.

____  Completed original Medication Authorization and Medication Administration forms placed together into Section 10 of the Classroom Emergency Response Procedures Notebook. (Place completed Medication Check-List in Notebook, too.) (Medication Authorization form copies: Yellow=Site file; Pink=Health Specialist)

____  Count and write down the number/volume of medication (tablets, etc.) received here: _____________

____  Non-emergency medication placed in designated, labeled and locked cabinet out of reach of children. Emergency medication placed in designated and labeled cabinet out of reach of children. (e.g. Oral, topical and refrigerated medications are stored separately and away from food and cleansers.)

____  Outlined ongoing plan of communication, regarding child’s medication usage and changes in behavior or physical symptoms, with parent/guardian. (The teacher, assistant teacher and/or EHS staff member are to record changes in a child’s behavior or physical symptoms, which have implications for drug dosage or type. This information is to be shared with the child’s parent/guardian, the Health Specialist, other appropriate staff members and the child’s physician.)

____  Discussed medication administration, for this child, with supervisor. (e.g. To discuss administration and as needed, request an Accommodation Plan meeting with parent, staff, RN, Health Specialist and Manager/Supervisor to review medication administration, medical condition(s) etc.)

Staff Member Signature ___________________________  Date ___________________________

(C: 03/01; R: 11/15)
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Medication Authorization Form

State licensing requirements permit child care facilities to administer medications to children only with a doctor’s written authorization and with written signed direction of a parent/guardian.

Please provide the following information:

<table>
<thead>
<tr>
<th>CHILD’S NAME</th>
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<tbody>
<tr>
<td>Health Problem</td>
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<tr>
<td>Name of Medication</td>
<td>Amount</td>
</tr>
<tr>
<td>(The container must have a childproof cap)</td>
<td></td>
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<tr>
<td>Frequency</td>
<td>Times Given at Home</td>
</tr>
<tr>
<td>Method of Administration at (name of facility)</td>
<td></td>
</tr>
<tr>
<td>Amount</td>
<td>Times to be Given</td>
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<tr>
<td>How Long Medication to be Continued</td>
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<tr>
<td>Medication Expiration Date</td>
<td></td>
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<tr>
<td>Amount Received</td>
<td>on</td>
</tr>
<tr>
<td>(number of pills, etc.)</td>
<td>(Date)</td>
</tr>
</tbody>
</table>

Date | Parent/Guardian Signature | Parent Phone Number

Date | Physician’s Signature or Original Prescription Bottle | Physician’s Phone #

Distribution: White: Emergency Response Notebook Yellow: Student File Pink: Health Specialist (C: 03/95; R: 08/15)
Los requisitos estatales de las licencias para guarderías permiten administrar medicamentos a niños sólo con una orden escrita del doctor y con las instrucciones escritas y firmadas por un padre/tutor.

Por favor proporcione la siguiente información:

**NOMBRE DEL NIÑO**

**Problema de Salud**

**Nombre del Medicamento**

*Cantidad*

*(El envase debe tener una tapadera a prueba de niños)*

**Frecuencia**

**Horario administrado en casa**

**Método de Administración en**

*(nombre del Centro)*

**Medicación Fecha de Vencimiento**

**Cantidad**

**Horario para ser administrado**

**Cuanto tiempo debe continuarse con el medicamento**

**Cantidad recibida**

(Número de pastillas, etc.)

(Fecha)

**Fecha**

**Firma del Padre/Tutor**

# Tel. del Padre

**Fecha**

**Firma del Doctor o Envase Original del Medicamento**

# Tel. del Doctor
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Medication Administration Form

Child's Name: ___________________________  Teacher/CFDS: ___________  Program Year: ____
Name of Medication: ______________________  Date of Medication Authorization Form: _______

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>AMOUNT (DOSE) AND HOW ADMINISTERED (Mouth, Skin, etc.)</th>
<th>STAFF SIGNATURE</th>
<th>COMMENTS</th>
</tr>
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</tbody>
</table>

*Comments: Note any side effects that you notice from medication. Print name(s) (teacher/EHS staff member and assistant teacher) assigned to administer medication: _____________

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Error/problem/reaction to medication</th>
<th>Action Taken</th>
<th>Name of parent/guardian notified and time/date</th>
<th>Teaching Staff Signature</th>
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</tbody>
</table>

Medication RETURNED to parent/guardian

<table>
<thead>
<tr>
<th>Date</th>
<th>FA/CFDS or Lead Teacher Signature</th>
<th>(circle one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Done</td>
<td>Unexpired</td>
</tr>
</tbody>
</table>

Amount Returned:

Medication Turned In to Health Specialist

<table>
<thead>
<tr>
<th>Date</th>
<th>FA/CFDS or Lead Teacher Signature</th>
<th>(circle one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expired</td>
<td>Unexpired</td>
</tr>
</tbody>
</table>

Amount Turned In:

Reminders:
1. Medication must be in original container (with label) from pharmacy.
2. Follow label instructions and refer to the Medication Authorization Form.
3. Keep medication in a locked and labeled cabinet.
4. The teacher/CFDS and/or assistant teacher are to record changes in a child’s behavior or physical symptoms that have implications for drug dosage or type. This information is to be shared with the Health Specialist, other appropriate staff members, parents and the child’s health care provider.
5. If changes are noted at any time during medication administration, they are recorded and immediately brought to the attention of the child’s parent. The parent must then contact the child’s health care provider and provide documentation of the contact.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Parent/Guardian Assistance with Student Health Services Policy

Our program communication systems provide for the ongoing communication between staff members and parent/guardians, of children with identified health needs, to facilitate the implementation of their individual follow-up plans. Our staff members assist parent/guardians with locating transportation and finding financial assistance for their child’s medical services, dental services and prescribed medications, aids and equipment. This assistance is provided as needed to guide parent/guardians in learning how to obtain the needed services. In determining the sources of financial assistance available to the child’s parent/guardian, program staff members utilize the determination instructions for program pay. Incorporated into these instructions are the determination of health insurance status, applying for health insurance coverage and the determination of immediacy of need for medical and/or dental services. As determined in this process, program financial assistance is provided.
Determine Health Insurance Status & Apply for Coverage
- The DST/EHS Staff reviews child and families health insurance status with the parent. If the child and/or another family member do not have health insurance coverage and are possibly eligible for coverage, the DST/EHS Staff assists the parent/guardian with applying for coverage. Apple Health for Kids applications are available in Center Resource files or via the internet. Applications may be downloaded or coverage applied for at www.wahealthplanfinder.org. Note: A completed and submitted Apple Health for Kids application simultaneously applies for Medicaid (free) and CHIP (low cost) Health Insurance. The Family Health Center (FHC) is a resource for assisting families in applying for Washington State Health Insurance Coverage. The FHC phone number is 636-3892.

Determine Immediacy of Need for Medical Services
- If the child appears to have a possibly disabling or immediate medical concern, the DST/EHS staff is to communicate this information to the Health Specialist via e-mail. The Health Specialist will respond to the communication.
- If the child does not appear to have a possibly disabling or immediate medical concern, the DST/EHS Staff will request updates from the child’s parent regarding insurance status.

Non-Qualifying Insurance Status or Immediate Need Determined
- The DST/EHS Staff reviews and verifies non-qualifying insurance status with parent.
- The DST/EHS Staff is to ensure a completed Release of Information form for the child’s current Primary Health Care Provider (PCP) is on file.
- The DST/EHS Staff is to forward a copy of the release to the Health Specialist and inform her of current health insurance status.
- If the child does not have a current PCP, the Health Specialist will facilitate a referral.

Physical Examination or Medical Service Appointment
- The Health Specialist contacts the child’s Primary Health Care Provider (PCP) to give notification of program pay for the child’s physical exam or medical service.
- The Health Specialist responds to the DST/EHS Staff communication e-mail. A copy of the communication is sent to the Fiscal Specialist to establish a field order for future payment.
- The parent and/or DST/EHS Staff contact the child’s PCP to schedule the child’s appointment.

Head Start Physical Exam Form
- The parent returns the Physical Exam or medical service record to the DST/EHS Staff or requests that the PCP mail the documentation to our program.
- The PCP bills the program for the child’s physical examination or medical service. Payment is rendered after the documentation is on file.
DERMINE HEALTH INSURANCE STATUS & APPLY FOR COVERAGE

- The DST/EHS Staff reviews child and families health insurance status with the parent. If the child and/or another family member do not have health insurance coverage and are possibly eligible for coverage, the DST/EHS Staff assists the parent/guardian with applying for coverage. Apple Health for Kids applications are available in Resource files or via the internet. Applications may be downloaded or coverage applied for at www.wahealthplanfinder.org. Note: A completed and submitted Apple Health for Kids application simultaneously applies for Medicaid (free) and CHIP (low cost) Health Insurance. The Family Health Center (FHC) is a resource for assisting families in applying for Washington State Health Insurance Coverage. The FHC phone number is 636-3892.

DETERMINE IMMEDIACY OF NEED FOR DENTAL SERVICES

- If the child appears to have a possibly disabling or immediate dental concern, the DST/EHS Staff is to communicate this information to the Health Specialist and to the Oral Health/ABCD Coordinator via e-mail or health memo. The Health Specialist will respond to the communication.
- If the child does not appear to have a possibly disabling or immediate dental concern, the DST/EHS Staff will request updates from the child’s parent regarding insurance status.

NON-QUALIFYING INSURANCE STATUS OR IMMEDIATE NEED DETERMINED

- The DST/EHS Staff reviews and verifies non-qualifying insurance status with parent.
- The DST/EHS Staff is to have the parent complete a Release of Information form for the appropriate dental provider.
- The DST/EHS Staff is to forward a copy of the release to the Health Specialist and provide current health insurance status information.

DENTAL EXAMINATION APPOINTMENT

- The Health Specialist responds to the DST/EHS Staff communication. As appropriate, a copy or e-mail of the communication is sent to the Fiscal Manager to establish a field order for future payment.
- The Health Specialist contacts the dental care provider to arrange for a free or program paid dental exam for the child.
- The parent and DST/EHS Staff contacts the dental care provider to schedule the child’s appointment. The parent takes a Dental Exam form to the appointment.

HEAD START DENTAL EXAM FORM

- The parent returns the completed Dental Exam Form or dental services record to the DST/EHS Staff or requests that the dental care provider mail the documentation to our program.
- As appropriate, the Dental Care Provider bills the program for the child’s dental examination. Payment is rendered after the Dental Exam documentation is on file.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Procedure for FREE Vision Care for Qualifying Children

The Lions Club will provide free vision care to qualifying children.

Process

- Head Start conducts vision screening and/or staff or parent request a vision referral.
- The Disabilities/Health Coordinator sends a Vision Referral letter to the child’s parent/guardian via the Direct Service Team/EHS staff member notifying them of the need for a vision exam by a health care professional.
- Parent notifies DST/EHS Staff that financial assistance is needed.
- DST/EHS Staff assists the parent with applying for insurance coverage.
- DST/EHS Staff, with parent, determines that free services are needed.
- DST/EHS Staff can obtain KEX KIDS FUND Application for Vision Exam and Eyeglasses from the Health Specialist.
- Direct Service Team and parent complete forms:
  1. Parent and DST/EHS Staff complete KEX KIDS FUND Application for Vision Exam and Eyeglasses *(Parent and Direct Service Team signatures required)*.
  2. Parent completes Release of Information forms for the Lions Sight and Hearing Committee of Cowlitz County *(see information at bottom of procedure)*.
- DST/EHS Staff gives the Health Specialist: Completed application and a copy of release.
- Health Specialist mails original application and copy of release to the Lions Sight and Hearing Committee of Cowlitz County.
- Lion’s Club Representative contacts parent to schedule an appointment.
- Child attends appointment, with program Vision Referral letter, and orders free glasses if needed.
- Program Vision Referral Letter is given to parent to return to Head Start or is mailed to Head Start.

*Siblings and other community children may also request these free services. However, referrals are to be made in conjunction with an educational or social service agency.*

Mail Application To:
Lions Sight and Hearing Committee of Cowlitz County
Attention: Hope Ramsdale
PO Box 265
Longview, WA 98632
(360) 431-9969
Lower Columbia College Head Start/EHS/ECEAP
Disaster & Emergency Preparedness Form

I acknowledge that I have received training on Disaster & Emergency Preparedness which includes review of Emergency Notebooks.

_________________________________   _________________________
Name (Please Print)                        Date

_________________________________
Signature

(C: 08/16)
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Emergency Evacuation and Safety Policy

Emergency Evacuation procedures are posted in each building classroom and main hallway. A program Emergency Response Procedure notebook is provided to and used by each classroom team, Assigned Office Staff Member and assigned Leadership Team member. This confidential notebook is updated annually and as needed and includes the following information and procedures: School Building Data, Preparedness Outline, Emergency Evacuation Parent Information; Classroom Evacuation Plan and Map; Emergency Phone Numbers; Emergency Procedures for Accidents or Critically Ill Children; School Calendar; Staff and/or Volunteer Emergency Information; Class Roster; Student Emergency Contact Information & Parent Agreement Contracts; Medical Concerns/Allergies List; Medication Policy, Procedure and Forms; Accident Forms & Procedure; Emergency Medical Assistance/Student Release Forms; Bomb Threats; Bus/Chemical Accidents; Earthquakes; Missing Child or Kidnapping; Classroom and Building Lockdown Procedures; Fire, Floods, Gas Leaks; Emergency Preparedness Supplies List; Lightning, Nuclear Accidents; Response for Death of Student/Staff; Riots; Volcanic Eruptions, Windstorms. Fire drills, earthquake drills and the classroom lockdown procedures are practiced regularly. Staff members are trained in the use of the Emergency Response Procedures notebook at regularly conducted New Staff Orientations and annually.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Special Health Care Needs of Children Policy

Provided our program can reasonably accommodate them, all eligible children are afforded an equal opportunity to be included in Head Start/EHS/ECEAP, regardless of special health needs or medication requirements, so that they and their families may benefit fully from the experience.

Policy and procedures, for children with special health care needs or medication requirements (i.e. HIV, Diabetes, etc.), are developed as needed with the assistance of the Health Consultant and/or Health Services Advisory Committee. Developed policies and procedures are to include:

- Making reasonable accommodations for the child. The Health Consultant, Health Services Advisory Committee and local agencies or organizations, such as hospitals, school, and local health departments, are utilized as resource for suggesting ways to accommodate the child in the program;

- Ensuring that parents and health care providers supply clear, thorough instructions on how best to care for the child, in order to protect his or her health, as well as the health of other children and staff;

- Ensuring that our program has adequate health policies and protocols, staff training and monitoring, and supplies and equipment to perform necessary health procedures;

- Reassuring parents of other children that their children are at no health risk;

- Promoting understanding of the child's special needs, without embarrassing or drawing attention to the child; and

- Protecting the privacy of the affected children and her or his family.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Acquired Immune Deficiency Syndrome (AIDS) and Hepatitis C Special Procedures

Upon identification of a student by a competent authority as having Hepatitis C or Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Condition (ARC), or antibodies to the AIDS virus, the following procedure will be followed:

The people who shall know the identity of a student who is infected with Hepatitis C or HIV are those who will, with the infected student's parent or guardian, determine whether the student who is infected with Hepatitis C or HIV has a secondary infection that constitutes a medically recognized risk of transmission in the school setting. They are as follows:

1. The Director, or a person designated by the director, to be responsible for the decision;
2. Supervisor;
3. Health Specialist;
4. The classroom teacher/CFDS and Family Advocate to whom the child is assigned;
5. The personal physician of the infected student;
6. A medical consultant from the Cowlitz County Health Department;
7. Interpreter and/or Assistant Teacher as determined by the Director, Supervisor and Health Specialist.

Notification of Additional Persons
The decision makers listed above and a child's parent or guardian will determine whether additional persons need to know that an infected student attends or works at a specific school. The additional persons will not know the name of the infected student without the consent of the infected child's parent or guardian. Depending on the circumstances of the case, the following persons may know about the student who is infected with Hepatitis C or HIV, but do not know his or her identity:

1. Health Consultant

Additional persons may be notified if the decision makers feel that this is essential to protect the health of the infected student, or if additional persons are needed to periodically evaluate or monitor the situation. Consent for notifying these additional persons must be given by the infected child's parent or guardian.

Confidentiality
All persons shall treat all information as highly confidential. No information shall be divulged, directly or indirectly, to any other individuals or groups. All medical information and written documentation of discussion, telephone conversations, proceedings, and meetings shall be kept in a confidential notebook by the DST in a locked file. Access to this file will be granted only to those persons who have the written consent of the infected student's parent or guardian. To further protect confidentiality, names will not be used in documents except when essential. Any document containing the name, or any other information that would reveal the identity of the infected student, will not be shared with any person, not even for the purposes of word processing or reproduction.

(C: 05/97; R: 06/13)
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Injury Prevention Policy

Our program establishes and implements procedures to ensure that staff members and volunteers can demonstrate safety practices, violence prevention practices and foster safety awareness among children and parent/guardians. Procedures incorporate maintaining safe and hazard free facilities and physical environments by providing effective supervision, taking action to eliminate or reduce hazards, appropriately responding to an emergency, and teaching children, parent/guardians and staff members about safety through activities and trainings which focus on safety practices in both the home and program.
REPORTS

Lower Columbia College Head Start/EHS/ECEAP utilizes three Accident Reporting forms.

1. The form titled: Lower Columbia College Head Start/EHS/ECEAP Child Accident Report Form is completed when a child has had an accident.

2. The form titled: Child Care Injury / Incident Report Form is completed when a child, in a Childcare Licensed Center, has had an accident and professional medical and/or dental treatment is sought. The Area Manager of child’s center, is to notify the Assistant Director of the accident and facilitate the Childcare Licensor being notified via phone or email. The completed form will then be faxed to the Childcare Licensor.

3. An Accident Report is to be completed and submitted online at https://cm.maxient.com/reportingform.php?LowerColumbiaCollege&layout_id=1 when an employee, work-study student, volunteer or other adult has had an accident.

WHEN AN ACCIDENT REPORT FORM NEEDS TO BE COMPLETED/SUBMITTED

The staff member administering first aid or that has had an accident is to use their best judgment when determining if an Accident Report needs to be completed/submitted. If in doubt about completing/submitting a report, the staff member needs to contact their Supervisor or another Leadership Team member. As a guideline, an Accident Report is to be completed/submitted anytime outside medical attention is considered to be warranted.

NOTIFICATION OF CHILD’S PARENT/GUARDIAN

If a Child Accident Report form is to be completed, the child’s parent/guardian or other responsible adult, noted on the child’s Family Information form, is to be contacted by phone or in person as soon as possible. All attempts to make this contact are to be noted in case management.

Regardless if a Child Accident Report form is completed or not, the parent/guardian of any child involved in an accident is to be notified of any injuries or potential injuries (i.e. A bump to the head that shows no visible injuries). This information is to be noted in the child’s site file.

The parent/guardian needs to sign and date the Accident Report form before distribution of copies. The parent/guardian is then given the pink copy of the form.

NOTIFICATION OF LEADERSHIP TEAM MEMBER OF A CHILD ACCIDENT

If a child has a serious injury and/or an emergency medical condition, the Staff Member who witnessed the accident is to complete a Child Accident Report form and give or fax it to the Health Specialist or another Leadership Team member immediately. All other completed Accident Report forms must be given to the Supervisor, Health Specialist or another Leadership Team member before the end of the same working day the accident occurred. A Leadership Team member or if unavailable, a main office staff member must be notified on the date the accident took place.

MEDICAL SERVICES FOR CHILD

If outside medical treatment is sought, the parent or health care provider is to complete the treatment section on their pink copy. (Health Care Provider Signature is requested.) The parent/guardian is then to return the pink copy, with the Medical Services section completed, to a Direct Service Team/EHS staff member. The DST/EHS staff member is to make a two copies, file one and give one to the Health Specialist. The pink copy is then returned to the parent.

LOWER COLUMBIA COLLEGE ONLINE ACCIDENT REPORT

Make a report online at https://cm.maxient.com/reportingform.php?LowerColumbiaCollege&layout_id=1 All areas of the online form are to be complete. When completing the report click on: Email a copy of this report. When you receive the email with your completed report, forward the email to your Supervisor and the Health Specialist. For assistance on completing a report online, contact your
Supervisor or the Lower Columbia College Human Resources Department located in the LCC Administration building or call 360-442-2120.

A Report of Industrial Injury or Occupational Disease (L&I form) will need to be completed if an employee seeks medical consultation for an accident that has occurred at work. Health Care Providers have L&I forms.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP  
Child Accident Report Form

**CHILD INFORMATION**
Name of Child (Last, First, MI): ________________________________
Date of Birth: __________________________ Address: ________________________________
Home Phone Number: __________________________
Center Name: __________________________ Room # ________ Teacher Name: __________________________

**ACCIDENT INFORMATION**
Date of accident: ____________ Time of accident: ________
Date reported to Parent/Guardian: ____________ Time reported to Parent/Guardian: ________
Date reported to Manager: ____________ Time reported to Manager: ________
Reported to: ____________________________ (Health Specialist or Other)
Manager – If unavailable, contact Main Office staff member at 442-2800)
Location of Accident:
☐ Classroom ☐ Bathroom ☐ Hallway ☐ Field Trip ☐ Bus
☐ On A Walk ☐ Playground ☐ Other ____________________________
Describe Accident in detail including full name of witnesses if any (attach additional sheets if necessary):
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
Nature of the Injury (cut, bite, burn, etc.): __________________________
(If a bite, state: skin broken or skin not broken.)

**FIRST AID INFORMATION**
Please check boxes of all first aid administered by staff.
☐ Washed with Soap & Warm Water ☐ Antiseptic Towelette (*bus & field trip only)
☐ Applied Bandage (*after cleansing area) ☐ Applied Pressure ☐ Applied Ice Pack
☐ Provided TLC ☐ Immobilized Injured Area ☐ Other __________________________
☐ Bump to the Head hand-out given to child’s parent/guardian.
Name(s) of staff member(s) who administered first aid: __________________________

**REPORTING INFORMATION**
Signature of Staff Member: __________________________ Date: ____________
Signature of Parent/Guardian: __________________________ Date: ____________
Parent/Guardian plans to seek medical attention: Yes _____ No _____ (please check one)

**MEDICAL SERVICES INFORMATION**
Health Care Facility: __________________________ Address: __________________________
Health Care Provider’s comments, including treatment given: __________________________
________________________________________________________________________________________
________________________________________________________________________________________
Date: ____________ Time: ____________
Name of Health Care Provider: __________________________
Signature of Health Care Provider: __________________________

Date Yellow Report Copy Received by Health Specialist: __________________________
Date Health Specialist Distributed Additional Copy to Supervisor: __________________________

Distribution: White-Student File Yellow: Health Specialist Pink: Parent/Guardian/Health Care Provider
HSAC Approved 11/13/00 Policy Council Approved 11/27/00 (C: 11/00; R: 06/16)
INFORMACIÓN DEL NIÑO
Nombre del niño (Apellido, Nombre, Inicial del segundo nombre): __________________________
Fecha de nacimiento: __________________________ Dirección: __________________________
Número de teléfono: __________________________
Nombre del Centro: ___________ # del Salón _____ Nombre de la Maestra(o): _____________

INFORMACIÓN DEL ACCIDENTE
Fecha del accidente: ___________ Hora del accidente: ___________
Fecha en que se reportó a los Padres/Tutores ___________ Hora del reporte a los Padres/Tutores ___________
Fecha en que se reportó a la Supervisora: ___________ Hora del reporte a la supervisora: ___________
Reportado a: __________________________ (Especialista de Salud o si no están disponibles contacte la oficina principal al 442-2800)
Lugar del accidente:
☐ Salón de Clases ☐ Baño ☐ Pasillo ☐ Excursión ☐ Autobús
☐ En una caminata ☐ Área de juego ☐ Otros ___________
Describa el accidente con detalles incluyendo el nombre completo de los testigos si los hubo (de ser necesario anexe hojas complementarias) __________________________

Tipo de lesión (cortada, mordida, quemadura, etc.): __________________________
(Si se trata de una mordida, indique si se le rompió la piel o no)

INFORMACIÓN DE PRIMEROS AUXILIOS
Por favor marque todos los primeros auxilios administrados por las trabajadoras.
☐ Lavado con jabón y agua tibia ☐ Toalla antiséptica (*Autobús y excursión solamente)
☐ Aplicación de vendaje (*Después de limpiar el área) ☐ Aplicación de presión ☐ Se proporcionó TLC ☐ Aplicación de hielo ☐ Inmovilización del área lesionada ☐ Otros ___________
☐ Se entregó a los padres folleto con información de golpes en la cabeza.
Nombre(s) del personal que administró los primeros auxilios: __________________________

INFORMACIÓN REPORTADA
Firma del personal __________________________ Fecha: ___________
Firma de Padre/Tutor: __________________________ Fecha: ___________
Planean los padres/tutores buscar atención médica: Si ☐ No ☐ (Favor de marcar una opción)

INFORMACIÓN DE LOS SERVICIOS MEDICOS
Lugar del cuidado de salud: __________________________ Dirección: __________________________
Comentarios de los proveedores del cuidado de la salud, incluyendo el tratamiento dado: __________________________

Fecha: __________________________ Hora: __________________________
Nombre del proveedor del cuidado de salud: __________________________
Firma del proveedor del cuidado de salud: __________________________

Date Yellow Report Copy Received by Health Specialist: __________________________
Date Health Specialist Distributed Additional Copy to Supervisor: __________________________
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP

Bicycle Helmets Outdoors Procedure

Overview: In order to prevent head injuries, bicycle helmets are to be worn by each child during the time he or she is riding a tricycle, scooter or wagon. When a child gets off the tricycle, scooter or wagon, he or she is to take the bicycle helmet off.

1. The staff member will assist each child with properly wearing a bicycle helmet at the time the child is to ride a tricycle, scooter or wagon. A properly fitting bicycle helmet means: the side buckles are at the child's ears; the helmet is not more than one finger-width from the child's eyebrows; and the helmet is securely tightened by the child buckle so that when the child "yawns" the helmet is pulled down by the action. The helmet should not significantly move when the child shakes his or her head "yes" and "no".

   **Helmet Measurement Ranges in Inches**

   - Small Helmet: 19” to 20.25”
   - Medium Helmet: 20.25” to 21.5”
   - Large Helmet: 21.5” to 22.75”

   The Health Specialist has a sizing tape that the Direct Service Team can checkout to measure a child's head to assist with making an appropriate helmet fit.

2. When a child gets off the tricycle, scooter or wagon, a staff member is to ensure that the child takes the helmet off. (There is a "hidden hazard" of strangulation if a child wears a helmet while playing on playground equipment, climbing trees, etc.)

3. Staff members perform daily head checks OR prior to the use of the helmet by another child and placement back into the storage shed, a wet-wipe will be used to clean the inside of a worn bicycle helmet. A staff member will perform this task or ensure that the child who originally wore the helmet has appropriately done so.

4. Once every two weeks, the teaching staff will check helmets for any worn sizing pads needing replacement and for cracks. (Any helmet with significant cracks should no longer be used.)
Do you know the correct way to wear a helmet?

- Make sure the helmet fits snugly and does not obstruct your field of vision.
- Make sure the chin strap fits securely and that the buckle stays fastened.

Wear the helmet flat atop your head, not tilted back at an angle!
Lower Columbia College Head Start/EHS/ECEAP

Nap and Quiet Rest Period Procedure for Toddlers (not in a crib) and Preschoolers

LCC Head Start/EHS/ECEAP will provide rest time each day to children in care for four (4) or more hours in a day. This rest time will be flexible and meet the individual developmental needs of the children. Quiet learning activities will be accessible for non-napping children and those that rise early. Safe sleep practices will be followed as outline below.

Nap & Quiet Rest Period:
1. Sleeping and nap equipment is available for each toddler and preschool-age child not using a crib and remaining in care for at least four hours and any other child requiring a nap or rest period.
2. Toddlers, twenty-nine months of age or younger, are allowed to follow an individual sleep schedule.
3. During naptime, staff to child ratios must be met and maximum group size maintained. When only one staff person is required to meet the staff to child ratio, a second staff person (who at least meets classroom staff qualifications) must be readily available in case of emergency. Staff members will remain alert and actively supervise sleeping children in an ongoing manner by visibly checking often and being within sight and hearing range when a child is going to sleep, is sleeping or waking up.
4. Mats are not placed directly on any floor that is cooler than 65 degrees F when children are resting.
5. To reduce the spread of communicable illnesses, mats or cots are placed three feet apart or if not enough space allows for this, children are spaced as far apart as possible and children alternated head to feet.
6. Children sleep in the same spot each day. In order to assure this, the Lead Teacher creates a map of where each child sleeps and has it posted or otherwise easily accessible in the classroom.

Requirements Specific to Toddlers:
1. Toddlers will be allowed to follow their own sleep patterns.
2. Rooms will have sufficient lighting in the room in which a toddler is sleeping in order to observe skin color.
3. A blanket, bedding, or clothing will not be allowed to cover any portion of a toddler’s head or face while sleeping, and staff members will adjust these items when necessary.
4. Staff members will supervise toddlers actively, in part, to prevent the child from getting too warm while sleeping, which may be exhibited by indicators that include, but not limited to, seating, flushed, pale, or hot and dry skin, warm to the touch; a sudden rise in temperature; vomiting; refusing to drink, a sunken fontanelle (soft spot); or irritability.
5. A sleep positioning devised will not be used unless directed to do so by a toddler’s health care provider. The directive must be in writing, signed and dated by the health care provider. This signed directive will be kept in the child’s site file and all applicable staff will be notified. A copy of the signed directive will be given to the Health Specialist and the Area Manager.

Mats and Cots:
1. Only mats and cots made with a waterproof material that can be easily washed and disinfected, will be used.
2. Each child is provided a separate, firm and waterproof mat or cot long enough so a child’s head or feet do not rest off of it. (Canvas cots will not be used by toddlers.)
3. Mats and cots are kept clean and in good repair. Once a mat is torn it is not cleanable and will be discarded. Duct tape or fabric to repair sleeping mats or cots is never done.

4. The sleeping surfaces of one child’s rest equipment is not to come in contact with the sleeping surfaces of another child’s rest equipment during storage.

Bedding:

1. Bedding for each child consists of a clean tight fitting sheet for the sleeping surface and a clean blanket or suitable cover for the child.

2. Bedding is laundered weekly or more often if necessary and between uses by different children.

3. Each child's bedding is stored separately from bedding used by other children. Once the bedding has been used, it is considered dirty. One child's bedding is not allowed to touch another child's bedding during storage.
This Safe Infant Sleep procedure will be reviewed annually with all staff to familiarize them with the program’s sleep procedures for infants and to provide them with current recommendations. Safe sleep practices reduce the risk of Sudden Unexplained Infant Deaths (SUIDs) including, Sudden Infant Death Syndrome (SIDS), suffocation and other deaths that may occur when an infant is in a crib or asleep.

Note: Most sleep-related deaths in child care facilities occur in the first day or first week that an infant starts attending a child care program. Many of these deaths appear to be associated with prone positioning (on their stomach), especially when the infant is unaccustomed to being placed in that position.

In order to maintain safe sleep practices and to advocate to parent/guardians their use in the home and in all infant care settings, the below procedures will be followed:

1. **Back to sleep for every sleep.**
   Infants up to 12 months of age are placed in a supine position (wholly on their back) for every nap or sleep time unless an infant’s primary health care provider has completed a signed waiver indicating that the child requires an alternate sleep position. This signed waiver will be kept in the child’s site file and all staff will be notified of the infant’s prescribed sleep position. A copy of the signed waiver will be given to the Health Specialist and one to the Area Manager. If an infant turns over while sleeping, the staff member will return the infant to his or her back until the infant is able to independently roll from back to front and front to back.

   A sleep positioning device will not be used unless directed to do so by an infant’s health care provider. The directive must be in writing, signed and dated by the health care provider. This signed directive will be kept in the child’s site file and all staff will be notified. A copy of the signed directive will be given to the Health Specialist and one to the Area Manager.

2. **Sleep patterns.**
   Staff will allow infants to follow their own sleep pattern.

3. **Use a safety-approved crib with a firm sleep surface.**
   Infants will be placed for sleep in safe sleep environments; which include a firm crib mattress covered by a tight-fitting sheet in a safety-approved crib (*the crib must meet the standards and guidelines reviewed/approved by the U.S. Consumer Product Safety Commission (CPSC) and ASTM International (ASTM)*). No monitors or positioning devices will be used unless required by the child’s primary health care provider and a signed waiver is on file. No other items will be in a crib except for a pacifier.

4. **If not already in their crib, a sleeping infant will immediately be placed in their crib.**
   Infants will not nap or sleep in a car safety seat or any type of furniture/equipment that is not a safety-approved crib (*that is in compliance with the CPSC and ASTM safety standards*). If an infant arrives at the facility asleep in a car safety seat, the parent/guardian or staff member will immediately remove the sleeping infant from this seat and place them in the supine position in the infant’s assigned crib. If an infant falls asleep in any place that is not a safe sleep environment, staff will immediately move the infant and place them in the supine position in their crib.

5. **No soft objects and loose bedding in, on or around crib.**
   Soft or loose bedding will be kept away from sleeping infants and out of cribs. These include, but are not limited to: bumper pads, pillows, quilts, comforters, sleep positioning devices, sheepskins, blankets, flat sheets, cloth diapers, bibs, etc. Also, blankets/items will not be hung on the sides of
crib or cover or drape over a crib. Note: Loose or ill-fitting sheets have caused infants to be strangled or suffocated.

6. **No toys, stuffed animals and mobiles.**
   Toys, including mobiles and other types of play equipment that are designed to be attached to any part of the crib will be kept away from sleeping infants and off of/out of cribs.

7. **Each infant will be assigned their own crib, will not share cribs and spacing between cribs will be appropriate.**
   - Each infant will have their own crib that is labeled with their name.
   - Space cribs a minimum of 30 inches apart. Cribs can be placed end-to-end if a barrier, to prevent communicable disease, is in place. If barriers are used, staff must be able to observe and have immediate access to each infant. Barriers must be solid, moisture resistant and easily cleanable and placed on the side or end adjacent to another crib.

8. **Avoid overheating and bundling.**
   - When caregivers/staff members place infants in their crib for sleep, they should check to ensure that the temperature in the room is comfortable for a lightly clothed adult, check the infants to ensure that they are comfortably clothed (not overheated or sweaty), and that bibs, necklaces and garments with ties or hoods are removed.
   - The infant’s face will remain uncovered.
   - The infant’s head will remain uncovered when sleeping.
   - There is currently insufficient evidence to recommend the use of a fan as a SIDS risk-reduction strategy.
   - Possible indicators of overheating may include, but are not limited to: sweating; flushed, pale, or hot and dry skin, warm to the touch; a sudden rise in temperature; vomiting; refusing to drink, a depressed or sunken fontanelle (soft spot); or irritability.

9. **Use sleep sack and do not use swaddling.**
   If an infant requires additional warmth, a sleep sack will be used. There is no evidence to recommend swaddling as a strategy to reduce the risk of SIDS.

10. **Infants will be observed and actively supervised when napping or sleeping.**
    - A staff member must be present in the room with infants at all times. Infants will be directly observed by sight and sound at all times, including when they are going to sleep, are sleeping, or are in the process of waking up.
    - The lighting in the room must allow the staff see each infant’s face, to view the color of the infant’s skin, and to check on / monitor the infant’s breathing and placement of the pacifier (if used).
    - A staff member trained in safe sleep practices and approved to care for infants will be present in each room at all times where there is an infant. This staff member will remain alert and actively supervise sleeping infants in an ongoing manner by visibly checking often. Also, the staff member will check to ensure that the infant’s head remains uncovered and re-adjust clothing and items (sleep sack and sheet) as needed.

11. **Provide consistent tummy time.**
    Supervised, awake tummy time will be provided to facilitate development and to minimize development of flat areas on the head.
12. Encourage breastfeeding.
Breastfeeding is associated with a reduced risk of SIDS. Unless contraindicated, mothers will be encouraged to breastfeed exclusively or feed with expressed milk (i.e. not offer any formula or other nonhuman milk-based supplements) for 6 months, in alignment with recommendations of the AAP.

13. Recommend crib in parent’s room.
It is recommended that infants sleep in the parents’ room, close to the parents’ bed, but on a separate surface designed for infants, ideally for the first year of life, but at least for the first 6 months.

14. Recommend consideration of offering a pacifier at nap time and bedtime.
- The pacifier should be used when placing the infant for sleep. It does not need to be reinserted once the infant falls asleep. If the infant refused the pacifier, he or she should not be forced to take it. In those cases, parents can try to offer the pacifier again when the infant is a little older.
- Because of the risk of strangulation, pacifiers will not be hung around the infant’s neck nor attached to infant clothing.
- Objects, such as stuffed toys and other items that may present a suffocation or choking risk, will not be attached to pacifiers.
- For breastfed infants, pacifier introduction should be delayed until breastfeeding is firmly established. Infants who are not being directly breastfed can begin pacifier use as soon as desired.

15. Recommend avoiding smoke exposure during pregnancy and after birth.


17. Recommend pregnant women obtain regular prenatal care.

18. Endorse and model.
Staff members will endorse and model the SUIDs risk-reduction recommendations from birth.
Our program staff members work together with families and health care professionals to ensure that all child health and developmental concerns are identified, and children and families are linked to an ongoing source of continuous, accessible care to meet their basic health needs. Program procedures are developed and implemented to: determine the health status of each child; screen for developmental, sensory and behavioral concerns; facilitate extended follow-up and treatment services; identify any new or recurring medical, dental, or developmental concerns for making timely and appropriate referrals; involve and assist parent/guardians with enrolling and participating in a system of ongoing family health care; respond to each child's individual characteristics, strengths and needs.
Dear Health Care Provider:

In order to meet Performance Standards for the Health Component of the Head Start/EHS/ECEA Program, each enrolled child must stay on a schedule of well child care. The well child exams are to include:

a) Hematocrit/Hemoglobin (*Please include blood test results with the physical exam document being sent to our program. If the child's Hct is below 34 or the HgB is below 11, Head Start is to refer to WIC unless the PCP states otherwise.);

b) Blood lead level (*From test done between 12 and 72 months of age.);

c) Necessary immunizations (*Please include all immunization dates and/or copies of all immunization records with the physical exam document being sent to our program);

d) Growth assessment;

e) Vision examination, including acuity and strabismus;

f) Hearing examination;

g) Urinalysis;

h) Blood pressure reading;

i) Physical examinations;

j) Developmental assessment;

It is a “Mandate” to have the results of examinations on file at Head Start/EHS/ECEAP. If a child is referred elsewhere or needs treatment, please indicate on the Health Assessment Form where/who child is being referred to and necessary treatment, so that our program can follow-up on the necessary documentation.

If a disabling condition is observed, please include:

a) Categorically;

b) Functional;

c) Recommendations to the Head Start/EHS/ECEAP staff.

The child must be diagnosed with a disability so he/she can receive additional Head Start/EHS/ECEAP services and other agency services available to diagnosed children.

Does this child have a disability? Yes ☐ No ☐

Diagnosed disability name or term: ________________________________

Health or Developmental Impairment

These impairments refer to illnesses of a chronic nature or with prolonged convalescence, including but not limited to epilepsy, hemophilia, severe asthma, severe cardiac conditions, severe anemia or malnutrition, diabetes or neurological disorders.

Please return the completed attached form or a Xerox copy of the appropriate Well Child EPSDT Exam form to LCC Head Start/EHS/ECEAP. Thank you for your assistance in helping us meet the federal and state guidelines.

Sincerely,

Health Specialist
CHILD HEALTH RECORD: Physical Examination/Assessment Record

CHILD NAME ____________________________ Sex _______ Birthdate ________

Immunization and Test Record

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Significant Child/Family History ________________________________________________

TB Test as Indicated __________________________________________________________

EXAMINATION RESULTS: Please fill in each area.

Hematocrit or Hemoglobin
(If Hct is <34 or HgB is <11, Head Start is to refer to WIC)

Blood Lead Level (ug/dl) __________________ (Test done between 12 and 72 months of age.)

Blood Pressure: Pass Fail (Circle One)

Height/Inches __________________________ Weight/Pounds __________________________

Skin __________________________ Heart __________________________

Lungs __________________________ Muscular Coordination __________________________

Speech __________________________ Abdomen __________________________

Gentitalia __________________________

Urinalysis __________________________ Vision Acuity R-20/ L/20/ Both-20/

Strabismus BIN ET XT

Eyes __________________________ Ears/Nose/Throat __________________________

Posture __________________________

Gait __________________________ Lungs __________________________

Neurological __________________________

Hearing R _____1000 _____2000 _____4000 L _____1000 _____2000 _____4000

Teeth __________________________ Hernia __________________________

Social __________________________

Findings/Recommendations: ________________________________________________________

Follow-up Treatment: ____________________________________________________________

SIGNATURE __________________________ EXAM DATE __________

Physician/Health Provider Name (Please Print) __________________________

Phone # __________ Fax # __________ Source of Payment: __________________________

HEALTH ORGANIZATION: Please return to:

Name: LCC HEAD START/EHS/ECEAP

Address: P.O. Box 3010 Longview, WA 98632-0310

City, State: Phone (360) 442-2800 FAX (360) 442-2819

Benefits of LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP are available to all children without regard to race, color, national origin, or handicapping/disabling condition. Print on Blue (C: 06/00; R: 06/14)
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Denial of Consent for Medical Services

As parent or legal guardian of ________________________________

(Name of Child)

It is my desire that no medical services be provided to my child by Head Start/EHS/ECEAP. I understand that services have been recommended for my child. I accept the consequences of this action and in no way hold Lower Columbia College Head Start/EHS/ECEAP responsible for any future medical problems resulting from the lack of medical services.

__________________________________________              ____________
Signature of Parent/Guardian                  Date

__________________________________________              ____________
Signature of Witness                        Date

Supervisor, Health Specialist, and DST/EHS staff will determine if and when a Denial of Consent for Medical Services form is completed.
Como padre o tutor legal de ____________________________________________
(Nombre del Niño)

Es mi deseo que ningún servicio médico sea proporcionado a mi niño por el Head
Start/EHS/ECEAP. Entiendo que se han recomendado servicios médicos a mi niño. Acepto las
consecuencias de esta acción y de ninguna hare responsable al Lower Columbia College Head
Start/EHS/ECEAP por cualquier problema médico futuro que resulte por de la falta de servicios
médicos.

__________________________________  ____________________________
Firma del Padre/Tutor                  Fecha

__________________________________  ____________________________
Firma de Testigos                      Fecha

Supervisor, Health Specialist, and DST/EHS staff will determine if and when a Denial of Consent for Medical Services form is completed.
RE: DENTAL EXAM

Dear Dentist:

In order to meet Federal Performance Standards for the Health Component of the LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP, each enrolled child one year of age or older, must have a dental examination which includes:

a) An oral exam;

b) Diagnostic radiographs;

c) Prophylaxis;

d) Instruction in self-care and oral hygiene;

e) Topical fluoride application (at the discretion of the dentist);

f) Any necessary treatment for pulp therapy to be determined and immediate follow-up arranged.

After completing the child's initial examination, please complete and return a Dental Health form to Head Start/EHS/ECEAP. Indicate specific services provided, the service date(s), and costs. Please also note all additional treatment and preventative care needed.

Following each dental treatment appointment, another Dental Health form needs to be completed and faxed or mailed to Head Start/EHS/ECEAP.

It is a federal "mandate" to have the results of this examination on file at Head Start/EHS/ECEAP.

Sincerely,

Health Specialist
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Dental Form

Child's Name ___________________________ Birthdate ________________

Is the child now receiving:  
Topical Fluoride Application?  ☐ Yes  ☐ No  
Fluoridated Water?  ☐ Yes  ☐ No  
Fluoride Supplement Diet?  ☐ Yes  ☐ No

EXAMINATION AND TREATMENT RECORD:  (List services provided in order.)

<table>
<thead>
<tr>
<th>Description of Work Completed</th>
<th>Date Service Performed</th>
<th>Actual Charges</th>
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PREVENTATIVE DENTAL CARE TO BE COMPLETED INCLUDES:

☐ Sealants  ☐ Cleaning  ☐ Fluoride

Approximate number of visits needed ___________  Appointment Date _________

CHILD ORAL HEALTH SUMMARY:

All planned treatment _____ is _____ is not complete.

<table>
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<tr>
<th>Description of Work Needed and NOT Completed</th>
<th>Date Scheduled</th>
<th>Estimated Charges</th>
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Approximate number of visits needed ___________  Approximate Cost _________

DENTAL HEALTH RECOMMENDATIONS AND/OR CONCERNS:

☐ Routine recall visits  ☐ Special home emphasis on oral hygiene
☐ Dietary Problem(s)  ☐ Developmental problem(s)
☐ Harmful oral habits  ☐ Needs fluoride supplement
☐ "Baby bottle" tooth decay

Other concerns: _______________________________________________________

Source of payment _________________________________________________

Dentist or Dental Office Name (Please Print)  PLEASE RETURN TO:

Signature of Dentist or Office Staff  LCC HEAD START/EHS/ECEAP

Date  P.O. Box 3010

Print on Blue  Longview, WA  98632-0310

(360) 442-2800  FAX: (360) 442-2819

Benefits of LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP are available to all children without regard to race, color, national origin, or handicapping condition.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP

Denial of Consent for Dental Services

As parent or legal guardian of ________________________________

(Name of Child)

It is my desire that no dental services be provided to my child by Head Start/EHS/ECEAP. I understand that services have been recommended for my child. I accept the consequences of this action and in no way hold Lower Columbia College Head Start/EHS/ECEAP responsible for any future dental problems resulting from the lack of dental services.

________________________________________  _________________
Signature of Parent/Guardian                  Date

________________________________________  _________________
Signature of Witness                         Date

Supervisor, Health Specialist, and DST/EHS staff will determine if and when a Denial of Consent for Dental Services form is completed.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Negativa de Consentimiento de Servicios Dentales

Como padre o tutor legal de ________________________________
(Nombre del Niño)

Es mi deseo que ningún servicio dental sea proporcionado a mi niño por el Head Start/EHS/ECEAP. Entiendo que se han recomendado servicios dentales a mi niño. Acepto las consecuencias de esta acción y de ninguna hare responsable al Lower Columbia College Head Start/EHS/ECEAP por cualquier problema dental futuro que resulte por de la falta de servicios dentales.

_________________________ _______________________
Firma del Padre/Tutor Fecha

_________________________ _______________________
Firma de Testigos Fecha

Supervisor, Health Specialist, and DST/EHS staff will determine if and when a Denial of Consent for Dental Services form is completed.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Well Child and Dental Exams Process

Assuring children have access to and receive preventative medical and dental care are LCC Head Start/EHS/ECEAP requirements. Regular well-child care and dental care greatly aid in the early detection of potential health concerns, which can affect a child’s growth, development, and learning. Records of these exams provide documentation that care has been provided and gives staff important information about a child’s individual health status. Information about the importance of Well Child and Dental exams is to be reviewed with parents at enrollment and ongoing according to the age appropriate schedule of Well Child Care below.

Age-appropriate Schedule of Well Child & Dental Care*:

- 1st Visit: Birth – 6 Weeks
- 2nd Visit: 2-3 Months
- 3rd Visit: 4-5 Months
- 4th Visit: 6-7 Months
- 5th Visit: 9-11 Months
- Three screening examinations are recommended for child 1 through 2 years of age. (12 month, 18 month and 2 years).
- One screening examination is recommended per 12-month period for children 3 through 6 years of age.

First Dental Exams occur at Twelve-Months of age. Direct Service Team and EHS staff members support families in locating a dental home for their children (i.e. Refer to Access to Baby and Childhood Dentistry Program (ABCD), etc.)

Procedure:

1. Clarify to be sure it was a Well-Child exam and not an office visit for illness. Well Child Exams can be documented on EPSDT Well Child Exam forms or on any record that comes from the provider. (Preschool student exams can also be documented on the LCC Head Start/ECEAP Physical Exam form HLTH 10c.)
2. Review the Well-Child Exam record to note the date it was completed and cross check with the Schedule of Well-Child Care to determine if the child is current with their Well-Child Care or behind. Dental exams need to be within the past 6-months to be current. Copy the exam and send the copy to the Disabilities/Health Coordinator to enter into the ChildPlus Health Database. Place the original exam in the child’s Site file and note on the Content sheet.
3. If a child has not had an exam or is due for an exam, provide the parent with the appropriate Well Child Exam form and/or Dental Exam form HLTH 10f and facilitate the scheduling of the appointment. Discuss upcoming exam appointments with parents. Assist them with making a list of questions to ask their health care provider regarding their child’s health, growth and development. (See “Using Bright Futures”).
4. If an exam was done but the parent did not provide a record to you, complete a Health Documentation Request Letter HLTH 11e1 attach a copy of the appropriate provider release and turn-in to the Program Assistant to fax to the provider.
Lower Columbia College Head Start/EHS/ECEAP
Spring Conference/End-of-Year Home Visit/Close-Out
PIR Health Questionnaire

Child’s Name: __________________________________________________________

Teacher: ___________________________ Loc ID: ____________________________

**Student’s Primary Health Insurance Coverage**

*Please check only one box.*

- [ ] Apple Health (Medicaid) and/or CHIP

- [ ] Private Health Insurance

- [ ] Other Health Insurance: ____________________________
  *e.g. Military Health (Tri Care, CHAMPUS) etc.*

- [ ] No Health Insurance

**Continuous & Accessible Medical & Dental Care**

*Please check each applicable box.*

- [ ] Child has an ongoing source of continuous, accessible health care?

- [ ] Child received medical services through the Indian Health Service?

- [ ] Child received medical services through a migrant community health center?

- [ ] Child has an ongoing source of continuous, accessible dental care provided by a dentist?
Lower Columbia College Head Start/EHS/ECEAP
Conferencia de Primavera/Visita de Fin de Año al Hogar/Conclusión
Cuestionario de Salud PIR

Nombre del Niño: ____________________________

Maestra: ____________________________ LOC ID: ____________________________

Cobertura Primaria de Seguro Médico del Estudiante

Por favor, marque solo uno.

- Apple Health (cupón médico) y/o CHIP
- Seguro de Salud Privado
- Otro tipo de seguros de salud__________________________
  Por ejemplo, seguros de salud de las fuerzas armadas (Tri-Care, CHAMPUS) etc.
- No tiene seguro de salud

Cuidado Médico y Dental Accesible y Continuo

Por favor, marque todos los que sean aplicables.

- ¿El niño tiene un lugar donde constantemente recibe servicios de salud?
- ¿El niño recibió servicios médicos a través de Indian Health Service?
- ¿El niño recibió servicios médicos a través de un Centro Comunitario para Migrantes?
- ¿El niño tiene acceso constante al cuidado dental, proveído por un dentista?
Lower Columbia College Head Start/ECEAP
End-of-Year Child Health Summary

Child’s Name: __________________________ LOC ID: ________

Date Reviewed/Given to Parent/Guardian: __________________________

Immunizations:

___ Current and Complete for Kindergarten Entry
___ Current Immunization(s) Due

___ Exempt
___ Up to Date as Possible
___ Past Due

Immunizations Needed & Due Dates: __________________________

Annual Well Child Exam:

___ Current and Due: __________________________

___ Past Due as of: __________________________

Lead Screening Record on File: ___ Yes ___ No
If no, plan to obtain: __________________________

Medical Follow-up or Treatment Currently Needed? ___ Yes ___ No
If yes, determine next steps and state here: __________________________

6-Month Dental:

___ Current and Due: __________________________

___ Past Due as of: __________________________

Dental Follow-up or Treatment Currently Needed? ___ Yes ___ No
If yes, determine next steps and state here: __________________________

Spring Growth (As per Health Services Advisory Committee guidance: If child’s Body Mass Index is below (5%) or above (95%) normal limits, recommend 6-month follow-up appointments with child’s Primary Health Care Provider.)

Discussed additional health/nutrition topics:

Copy of existing Emergency Action Plan (Anaphylaxis, Seizure or Asthma) given to parent/guardian to take to next education setting (Kindergarten, etc.) to notify school. Child’s new school could require an updated plan on one of their forms.

Copy of existing Dietary Restriction Form (CACFP Fluid Milk Substitution Form, CACFP Medical Disability Statement for Food Substitutions and/or CACFP Medical Non-Disabling Statement for Food Substitutions) given to parent/guardian to take to next educational setting (Kindergarten, etc.) to notify school. Child’s new school could require additional intolerance/allergy documentation in order to provide food substitutions.
End-of-Year Child Health Summary

Lower Columbia College Head Start/ECEAP
Resumen de Fin de Año de la Salud del Niño

Nombre del Niño: ___________________________ LOC ID: ____________

Fecha de Revisión/Entregado a los Padres/Tutor: ____________________________

Vacunas: 
___ Actualizadas y completas para entrar al Kínder
___ Vacuna(s) Actualizadas: Próxima Fecha:

_________________________________ ______________________
_________________________________ ______________________

___ Exentas
___ Actualizadas lo más posible a la fecha
___ Vencidas

Vacunas Necesarias y Fechas Límites: ____________________________

Examen Físico del Niño: 
___ Actual y Próximo:
___ Vencido:

Reporte del Plomo en el expediente: ___ Sí ___ No
Sí no, cual es el plan para obtenerlo: ____________________________

¿Seguimiento Médico o Tratamiento Actualmente Necesario? ___ Sí ___ No
Si contestó sí, determine el próximo paso y anótelo aquí: ____________________________

Examen Dental de cada 6-Meses: 
___ Actual y Próximo:
___ Vencido:

¿Seguimiento Dental o Tratamiento Actualmente Necesario? ___ Sí ___ No
Si contestó sí, determine el próximo paso y anótelo aquí: ____________________________

Crecimiento de Primavera (Según las guías del Comité de Consejos para los Servicios de
la Salud: Si el Índice de Masa Corporal (BMI) del niño es menos de (5%) o mas de
(95%) dentro de los límites normales, se recomienda un seguimiento dentro de 6 meses
con el Proveedor Primario de los Cuidados de la Salud de su niño.)

Temas adicionales comentados acerca de salud/nutrición: ____________________________

Copia del existente plan de acción en situación de emergencia (“Anaphylaxis”, “Seizure”
o “Asthma”) fue entregado al padre/tutor para llevar a la próxima escuela del niño
(Kindergarten, etc.) como notificación. Es posible que la nueva escuela requiera un plan
actualizado, escrito en un formulario de su propia organización.

Copia del existente formulario de restricción alimenticia (“CACFP Fluid Milk
Substitution Form”, “CACFP Medical Disability Statement for Food Substitutions” y/o
“CACFP Medical Non-Disabling Statement for Food Substitutions”) fue entregado al
padre/tutor para llevar a la próxima escuela del niño (Kindergarten, etc.) como
notificación. Es posible que la nueva escuela requiera documentación adicional sobre la
intolerancia alimentaria o alergia del niño antes de poder proporcionarle una sustitución.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Health Referral for New or Recurring Concerns

Policy
Our program utilizes procedures to ensure the ongoing identification of any new or recurring medical, dental, or developmental concerns of our children. These procedures include: periodic observations (from parents and staff) and recordings, as appropriate, of individual children’s developmental progress, changes in physical appearance (e.g., signs of injury or illness) and emotional and behavioral patterns.

Procedure
1. Center-based children are observed throughout the day, as they participate in indoor and outdoor activities, routines, transitions, arrivals, and departures. Pertinent observations are recorded in case management and if appropriate in the child’s developmental tracking tool. Whereas, home-based children are observed at weekly home visits and socializations.
2. Parents are regularly provided with information on developmental milestones, and are asked for their observations concerning their child’s development.
3. When parents or staff members observe medical, dental or developmental changes, which are of possible concern, those observations are to be shared with a health professional. The DST/EHS Staff member will ask the parent if the child has been seen, by a health professional, for these concerns. If the child has, the DST/EHS staff and parent will discuss the follow-up plan(s) and complete a request letter (HLTH 11e1) for forwarding to the Program Coordinator. All sources of information are to be used in evaluating each child.
4. When a child has been identified as possibly benefiting from diagnostic evaluation, the DST/EHS Staff member is to contact their supervisor and the Health Specialist. As determined, the DST/EHS Staff or Health Specialist will contact the Health Consultant.
5. As warranted, a letter stating concerns, observations, and request for further diagnostic evaluation will be sent to the child’s Primary Health Care Provider.
6. A Health Accommodation Plan meeting can be arranged and/or the child/family can be staffed at a Content Area Support Team (CAST) meeting.
7. The DST/EHS Staff member is to note all pertinent information in case management.
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Request for Child Developmental and/or Health Records Procedure

1. When making a request for child developmental and/or health records, the staff member is to complete a Request Letter (HLTH 11e1).

Guidance on filling out Request for Health Documentation Letter
- Check ChildPlus.net health module for date of most recent request if made.
- When sending the request letter (HLTH 11e1) please make sure each field LOC ID, Child’s Name, Parent/Guardian Name, Clinic Name and Request line are completed and that your request for information is as specific as possible before sending to the Program Coordinator for processing.

Please do not date the form. Due to the high volume of requests and workload, there are some days that delay process and Office Staff need dates to coincide with the date they are faxed and data based. The Office Staff member will date the letter on the date he/she processes it.

The following are examples of the language to be used when requesting records:

Physical Exam/WCE – Most recent Phys/WCE, including Ht/Wt, Immunizations, Hct/Hgb, Lead Screening and UA (include date of exam in your Request Letter, if known). EHS Staff: Please also include “most recent OAE hearing screening date and results” in your request.

Dental Exams – Most recent dental exam records (include date, if known).

Dental Treatments – Most recent dental treatment (include date, if known).

WIC – Most recent office visit, including Ht/Wt, Hgb/Hct and recommendations (include date, if known).

Sick Visit – Most recent sick visit, diagnosis, recommendations and follow-up if needed (include date, if known). *Sometimes the child visits the Emergency Room. At this time you would request ER visit.

Vision – Most recent vision exam, treatment plan and recommendations (include date, if known).

Hearing – Most recent hearing exam, treatment plan and recommendations (include date, if known).

Allergies – Verification of allergies to… (List what parent states child is allergic to: foods, medications, insects, etc. and request treatment plan and/or special dietary accommodations.) As appropriate, the Intake, DST or EHS staff member will assist the child’s parent/guardian with completing, signing and dating section of a Request for Special Dietary Accommodations form. The staff member will then send in a copy of it to the Health Coordinator or Health Specialist to have it faxed or mailed to the child’s health care provider to complete the Diet Order section of the form and return it to the Head Start Health Specialist.
Asthma – Verification of asthma, please include medication list and asthma action plan. *Note: These are often included in physical/WCE if we are aware of the condition prior to requesting records. However, if not, we will request verification separately.

2. The DST/EHS staff member is to enter the request onto ChildPlus Family Services.

3. Send the completed Request Letter (HLTH 11e1) to the Program Coordinator. (If the Parent/Guardian Permission to Reveal or Obtain Confidential Information form (ERSEA 1d) for the provider is new, attach the original to the letter. This can be printed from ChildPlus.net. The Program Coordinator will database into the health module of ChildPlus.net; initial and date bottom corner of original ROI; scan and attach the original ROI into the enrollment module of ChildPlus.net; and send the original to the DST. The Program Coordinator will coordinate the requesting of documentation.

Use of the Parent/Guardian Permission to reveal or Obtain Confidential Information form: At the request of the parent/legal guardian and/or appropriate staff, staff will print a copy of the pertinent ROI from the database and attach to the request.

4. Prior to faxing or mailing the letter with a copy of the release to the provider, the Program Coordinator will write the date and his/her initials on the letter.

5. If the letter is to be mailed, the Program Coordinator will make a copy of it.

6. The Program Coordinator will fax or mail the letter with a copy of the release to the provider.

7. The Program Coordinator will enter request information onto the ChildPlus/Health Database; note this has been done on the original letter (if faxed) or on the copy of the letter (if mailed) and then forward the documentation to the DST/EHS Staff for placement in the child’s Site file.
Dear: ______________________

(Health Care Provider Name or Clinic Name)

Your patient is currently enrolled in the Lower Columbia College Head Start/EHS/ECEAP Program. At this time, program staff and I are requesting the following medical, dental, or growth and developmental documentation as required by our program:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Included with this letter is a completed Release of Information form signed and dated by the child’s parent/guardian. Please send the requested information to my attention at:

LCC Head Start/EHS/ECEAP
P.O. Box 3010
Longview, WA. 98632

OR

Fax to (360) 442-2819
e-mail: headstart.info@lowercolumbia.edu

Your time and assistance regarding this matter are greatly appreciated. I look forward to your reply.

Sincerely,

Lily Terry
Health Specialist

Fax Date & Staff Member Initials: ______________________

(C: 01/07; R: 10/18)
Head Start /EHS
ECEAP

Date: __________________________

Expectant Mother’s Name: ________________________________

Date of Birth: __________________________

Dear: ____________________________:

(Health Care Provider Name or Clinic Name)

Your patient is currently a participant of the Lower Columbia College Early Head Start program. At this time, program staff and I are requesting the following medical or dental documentation.

____________________________________________________
(State documents and/or information being requested and include date(s) if known.)

Included with this letter is a completed Release of Information form signed and dated by the program participant. Please send the requested information to my attention at:

LCC Head Start/EHS/ECEAP OR Fax to (360) 442-2819
P.O. Box 3010 email: headstart.info@lowercolumbia.edu
Longview, WA. 98632

Your time and assistance regarding this matter are greatly appreciated. I look forward to your reply.

Sincerely,

Lily Terry
Health Specialist

Fax Date & Staff Member Initials: __________________________

(C: 10/12; R: 10/18)
The attached health document requires medical and/or dental follow-up by you. Please:

1. Review highlighted comments / notations on the document regarding a screening and/or follow-up/referral/treatment for:
   - Allergy
   - Anemia
   - Asthma
   - Communicable Disease
   - Development
   - Referral to Specialist(s)
   - Other____________
   - Growth
   - Hearing
   - Heart/Lungs/Pulmonary
   - Lead
   - MH
   - Orthopedic
   - Urinalysis
   - Vision
   - Other____________
   - Additional Info

2. Follow-up with the parent/guardian, assist with scheduling appointment(s) etc., obtain release(s) and request records as appropriate;

3. Document actions/follow-up/ongoing status, etc. in ChildPlus/Family Services &

4. E-mail health status updates (applicable ChildPlus/Family Services entries such as scheduled appointments dates, parent statements of when they plan to address, etc.) to the Health Specialist, Health Coordinator & Area Manager;

5. File in Health section of child’s Site file.

(C: 02/18)
LOWER COLUMBIA COLLEGE HEAD START/ECEAP
Hearing Screening Policy and Procedure

Policy
Each child's hearing must be screened within 45 calendar days of his or her entrance into the program. These screenings are authorized and done in collaboration with each child's parent/guardian. The screenings are used for identification purposes only and are not intended or used for diagnostic purposes.

Hearing Screening Procedure
1. Each child's hearing is screened yearly and as needed or requested by the child's parent/guardian and/or Direct Service Team. The child's parent/guardian is informed of the screening results by receiving a copy of their child's completed Vision, Hearing & Strabismus Screening form.

A hearing screening using evidenced-based screening equipment (audiometer, etc.) completed by a Health Care Provider, three (3) months or less prior to a child’s enrollment date for the current program year, can be used to meet the child's 45-count hearing screening deadline if the record is received prior to the child’s 45-count deadline.

2. If a child fails their program hearing screening, the screener (Health Coordinator or Office Assistant) will determine whether or not the program will screen the child's hearing a second time or make a referral to the child's health care provider. A hearing referral can also be made based upon a parent/guardian and/or Direct Service team request.

3. When a child's hearing is unscreenable:
   a. The Health Coordinator and/or Office Assistant will make at least two (2) additional attempts to screen the hearing of child who is not in process of or receiving Special Needs Services.
   b. If a child is in process of or receiving Special Needs Services, the Health Coordinator and/or Office Assistant will make a hearing referral to the child's health care provider. The Health Coordinator will also work with the child's Family Advocate/CFDS and school district to arrange for an ESD 112 (van) hearing screening as appropriate.

4. When a hearing referral is made:
   a. The child's Hearing, Vision & Strabismus Screening form provides the initial notification of the referral to both the parent/guardian and the Direct Service Team.
   b. The Family Advocate/CFDS notes the screening results (pass, unscreenable or failed/referral) in ChildPlus/Family Services. The original of the screening form is then placed into the Health section of the child's Site file.
   c. The Health Coordinator and/or Office Assistant completes and mails a Hearing Referral letter to the child's parent/guardian. At this time, the referral is entered into ChildPlus/Health.
   d. The Health Coordinator and/or Office Assistant will fax a copy of child’s Hearing, Vision and Strabismus form, with the appropriate release, to child’s primary health care provider.
   e. The Family Advocate/CFDS appropriately documents in ChildPlus/Family Services and works with the child's parent/guardian and their other DST members to ensure that needed follow-up (appointments, etc.) and treatment services, for each child, are arranged and provided in a timely manner.
LOWER COLUMBIA COLLEGE HEAD START/ECEAP  
Vision Screening Procedure

**Policy**
Each child’s vision must be screened within 45 calendar days of his or her entrance into the program. These screenings are authorized and done in collaboration with each child's parent/guardian. The screenings are used for identification purposes only and are not intended or used for diagnostic purposes.

**Vision/Strabismus Screening Procedure**
1. Each child’s vision is screened yearly and as needed or requested by the child's parent/guardian and/or Direct Service Team. The child's parent/guardian is informed of the screening results by receiving a copy of their child's completed Vision, Hearing & Strabismus Screening form.

   A vision screening using evidenced-based screening equipment (SPOT Vision Screener, etc.) completed by a Health Care Provider, three (3) months or less prior to a child’s enrollment date for the current program year, can be used to meet the child’s 45-count vision screening deadline if the record is received prior to the child’s 45-count deadline.

2. If a child fails their program vision screening, the screener (Health Coordinator and/or Office Assistant) will refer the child or meet with the Health Specialist to determine whether or not the program will screen the child a second time or make the referral. A referral can also be made based upon a parent/guardian and/or Direct Service Team request.

3. When a child's vision is unscreenable:
   a. The Health Coordinator and/or Office Assistant will make at least two (2) additional attempts to screen the vision of child who is not in process of or receiving Special Needs Services.
   b. If a child is in process of or receiving Special Needs Services, the Health Coordinator and/or Office Assistant will make a vision referral to the child's health care provider.

4. When a vision referral is made:
   a. The child's Hearing, Vision & Strabismus Screening form provides the initial notification of the referral to both the parent/guardian and the Direct Service Team.
   b. The Family Advocate/CFDS notes the screening results (pass, unscreenable or failed/referral) in ChildPlus/Family Services. The original of the screening form is then placed into the Health section of the child's Site file.
   c. The Health Coordinator and/or Office Assistant completes and mails a Vision Referral letter to the child's parent/guardian. At this time, the referral is entered into ChildPlus/Health.
   d. The Health Coordinator and/or Office Assistant will fax a copy of child’s Hearing, Vision and Strabismus form, with the appropriate release, to child’s primary health care provider.
   e. The Family Advocate/CFDS appropriately documents in ChildPlus/Family Services and works with the child's parent/guardian and their other DST members to ensure that needed follow-up (appointments, etc.) and treatment services, for each child, are arranged and provided in a timely manner.
LOWER COLUMBIA COLLEGE HEAD START/ECEAP
Hearing, Vision & Strabismus Screening Form

Student Name: ____________________________________________________________
Teacher: _______________________________ LOC ID #: _________________________

HEARING SCREENING
Screening Date: _______________ Signature of Screener: _______________________
   Rt.  1000 _____ 2000 _____  4000 _____
   Lt.  1000 _____ 2000 _____  4000 _____
   Pass ☐ Unscreenable ☐ Failed ☐
   Referral Letter To Parent: ______________________________

Comments: ______________________________________________________________
   ______________________________________________________________
   ______________________________________________________________

VISION SCREENING (Includes Strabismus Screening)
Screening Date: _______________ Signature of Screener: _______________________
   PASS ☐ UNSCREENABLE ☐ REFERRAL ☐
   Referral Letter To Parent: ______________________________

Comments: ______________________________________________________________
   ______________________________________________________________
   ______________________________________________________________
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP

Hearing Referral

Date: ________________________________  LOC ID #: ________________________________

Dear Parent/Guardian of: ____________________________________________________________

Recently, your child's hearing was screened. It was found that your child needs to have his/her hearing checked by a health care professional.

Please take this hearing referral notice to your child's Primary Care Physician and/or a local health care provider. Please have the doctor complete and sign the lower portion of this form. Then return the form to your child's classroom teacher or have your doctor mail or fax it to my attention at the address stated below.

If you have any questions or concerns, please call me at (360) 442-2807.

Sincerely,

Health Specialist

________________________________________________________________________

HEARING EXAMINATION--To be completed by health care provider.

Patient Name: ________________________________________________________________

Hearing Examination Date: _____________________________________________________

Hearing Results:  R - ___________________       L - ___________________

Examination Results/Recommendations: ____________________________________________

________________________________________________________________________

________________________________________________________________________

_____________________________  __________________________
Physician/Health Care Provider's Name  Signature  Date

Please mail or fax the completed form to: Lower Columbia College Head Start/EHS/ECEAP

P.O. Box 3010
Longview, WA  98632-0310
(360) 442-2800
Fax:  (360) 442-2819

(C: 04/95; R: 11/13)
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Reexaminación del Oído

Fecha: ________________________________ LOC ID#: __________________________

Querido Padre Guardián de: ________________________________________________

El oído de su hijo fue examinado recientemente. Se encontró que su niño necesita que su oído
sea examinado por un médico profesional.

Por favor tome esta nota de reexaminación al doctor familiar de su niño y/o a un proveedor de
servicios de salud local. Por favor haga que el doctor llene y firme la parte de abajo de esta
forma. Después, regrese la forma a la maestra del salón de clases de su hijo o haga que su doctor
la mande por correo o por fax para mi atención, al domicilio señalado abajo.

Si usted tiene alguna duda o pregunta, por favor llámeme al (360) 442-2807.

Atentamente,

Directora de Salud

HEARING EXAMINATION – To be completed by health care provider.

Patient Name: ________________________________________________________________

Hearing Examination Date: ______________________________________________________

Hearing Results: R: ___________________________ L: ____________________________

Examination Results/Recommendations: __________________________________________

____________________________________________________________________________

_________________________ ________________________
Physician/Health Care Provider’s Name Signature Date

Please mail or fax the completed form to: Lower Columbia College Head Start/EHS/ECEAP
P.O. Box 3010
Longview, WA, 98632-0310
(360) 442-2800
Fax: (360) 442-2819

(C: 04/95; R: 11/13)
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Vision Referral

Date: ________________________________        LOC ID # __________________________

Dear Parent/Guardian of: ___________________________________________________________

Your child's vision was recently screened. We found that your child needs to have his/her vision checked by an Eye Care Professional.

Please take this vision referral notice to your Primary Health Care Provider, a local ophthalmologist or optometrist and have your child's vision screened. Please have the Health Care Provider complete and sign the lower portion of this form and return it to your classroom teacher or have your Health Care Provider mail this form, to my attention, to the address stated below.

If you have any questions or concerns, please call me at (360) 442-2807.

Sincerely,

Health Specialist

VISION EXAMINATION -- To be completed by health care provider

Patient Name: ________________________________________________________________

Vision Examination Date: ________________________________

Vision Acuity: R-20/___________        L-20/___________        Both 20/___________

Examination Results/Recommendations: __________________________________________

_____________________________________________________________________________

Physician/Health Care Provider's Name

___________________________________________        __________________________
Signature                    Date

Please mail or fax the completed form to: Lower Columbia College Head Start/EHS/ECEAP
P.O. Box 3010
Longview, WA  98632-0310
(360) 442-2800
Fax: (360) 442-2819
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Remisión para Examen de la Vista

Fecha: ___________________________ LOC ID # _______________________

Querido Padre/Tutor de: _____________________________

La visión de su niño fue recientemente examinada. Nosotros encontramos que su niño necesita que su vista sea evaluada por un Profesional en el Cuidado de la Vista.

Por favor tome esta notificación de remisión para la visión a su Doctor, a un Oftalmólogo u Optometrista y haga que la vista de su hijo sea examinada. Por favor pídale al Doctor que llene y firme la parte de inferior de esta forma y regrésela a la maestra del salón de clases o pida al Doctor que envíe esta forma por correo, para mi atención, a la dirección indicada en abajo.

Si tiene alguna pregunta o duda, por favor comuníquese conmigo al teléfono (360) 442-2807.

Atentamente,
Especialista de Salud

-------------------------------------------------------------------------------------------------
VISION EXAMINATION – To be completed by health care provider.

Patient name: _____________________________________________________

Vision Examination Date: ________________________________

Vision Acuity: R-20/ ___________ L-20/ ___________ Both 20/ ___________

Examination Results / Recommendations: ______________________________________________________

-----------------------------------------------------------------------------------------------

Physician/Health Care Provider’s Name

___________________________ __________________
Signature Date

Please mail or fax the completed form to: Lower Columbia College
Head Start/ECEAP
P.O. Box 3010
Longview, WA 98632-0310
(360) 442-2800
Fax: (360) 442-2819

(C: 08/02; R: 11/13)
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Record of Vision Exam

PATIENT NAME: __________________________

BIRTH DATE: __________________________

DATE: __________________________

VISION REFERRAL RESULTS AND RECOMMENDATIONS:

_____ Normal eye exam for age. No need for glasses at this time. Re-evaluate in ___________ months/years.

_____ Glasses to be worn at school only. Re-evaluate in ___________ months/years.

_____ Glasses to be worn continuously. Re-evaluate in ___________ months/years.

_____ Glasses to be worn for reading/distance only. Re-evaluate in ___________ months/years.

_____ Patching of LEFT/RIGHT eye. _________ Hr/day Re-evaluate in ___________ months/years.

_____ Other vision recommendations:


Date of exam: ___________

Doctor/Clinic Name: __________________________

Signature of Doctor or Staff Member Completing Form: __________________________

Please mail or fax the completed form to: Lower Columbia College Head Start/EHS/ECEAP P.O. Box 3010 Longview, WA. 98632-0310 (360) 442-2800 Fax: (360) 442-2819

(C: 01/06; R: 11/13)
LOWER COLUMBIA COLLEGE EARLY HEAD START
Three-Pronged Approach I. Parent Interview Questions

RELATED TO VISION AND HEARING CONCERNS

Child’s Name: ___________________________________________ LOC ID # __________

These topics are meant to be introduced within the first home visits to alert staff to the need to look more carefully at a child’s vision and hearing. This piece of the summary is to be done by an EHS staff or health professional.

1. When was your baby’s last “well baby” check up?

2. How would you describe (child’s name) birth?

3. Did your baby have newborn hearing screening done in the hospital or at the doctor’s office? Did he/she pass? (If not, what happened next?)

4. Has (child’s name) has any ear infections that you’re aware of?

5. Has (child’s name) hearing or vision ever been tested by a doctor? If yes, when and who did the evaluation?

6. Do you have any concerns about the way (child’s name) looks at you (or at books, or watches TV)?

7. Do you have any concerns about the way (child’s name) is learning to talk?

8. Do any of your family members or close friends have concerns regarding your child’s vision or hearing?

9. Does anyone in your family (immediate family, uncles, grandparents, etc.) have a hearing loss or vision problem? If yes, what are the reasons for the hearing or vision loss?

(C: 05/10; R: 07/18)
Medical/Family History Review Supplement for Vision and Hearing Concerns

Check off any of the following factors noted during the parent interview and/or in reading the child’s medical records.

Family History:

____ Family history of vision impairment or hereditary childhood hearing loss.

Prenatal History:

____ Mother has history of infection during pregnancy.
(e.g., toxoplasmosis, rubella, cytomegalovirus, herpes, syphilis).

____ Child was exposed to alcohol or drugs (e.g., cocaine, medications) prenatally.

Perinatal History:

____ Child’s birth weight was less that 1500 grams (3.3 pounds).

____ Child had Apgar score of 0-4 at 1 minute or 0-6 at 5 minutes, (i.e. blue, needed oxygen, not crying).

____ Child was premature (less than 37 weeks gestation) and exposed to oxygen in hospital.

____ Child had elevated bilirubin (hyperbilirubinemia) requiring transfusion.

____ Child required mechanical ventilation lasting 5 days or longer.

Postnatal History:

____ Child had bacterial meningitis or encephalitis.

____ Child sustained head trauma associated with loss of consciousness or skull fracture.

____ Child has neurological disorders such as seizures.

____ Child has syndrome known to include hearing loss and/or visual impairment (e.g., Down Syndrome, Fetal Alcohol Syndrome, CHARGE, Coldenhar, Hurler, Norrie, Refsum, Trisomy 13, Waardenburg).

____ Child has cerebral palsy.

____ Child has hydrocephaly.

____ Child had excessive fever for a prolonged period of time.

____ Child was given “mycin” drugs or other known ototoxic medications (e.g., chemotherapeutic agents or aminoglycosides).

Original Screening: __________________________  Update: __________________________
Update: __________________________  Update: __________________________
Update: __________________________  Update: __________________________

(C: 05/10; R: 07/18)
# LOWER COLUMBIA COLLEGE EARLY HEAD START
## Three-Pronged Approach II. Developmental Skills Checklist

### RELATED TO SEEING AND HEARING IN YOUNG CHILDREN

**Child’s Name:** ____________________________  **LOC ID #:** ____________________________

### SEEING: Does the Child…

<table>
<thead>
<tr>
<th>BIRTH TO 3 MONTHS OLD:</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Look at your face? (briefly looking by 1 month old)</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>• Imitate your smile? (2 mo.)</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BY 3 TO 6 MONTHS OLD:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Smile at others?</td>
<td></td>
</tr>
<tr>
<td>• Look at own hands?</td>
<td></td>
</tr>
<tr>
<td>• Watch you as you enter or cross the room? (from 6 feet away)</td>
<td></td>
</tr>
<tr>
<td>• Reach out and bat at objects?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BY 6 TO 12 MONTHS OLD:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Try to reach out and grasp at toys or other objects? (6 mos.)</td>
<td></td>
</tr>
<tr>
<td>• Notice something small (ex: raisin) when 12 inches from him? (6 mos.)</td>
<td></td>
</tr>
<tr>
<td>• Try to move toward an object that is at least 5 feet away? (7 mos.)</td>
<td></td>
</tr>
<tr>
<td>• Pick up or attempt to pick up a Cheerio, raisin, or lint? (8 mos.)</td>
<td></td>
</tr>
<tr>
<td>• Imitate movements or actions of another person or a toy? (9 mos.)</td>
<td></td>
</tr>
<tr>
<td>• Stare at or try to grab your jewelry or glasses? (9 mos.)</td>
<td></td>
</tr>
<tr>
<td>• Look for dropped toy? (9 mos.)</td>
<td></td>
</tr>
<tr>
<td>• React to facial expressions of others (ex: frowns, smiles, funny faces)? (10-12 mos.)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BY 12 TO 24 MONTHS OLD:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Show an interest in picture books? (12 mos.)</td>
<td></td>
</tr>
<tr>
<td>• Imitate scribbling? (8-15 mos.)</td>
<td></td>
</tr>
<tr>
<td>• Reach into a container and pull out objects out easily? (12-18 mos.)</td>
<td></td>
</tr>
</tbody>
</table>

### HEARING: Does the Child…

<table>
<thead>
<tr>
<th>BIRTH TO 3 MONTHS OLD:</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Startle or jump when there is a sudden loud sound?</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>• Stir or awaken from sleep, or cry, when someone talks or makes a loud noise?</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>• Recognize and get comforted by a familiar voice?</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BY 3 TO 6 MONTHS OLD:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Turn his or her eyes to look for an interesting sound?</td>
<td></td>
</tr>
<tr>
<td>• Respond to mother’s or other caregiver’s voice?</td>
<td></td>
</tr>
<tr>
<td>• Turn eyes forward when his or her name is called?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BY 6 TO 12 MONTHS OLD:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Turn toward an interesting sound or toward caregiver when his or her name is called from behind?</td>
<td></td>
</tr>
<tr>
<td>• Search or look around when new sounds are present?</td>
<td></td>
</tr>
<tr>
<td>• Understand “no” “mommy” “bye bye” and similar common words?</td>
<td></td>
</tr>
<tr>
<td>• Participate in vocal play with parents; experiment with different speech and non-speech sounds? (9 mos.)</td>
<td></td>
</tr>
<tr>
<td>• Babble in speech-like strings of single syllables? (ex: “dad a da” “ga ga”) (10 mos.)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BY 12 TO 24 MONTHS OLD:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Say one or more real, recognizable words? (12 mos.)</td>
<td></td>
</tr>
<tr>
<td>• Put words together? (ex: mommy shoe, big boat) (18 mos.)</td>
<td></td>
</tr>
<tr>
<td>• Use at least 50 words? (24 mos.)</td>
<td></td>
</tr>
</tbody>
</table>
### SEEING: Does the Child…

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BY 24 TO 36 MONTHS OLD:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Imitate crayon stroke? (24-30 mos.)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>• Copy circle made by another person?</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

**Color Identification:**

- Match two items that are the same color? (24-32 mos.)
- Sort items by color? (36 mos.)
- Point to a color when asked? (36-42 mos.)

**Object to Picture Matching and Picture Identification:**

- Identify one picture of a familiar item? (18-24 mos.)
- Identify two or more pictures? (24-32 mos.)
- Match objects with pictures of objects? (24-36 mos.)

**Does your child say. . .?**

- “My eyes are itchy.”
- “My eyes hurt.”
- “Things look blurry.”

---

The “seeing” developmental skills on this page are from Dr. Tanni Anthony’s doctoral work (2005) on visual skills for Transdisciplinary Play-Based Assessment.

---

### HEARING: Does the Child…

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BY 24 TO 30 MONTHS OLD:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Follow two requests combined? (ex. “Get the ball and put it on the table”) (24 mos.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Understand conversation easily?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hear when you call from another room?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Point to objects in a book when they are named?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Say the following sounds clearly: P, B, M, K, G, W, H, N, T, D?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Use three-word sentences?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Use past tense verbs? (ex: walked, batted, fished, ran)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Name five pictures?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Answer questions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Use 1-2 prepositions (in, on, under)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Use sentences with real words instead of using nonsense-sounding “word” strings?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BY 30 TO 36 MONTHS OLD:**

- Hear TV or radio at same loudness level as other family members?
- Notice sounds – dogs barking, phones ringing?
- Can make most sounds correctly at start of words? (ex: says the “th” sound in “think,” but says “baff” instead of “bath.”)
- Use 1-2 prepositions (in, on, under)?
- Use plurals? (ex: dogs, cookies)
- Refer to self using a pronoun (I, me)?
- Use 200+ words? (300+ by age 3)?
- Give full name when asked?
- Help tell stories?
- Ask questions beginning with “what” “where” or “when”?
- Use speech that can be understood by others most of the time?

---

The “hearing” developmental skills are adapted from the Hawaii Early Learning Profile Language Scale.

---

Initial Screening Date ______________________

6 Month/Annual Screening Dates

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

(C: 05/10; R: 07/16)
## LOWER COLUMBIA COLLEGE EARLY HEAD START
### Three-Pronged Approach III. Observations

Child’s Name: ____________________________  LOC ID # ______________

<table>
<thead>
<tr>
<th>Associated with Visual Impairment</th>
<th>Associated with Hearing Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Differences in How Eyes Look:</strong></td>
<td><strong>Differences in How Face or Ears Look:</strong></td>
</tr>
<tr>
<td>- Drooping eyelid</td>
<td>- Cleft lip and palate</td>
</tr>
<tr>
<td>- One eye slightly higher or lower than the other eye</td>
<td>- Head or neck have malformations</td>
</tr>
<tr>
<td>- Obvious differences in the shape or structure of the eyes</td>
<td>- Ears are malformed, or there may be no opening at ear canal</td>
</tr>
<tr>
<td>- Pupil of the eye is not round, clear, black</td>
<td>- Frequent earaches or ear infections</td>
</tr>
<tr>
<td>- White of the eye is red and sore looking</td>
<td>- Discharge from the ears</td>
</tr>
<tr>
<td>- Eyes are watery even when baby is not crying</td>
<td><strong>Unusual Listening Behaviors:</strong></td>
</tr>
<tr>
<td>- Baby is very sensitive to bright light and squints, closes eyes, or turns away from it</td>
<td>- Few or inconsistent responses to sounds</td>
</tr>
<tr>
<td><strong>Unusual Eye Movements:</strong></td>
<td>- Does not seem to listen</td>
</tr>
<tr>
<td>- Eyes move in jerky way back and forth or up and down</td>
<td>- Does not turn when name is called</td>
</tr>
<tr>
<td>- Eyes do not move together</td>
<td>- Notices certain types of sounds more than others</td>
</tr>
<tr>
<td>- Eye turns inward or outward after 4 to 6 months of age</td>
<td><strong>Unusual Vocal Development</strong></td>
</tr>
<tr>
<td><strong>Unusual Gaze or Head Positions</strong></td>
<td>- Does not make a lot of different sounds</td>
</tr>
<tr>
<td>- Tilts or turns head in certain ways when looking at an object</td>
<td>- Voice sounds different; can’t make certain speech sounds</td>
</tr>
<tr>
<td>- Holds object close to eyes</td>
<td>- Is behind in talking (no spoken words at 15 months; fewer than 50 words at 24 months)</td>
</tr>
<tr>
<td>- Seems to be looking beside, under, or above the person or object</td>
<td><strong>Other Behaviors</strong></td>
</tr>
<tr>
<td><strong>Absence of Visual Behaviors</strong></td>
<td>- Pulls on ears or puts hands over ears</td>
</tr>
<tr>
<td>- No eye contact by 3 months</td>
<td>- Breathes through mouth</td>
</tr>
<tr>
<td>- Does not look at objects, or follow moving objects, by 3 months</td>
<td>- Cocks head to one side</td>
</tr>
</tbody>
</table>

At the beginning of each EHS program year or at the time of enrollment, each child will have their vision and hearing screened using the Three-Pronged Approach as well as the Infant Vision Development Checklist (Infants Only) or SPOT Vision Screener (Toddlers Only) and OAE Screener within 45 days.

I. A Three-Pronged Approach: Early Head Start uses a three-pronged approach designed by Washington Sensory Disabilities Services. Parents, EHS staff and other service providers can document parent concerns, observable infant behaviors, and signs that may indicate high risk for vision impairment or hearing loss. The purpose of gathering this information is to determine the need for further diagnostic evaluation of a child’s vision and hearing status, and to provide evidence that these areas have been addressed.

II. General Instructions:
Within 45 days of enrollment, the Child & Family Development Specialist will screen each child’s vision and hearing using the following:

1. Parent Interview (I) – Contains questions that can be included in first conversations with families.
   i. Medical/Family History Review Supplement for vision and hearing concerns.
3. Observations: What to Look For (III) – A resource tool with pictures and descriptive of signs that may be observable or reported by parents. Not to be used as a checklist.
4. Infant Vision Development Checklist (Infants Only) or SPOT Vision Screening (Toddlers Only) and Otoacoustic Emissions (OAE) Hearing Screening – As required by Head Start/EHS Performance Standards, within 45 calendars after the child first attends the program or, for the home-based program option, receives a home visit, a program must either obtain or perform evidence-based vision and hearing screenings.
5. Guidance on Using a Vision and/or Hearing Screening from a Previous Program Year for a Returning EHS Child – If a returning EHS child’s vision and/or hearing screening(s), for the prior program year were completed 45 days or less before their enrollment date for the new program year, the screening(s) can be used to meet the 45-day count for the new program year.
6. Guidance on Using Newborn Hearing Screening to Meet 45-Day Count for an Infant’s Required OAE Hearing Screening – A new born hearing screening Otoacoustic Emissions (OAE) or Auditory Brainstem Response (ABR) can be used to meet an infant’s OAE hearing screening requirement if the newborn hearing screening was administered 45 days or less prior to infant’s EHS enrollment date and the record is received prior to the child’s 45-day count deadline.

Relevant information and results from each of the sources listed above, as well as other sources (i.e. Well Child Exam, Health History forms, etc.) is to be transferred to the corresponding section on:

7. Developmental & Sensory Screening Summary form. Parents may take a copy of this form to their child’s Primary Care Provider to support the request for further evaluation of the child’s vision or hearing.
III. **Review Of Instructions For Infants & Toddlers Up To Two Years Of Age:**

   Every six months, from the date of initial 45-day screening, the staff and parents will review and update the Postnatal History section of the Medical/Family History Review Supplement for Vision and Hearing Concerns and the Developmental Skills Checklist II. If a child’s original vision screening was done using the Infant Vision Development Checklist and the child is now 12 months old or older, staff will arrange for the child to have a SPOT Vision Screening. Results from these instruments along with parent/staff observations and other pertinent prenatal, health, developmental, and/or nutrition information is to be recorded on a new Screenings Summary form and the appropriate copies given to the Health Specialist.
**LOWER COLUMBIA COLLEGE EARLY HEAD START**

**Screenings Summary Form**

Child’s Name: ____________________________ Birthdate: ________________

Child & Family Development Specialist: _____________________________ LOC ID# __________

Primary Health Care Provider: ____________________________ Screening Start Date: __________

<table>
<thead>
<tr>
<th>I. Parent/Guardian Interview (Three-Pronged Approach)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The parent/guardian has concerns about the child’s vision and/or hearing at this time:</td>
</tr>
<tr>
<td>□ No  □ Yes  If yes, the concern is related to the child’s:</td>
</tr>
<tr>
<td>□ Vision  □ Hearing  □ Speech/Language (rule out hearing loss)</td>
</tr>
<tr>
<td>Describe the concerns regarding the child’s hearing or vision skills development:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Health History &amp; Screening Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Three-Pronged Approach) note any high-risk factors</td>
</tr>
<tr>
<td>a. Prenatal History</td>
</tr>
<tr>
<td>b. Birth, Health/Nutrition History</td>
</tr>
<tr>
<td>c. ASQ (when age eligible) ASQ SE</td>
</tr>
<tr>
<td>d. Other screening results (e.g. well child visit)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. Observations &amp; Developmental Skills Related to Seeing &amp; Hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Three-Pronged Approach) note any high-risk signs observed</td>
</tr>
</tbody>
</table>

Results of newborn hearing screening or OAE or BAER screening through Primary Health Care Provider, if applicable:

Date: ________________

| □ Pass  □ Rescreen  □ Refer |

<table>
<thead>
<tr>
<th>IV. EHS Spot Vision Screening (Toddler) or Vision Milestones Tool (Infant) &amp; OAE Screening Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: ________________ SPOT or Milestones Tool Results:</td>
</tr>
<tr>
<td>□ Pass  □ Rescreen  □ Refer</td>
</tr>
</tbody>
</table>

Date: ________________ Comments:

Date: ________________ OAE Screening Results: |
| □ Pass  □ Rescreen  □ Refer |

Date: ________________ Comments:

Date: ________________ Comments:

<table>
<thead>
<tr>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ We have no concerns regarding the child’s vision or hearing at this time.</td>
</tr>
<tr>
<td>□ We have identified high risk factors/signs/observations, as noted above for:</td>
</tr>
<tr>
<td>□ Vision  □ Hearing  Note: These concerns and a follow-up plan, will be addressed in Family Partnership Plan.</td>
</tr>
<tr>
<td>□ Referral to child’s Primary Health Care Provider  □ Referral back to specialist</td>
</tr>
</tbody>
</table>

Parent/Guardian Date EHS Staff Member Date

Original: Site File Yellow: Parent Pink: Primary Care Provider Goldenrod: Health Specialist (C: 06/10; R: 10/17)
Lower Columbia College Early Head Start
Otoacoustic Emission (OAE) Screening Procedure

Objective Screening Method:
Otoacoustic emissions (OAE) screening is an objective screening method that screens hearing in a range of sound frequencies critical for normal speech and language development. The procedure is performed with a portable handheld screening unit. A small probe is placed in the child's ear canal. This probe delivers a low-volume sound stimulus into the ear. The cochlea responds by producing an otoacoustic emission, sometimes described as an “echo,” that travels back through the middle ear to the ear canal and is analyzed by the screening unit. In approximately 30 seconds, the result is displayed on the screening unit as a "pass" or a "refer." Otoacoustic emissions (OAE) screening can help to detect sensorineural hearing loss occurring in the cochlea. It can also call attention to hearing disorders affecting the pathway to the inner ear. Please Note: OAEs are a direct measure of outer hair cell and cochlear function in response to acoustic stimulation and yield an indirect estimate of peripheral hearing sensitivity. OAEs do not technically test an individual's hearing, but rather OAE results reflect the performance of the inner ear mechanics. OAEs are not sensitive to disorders central to the outer hair cells, such as auditory neuropathy spectrum disorder (ANSD), which is a neural hearing loss that leaves cochlear (outer hair cell) function intact.

Mechanics of an OAE Screening:
- Before beginning a screening session, the staff member will check the OAE equipment by conducting a self-screening. The staff member will also have the required forms and procedure as well as the following materials: appropriate sized foam tips for OAE probe, gloves, tissues and alcohol wipes.
- Tones are presented to each ear by placing a tiny sound transmitter/microphone (probe) into the child's ear canal.
- The child does not need to make a behavioral response to the sound.
- Child cannot have anything (including a bottle or pacifier) in her mouth during screening.
- The screening is painless and goes more quickly when the child is sitting quietly.
- Screening can be done when the child is sleeping.
- A quiet environment is helpful, but silence is not required.
- Having another adult (parent/guardian or staff member) hold the child on their lap or distracting child with quiet toys, can be helpful to the screener; occupying or re-directing the child’s hands away from the probe in the ear canal can be especially helpful.
- Be prepared to soothe children who may become distressed during the screening.
- It usually takes about 3-5 minutes to conduct each child’s screening.

Visual Inspection and Use of Otoscope:
1. Prior to placing the OAE probe into a child’s ear, the staff member will look at child’s outer ear, determine if an otoscope is appropriate for use (no visible drainage from ear, foreign body, etc.) and then look into child’s ear canal and ear drum. When using the otoscope, the staff member: will not insert the viewing piece very far into the ear canal, will angle the tip
of the viewing piece slightly toward the person’s nose to follow the normal path of the canal, move it gently at different angles to see the ear canal walls and the eardrum and stop at any sign of pain.

2. If there is some type of visible drainage, foreign bodies, impacted cerumen, infection, or a significant malformation which affects the ear canal, the staff member will not place the OAE probe into child’s ear canal. Instead, the staff member will inform the child’s parent/guardian (or Child & Family Development if parent/guardian is not present) of the issue/concern and refer child to their Primary Health Care Provider for an ear exam and possible hearing screening.

3. If child has PE Tube(s) or buttons, the staff member will not proceed with the OAE Screening. Instead, the staff member will check the Program Database and child’s Site file (if appropriate) to determine if ENT records are on file, have been requested and/or need to be requested. The staff member will follow-up with the child’s parent/guardian and/or Child & Family Development Specialist and request records as appropriate.

Conducting Screening:
A screening shall consist of either a passing test or 3 “refers” per ear that are deemed reliable by the tester on the same day. Testing is discontinued on an ear once a passing result is obtained and that ear is recorded as a pass. Testing is repeated on an ear if a “refer” is obtained until either 3 reliable “refer” tests are obtained or the screening is discontinued for another reason (e.g. poor child cooperation). Ears producing 3 “refer” results that are deemed reliable shall be recorded as a “refer”. A test may be deemed unreliable due to extraneous noise, probe placement issues, an uncooperative child, equipment malfunction, etc. Tests deemed unreliable may be repeated and not count toward the screening session results at the discretion of the tester.

1. Conduct an initial screening of both ears on every child (birth to three years of age). Each ear is screened independently; whenever one does not pass, proceed to the next step for that ear.

2. Any ear not passing the initial (1st OAE) screening is screened again (2nd OAE) within approximately 2 weeks of the first screen.

3. If the ear does not pass the 2nd OAE screen, the child will be referred to their Primary Health Care Provider to be evaluated and determine whether there is an outer or middle ear condition (blockage, fluid, structural anomaly, etc.) interfering with accurate completion of the OAE screening. Treatment or monitoring may be needed.

4. Once the child’s Primary Health Care Provider gives medical clearance, indicating that there are no conditions present that would impede an accurate screening, an OAE rescreen (3rd OAE screen) is conducted. (Results of OAE screening or other appropriate audiological evaluation performed by the child’s Primary Health Care Provider or other healthcare provider may be substituted for a 3rd OAE screen.) If the ear does not pass the OAE rescreen, the child will be referred back to their Primary Health Care Provider with a request for consideration of a referral for comprehensive audiological evaluation.
## Lower Columbia College Early Head Start

### SPOT Vision and OAE Hearing Screening Form

LOC ID: ________

**Child’s Name:** ____________________________  **Birthdate:** __________

### HEARING SCREENING

**Had Newborn Hearing Screening?**  
- [ ] Unknown  
- [ ] Not Screened  
- [ ] Passed  
- [ ] Referred

#### Left Ear

**Screener for Initial Screening:**

<table>
<thead>
<tr>
<th>Otoscope Visual Inspection-Okay to screen?</th>
<th>Yes-Perform OAE Screen</th>
<th>Yes-Perform OAE Screen</th>
<th>Yes-Perform OAE Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] No-Refer: Date (<em><strong>/</strong></em>/___)</td>
<td>[ ] No-Refer: Date (<em><strong>/</strong></em>/___)</td>
<td>[ ] No-Refer: Date (<em><strong>/</strong></em>/___)</td>
<td></td>
</tr>
<tr>
<td>_________________</td>
<td>_________________</td>
<td>_________________</td>
<td></td>
</tr>
</tbody>
</table>

If no, refer to health care provider; **conduct OAE screening after medical clearance** if hearing not screened by healthcare provider.

<table>
<thead>
<tr>
<th>1st OAE Date (<em><strong>/</strong></em>/___)</th>
<th>2nd OAE Date (<em><strong>/</strong></em>/___)</th>
<th>3rd OAE Date (<em><strong>/</strong></em>/___)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Can’t test (need 2nd OAE)</td>
<td>[ ] Can’t test</td>
<td>[ ] Can’t test</td>
</tr>
<tr>
<td>[ ] Refer (need 2nd OAE)</td>
<td>[ ] Refer</td>
<td>[ ] Refer</td>
</tr>
<tr>
<td>[ ] Pass _____ Initial</td>
<td>[ ] Pass _____ Initial</td>
<td>[ ] Pass _____ Initial</td>
</tr>
</tbody>
</table>

**Notes:**


#### Right Ear

**Screener for Initial Screening:**

<table>
<thead>
<tr>
<th>Otoscope Visual Inspection-Okay to screen?</th>
<th>Yes-Perform OAE Screen</th>
<th>Yes-Perform OAE Screen</th>
<th>Yes-Perform OAE Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] No-Refer: Date (<em><strong>/</strong></em>/___)</td>
<td>[ ] No-Refer: Date (<em><strong>/</strong></em>/___)</td>
<td>[ ] No-Refer: Date (<em><strong>/</strong></em>/___)</td>
<td></td>
</tr>
<tr>
<td>_________________</td>
<td>_________________</td>
<td>_________________</td>
<td></td>
</tr>
</tbody>
</table>

If no, refer to health care provider; **conduct OAE screening after medical clearance** if hearing not screened by health care provider.

<table>
<thead>
<tr>
<th>1st OAE Date (<em><strong>/</strong></em>/___)</th>
<th>2nd OAE Date (<em><strong>/</strong></em>/___)</th>
<th>3rd OAE Date (<em><strong>/</strong></em>/___)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Can’t test (need 2nd OAE)</td>
<td>[ ] Can’t test</td>
<td>[ ] Can’t test</td>
</tr>
<tr>
<td>[ ] Refer (need 2nd OAE)</td>
<td>[ ] Refer</td>
<td>[ ] Refer</td>
</tr>
<tr>
<td>[ ] Pass _____ Initial</td>
<td>[ ] Pass _____ Initial</td>
<td>[ ] Pass _____ Initial</td>
</tr>
</tbody>
</table>

**Notes:**


### VISION SCREENING:  

**Date:** __________

- [ ] Pass  
- [ ] Unscreenable  
- [ ] Referral  
- [ ] Referral letter to Parent: ____________________

**OR Infant, CFDS to use paper tool**  
- [ ] Date of First Birthday: __________

**Notes:**


---

*Copy – After Each Screening Attempt / Completion to: Health Coordinator  
Copy – After Each Screening Attempt / Completed to: Area Manager  
Original Site File – After Completion of All Screening Attempts and/or Screenings*  

(C: 07/17; R: 06/18)
I. **Intake Staff Member Activities:**
1. The Intake Staff member reviews each child's Washington State Certificate of Immunization (CIS) form to determine the child's immunization status and whether or not the child needs a completed Immunization Agreement (and possibly a COE) on file.
2. The parent/guardian and Intake Staff member complete an Immunization Agreement. Immunizations needed (out of compliance and conditional) are noted directly from the Immunization form. However, numbers needed are not noted on this form. (Example: 3 DTP's and 2 OPV's are needed; the Immunization Agreement will simply state DTP and OPV.)
3. The Intake Staff member distributes the copies of the Immunization Agreement: Original: Site File, Copy: Health Specialist, Copy: Parent/Guardian.
   *The Health Coordinator or Health Specialist will enter the Immunization Agreement date and other applicable information in the immunization notes on the database.*
4. The Intake Staff member gives the parent/guardian a Washington State Certificate of Exemption (COE) to take to their child's Primary Health Care Provider to begin the discussion of whether the child will receive the needed immunization(s) and/or if the COE will be completed.
5. The Intake Staff member asks the parent/guardian to bring in a record of the needed immunizations (at least the first or next ones needed in a series) or a COE completed by their child’s Primary Health Care Provider or both if applicable.

II. **Health Coordinator Activities:**
1. The Health Coordinator and/or Health Specialist reviews the copies of the Washington State Certificate of Immunization (CIS) form and the Immunization Agreement.
2. The child's immunization status, as determined by the Intake Staff member, is verified or revised and this information is entered on the Student Health Database. (*Revisions will be noted on the Immunization Agreement.*) Due dates for children with Conditional Immunization Status are also entered on the database and noted on the Health Specialist's Immunization Agreement copy. As with all data based health documentation, the copies are returned to the child's Site File.

III. **DST/EHS Staff Follow-Up:**
1. If a child has **Out of Compliance Immunization Status**, documentation to gain Current Status, Conditional Status or a Certificate of Exemption must be on file prior to the finalization of enrollment or approval by the Health Specialist given and databased.
2. If a child has **Conditional Immunization Status**, the Intake Staff member will have established a due date for receiving the needed immunization(s). If a child misses this due date, the child will have one month (30 calendar days) from the due date to turn-in the necessary documentation.
3. If it is determined that a child is not to receive an immunization noted on their Immunization Agreement, for medical reasons, **the parent/guardian must complete, with their child’s Primary Health Care Provider, a Washington State Certificate of Exemption form.**
4. If the above guidelines are not followed, the DST/EHS Staff is to contact their supervisor to discuss and problem-solve a resolution. Based upon the decision made, with the supervisor, the parent/guardian can be given a new deadline (7 days or less).
LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Immunization Agreement

Date: _______________________

Child's Name: ___________________________ Date of Birth: ________________

Parent/Guardian Name: ___________________________

I am aware of the state regulation that my child be fully immunized. I am also aware that a Washington State Certificate of Immunization must be on file before my child may attend this program.

In order for my child to continue attending this program, the following immunizations need to be administered or Washington State Certificate of Exemption must be completed and turned in:

(* I acknowledge that the Health Specialist may determine that additional immunizations are needed.)

If a child has Conditional Immunization Status, the Health Specialist will establish a due date for receiving the needed immunization(s). If a child misses this due date, the child will have one month from the due date to turn-in the necessary documentation.

Immunization documentation must state the immunization(s) given, the date of administration and be signed or initialed by a Health Care Provider. (*If it is determined that your child is not to receive an immunization, for medical reasons, the parent/guardian must complete, with their child’s Primary Health Care Provider, a Washington State Certificate of Exemption form.)

________________________________________  __________________________  ______________
Signature          Relationship          Date
Acuerdo de Inmunizaciones

Fecha: __________________________

Nombre del niño: ___________________ Fecha de Nacimiento: ___________________

Nombre del Padre/Tutor: _______________________________________________________

Estoy consciente del Reglamento del Estado acerca de que mi niño debe contar con todas las vacunas. También estoy consciente de que un Certificado de Vacunación del Estado de Washington deberá estar archivado en el expediente de mi niño antes de que él pueda asistir al programa.

Para que mi niño pueda continuar asistiendo al programa, necesita recibir las siguientes vacunas o deberá completar y entregar un Certificado de Exención del Estado de Washington para las siguientes:

(Estoy de acuerdo en que la Especialista de Salud podría determinar que son necesarias otras vacunas adicionales).

Si un niño tiene Situación de Inmunización Condicional, la Especialista de Salud establecerá una fecha límite para recibir las vacunas necesarias. Si el niño no recibe las vacunas en la fecha acordada, el niño contará con un mes a partir de la fecha límite para entregar la documentación necesaria.

La documentación de las vacunas tiene que indicar cuáles fueron administradas, la fecha de administración y debe estar firmada o con las iniciales doctor. (*Si se determina que su niño por razones medicas no puede recibir una vacuna, el padre/tutor deberá llenar con el Proveedor de Cuidados de la Salud del niño, un Certificado de Exención del Estado de Washington)

<table>
<thead>
<tr>
<th>Firma</th>
<th>Relación con el niño</th>
<th>Fecha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original – Site File</td>
<td>Copy to Parent</td>
<td>Copy to Health Specialist</td>
</tr>
</tbody>
</table>
Lower Columbia College Head Start/EHS/ECEAP
Immunization Records Requirements

Per the Washington State Administration Code (WAC) 246-105-050: The required documentation of immunization status, to be on file, before a child attends LCC Head Start/EHS/ECEAP is a Washington Certificate of Immunization Status (CIS) and/or a Washington State Certificate of Exemption (COE). (As outlined in section III below, a letter from the health care provider can be used in place of the health care practitioner statement on the COE but the parent/guardian portion of the COE must still be completed.)

I. A CIS form must include:
   - Name of child;
   - Birth date;
   - Type of vaccine(s) administered;
   - Month, day, and year of each dose of vaccine received;
   - The CIS is to have least one immunization date on the form.
   - A check mark in the appropriate section indicating whether or not a COE form accompanies the CIS form;
   - As appropriate, completion of the section to document serologic proof of immunity signed by a health care provider and including a copy of a lab report (i.e. Varicella, etc.);
   - Parent/guardian signature and date.

II. A COE form must include:
   - Name of child;
   - Birth date;
   - Indication by parent/guardian of the type of exemption being claimed: a medical, religious, personal, or philosophical exemption. This must include:
     - The appropriate statement, on the COE, signed and dated by a health care practitioner stating that he or she has provided the parent information about the benefits and risks of immunization to the child as a condition of obtaining a medical, religious, personal, or philosophical exemption. (This health care practitioner section (statement) is not required if the parent/guardian demonstrates a religious membership.)
     - Indicate if any permanent or temporary medical exemption for one or more vaccines which must be signed and dated by a health care practitioner;
     - Indicate if any personal or philosophical exemption for one or more vaccines;
     - Indicate if any religious exemption for one or more vaccines; and
     - If religious membership exemption, indicate religious membership. This must include the parent/guardian identifying the name of the church or religious body, affirming membership in it, and affirming that the religious beliefs or teachings of the church or religious body preclude a health care practitioner from providing medical treatment to the child;
     - Staff must review the notice on the COE with parent/guardian that if an outbreak of vaccine-preventable disease for which the child is exempted occurs, the child may be excluded from program for the duration of the outbreak; and
     - Parent/guardian signature and date.

III. Additional Information Regarding Immunization Exemptions:
A parent/guardian who must include a signed statement from a health care practitioner in order to fulfill exemption requirements may:
   - Provide a photocopy of the signed COE in place of the original; or

(C: 08/18)
Along with the COE form, may provide a letter from the health care practitioner in place of the signed statement on the COE form. The letter must:

- Indicate that the health care practitioner has provided the parent/guardian information about the benefits and risks of immunization to the child;
- Reference the child's name; and
- Be signed and dated by the health care practitioner.

IV. **Guidance on Temporary Medical Exemption:**
If immunizations are deferred on a temporary basis for medical reasons, the child must make satisfactory progress toward full immunization once the medical exemption has expired.

*A staff member needing guidance on enrolling a child, after an Intake Appointment, who has no immunization records to enter onto a CIS or a completed COE, is to contact the ERSEA Program Support Supervisor and/or the Health Specialist.*
### Lower Columbia College Head Start
#### Caries Risk Assessment

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>Discussion</th>
<th>Educational Resource</th>
<th>Comments/Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child complain of tooth pain?</td>
<td></td>
<td>Toth pain may indicate serious dental caries.</td>
<td>Community Dental Providers List, <em>Taking Care of Your Child’s Baby Teeth</em></td>
<td></td>
</tr>
<tr>
<td>Has your child seen the dentist in the last 6 months?</td>
<td></td>
<td>Childhood cavities are fast moving, therefore, children should see the dentist every 6 months.</td>
<td>“Tooth Tips for Dental Trips” sheet</td>
<td></td>
</tr>
<tr>
<td>Do you feel your child needs to see a dentist soon?</td>
<td></td>
<td>Baby teeth are important to a child’s early physical, social and emotional development.</td>
<td><em>Taking Care of Your Child’s Baby Teeth. What causes tooth decay?</em></td>
<td></td>
</tr>
<tr>
<td>Does your family drink fluoridated water, or do your children take fluoride supplements?</td>
<td></td>
<td>Children drinking non-fluoridated water should begin fluoride supplements at the age of six months.</td>
<td><em>Taking Care of Your Child’s Baby Teeth: How do you prevent tooth decay?</em></td>
<td></td>
</tr>
<tr>
<td>Does your child use toothpaste with fluoride?</td>
<td></td>
<td>Children should use a rice size amount of toothpaste and should be supervised while brushing.</td>
<td><em>Taking Care of Your Child’s Baby Teeth: Brushing</em></td>
<td></td>
</tr>
<tr>
<td>Do you help your children under eight with tooth brushing?</td>
<td></td>
<td>Caregiver should assist children less than eight years with tooth brushing.</td>
<td><em>Taking Care of Your Child’s Baby Teeth: To Keep Teeth Healthy</em></td>
<td></td>
</tr>
<tr>
<td>Does your child take a bottle to bed filled with something other than water?</td>
<td></td>
<td>Child at risk of Baby Bottle Tooth Decay (BBTD). Offer alternative behaviors.</td>
<td><em>Taking Care of Your Child’s Baby Teeth: To Keep Teeth Healthy</em></td>
<td></td>
</tr>
<tr>
<td>How often does your child snack and/or have juice between meals each day?</td>
<td></td>
<td>Nutritional Counseling</td>
<td><em>Taking Care of Your Child’s Baby Teeth: How do you prevent tooth decay?</em></td>
<td></td>
</tr>
</tbody>
</table>

**Score:**

**Parent Name:**

**Phone #:**

**RDH Contact:**

**Staff Member:** If any of your client’s responses fell in the shaded area, the child may be at risk for Early Childhood Caries and should be referred to a dental professional. If the score is 5 or more, the risk is high and the child should have immediate referral.

**Dentist:**

**Or None**

**Last Date Seen:**

**Services Provided:** (circle)

- Exam
- Cleaning/Fluoride
- Fillings/Treatment

**Dental Insurance:**

(circle) HEAD Start or ECEAP

(C: 05/06; R: 05/16)
Lower Columbia College Head Start/EHS/ECEAP
Dental Screening / Evaluación Dental

Name/Nombre: ___________________________ Loc ID: _______
Last/Apellido First/Nombre MI
Date/Fecha: ________________ Student/Estudiante M or/o F
DOB/Fecha de Nacimiento: ___________________

Findings today indicate that your child/Los resultados de hoy indican que su niño:
_____ Needs immediate care by a dentist within 24 hours. Necesita cuidado dental urgente en 24 horas.
_____ Needs care by a dentist as soon as possible, if an appointment is not already scheduled. Necesita cuidado dental lo más pronto posible, si no tiene una cita programada.
_____ Needs routine dental care, at the next regularly scheduled appointment. Necesita cuidado dental de rutina, en su próxima visita.

Provider Signature: ___________________________ Date/Fecha: __________
Firma del Proveedor: Dental Hygienist

You may contact your Family Advocate if you need assistance with getting a dental appointment or have questions. Thank you. Si necesita ayuda para obtener una cita dental o si tiene preguntas hable con su Trabajadora Social. Gracias.

For Examiner Use/Para Uso de la Examinador

1. Early Childhood Caries ________
   0 = none
   Yes = enter # of front teeth

2. White Spots: Y or N
   Pre-decay

3. Untreated Decay: Y or N ________

4. Treated Decay History: Y or N
   DMF (decayed, missing, filled)

5. Rampant Decay History: Y or N
   Rampant ≥7 teeth

6. Treatment Referral: __________
   0 = no obvious problem
   1 = decay noted
   2 = urgent: get care as soon as possible
   3 = emergent; get care within 24 hours

7. Plaque Assessment: __________
   0 = none to minimal
   2 = severe amount
   1 = moderate amount

8. _____ Child would not allow visual exam.

Comments/Comentarios: ____________________________________________
Lower Columbia College Head Start  
Prenatal Dental History Questionnaire

Name: ___________________________ Today’s Date: ____________________

Name of OB/GYN: ___________________________ Due Date: ________________

Start of Care: ____________  Are you going regularly?  Yes  No

Do you have any medical conditions we should know about?  Yes  No

Dental History:

1. What is your main concern? ____________________________

2. Are you in pain?  Yes  No

3. Do you have a dentist?  Yes  No

4. If so, who is your dentist? ____________________________

5. When were you last seen by a dentist? ____________________________

6. What were you seen for? ____________________________

7. When did you last have X-Rays? ____________________________

8. Topical Fluoride Treatment in Last 6 mos.  Yes  No

9. Do you have dental insurance?  Yes  No

   If yes, what kind of insurance? ____________________________

10. Do you have Medicaid coverage?  Yes  No

    If yes, is it (Circle) CNP  Healthy Options  Family Planning

Mouth Care:

1. How often do you brush your teeth? ____________________________

2. How often do you floss your teeth? ____________________________

3. Do you use fluoride toothpaste?  Yes  No

4. Do you drink tap water or bottled water?  Tap  Bottled

5. Do you smoke cigarettes?  Yes  No

6. Do you regularly consume any of the following BETWEEN meals?

   Breath Mint/Chewing Gum  Sugared Liquids/ Juice /Carbonated Drinks
   Dried Fruits  Cookies/Crackers  Other ____________________________

7. How likely do you think you are to have cavities or other dental problems?

   Very likely  Likely  Not likely

8. How important is it for you to prevent cavities, gum problems or other diseases of the mouth?

   Very important  Somewhat important  Not important

Comments:

(C: 05/06; R: 09/11)
**LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP**

**Prenatal Dental Services Form**

Name ____________________________________________  Birthdate _______________________

**EXAMINATION AND TREATMENT RECORD:** (List services provided in order.)  

<table>
<thead>
<tr>
<th>Description of Work Completed</th>
<th>Date Service Performed</th>
<th>Actual Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**PREVENTIVE DENTAL CARE TO BE COMPLETED INCLUDES:**

- □ Cleaning  
- □ Fluoride  

Approximate number of visits needed ____________

**ORAL HEALTH SUMMARY:**

All planned treatment _____ is _____ is not complete.

<table>
<thead>
<tr>
<th>Description of Work Needed and NOT Completed</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Approximate number of visits needed ____________  Approximate Cost ____________

**DENTAL HEATLH RECOMMENDATIONS AND/OR CONCERNS:**

- □ Routine recall visits  
- □ Special home emphasis on oral hygiene  
- □ Periodontal Maintenance  
- □ Rampant Decay  
- □ Dietary Problem(s)  
- □ Harmful oral habits

Other concerns: ____________________________________________________________

________________________________________________________

Source of payment ____________________________________________

**Dentist or Dental Office Name (Please Print)**  

**PLEASE RETURN TO:**

LCC HEAD START/EHS/ECEAP  
P.O. Box 3010  
Longview, WA  98632-0310  
(360) 442-2800  
FAX: (360) 442-2819

**Signature of Dentist or Office Staff**

**Date**

Benefits of LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP are available to all children without regard to race, color, national origin, or handicapping condition.
All About My Day

Name: __________________________
Date: __________________________

I napped at ______________________
I last ate at _____________________
At school we ____________________

I really enjoyed playing with ______________

My mood today ___________________

I ate: ____________________ at __________
____________________ at __________
____________________ at __________
____________________ at __________
____________________ at __________

My Diaper was: ________________ at __________
____________________ at __________
____________________ at __________
____________________ at __________
____________________ at __________
____________________ at __________

Nap: ____________________ to __________
____________________ to __________
____________________ to __________

Gums/Teeth Cleaned/Brushed at: ______________

Please bring me: Diapers Change of Clothes
Formula

Distribution: White – Site File Yellow - Parent
(C: 04/10)
LOWER COLUMBIA COLLEGE EARLY HEAD START
Home Safety Checklist

Name ___________________________________________ Date ____________________________ Loc ID ________________

Home Safety Checklist

Yes          No

___ ___ I keep cleaning products, pesticides, medicine, liquor, matches, and lighters out of the reach of children.

___ ___ I have a list of emergency telephone numbers near my phone.

___ ___ I know the temperature of my hot water where I live.

___ ___ My child does not play with objects that are small enough to fit through a paper towel roll.

___ ___ Furniture and large toys are placed away from walkways.

___ ___ Dangerously placed lamps and electrical cords are removed.

___ ___ Outlets are covered with sliding safety plates, plastic plugs or heavy furniture.

___ ___ Electrical cords are out of reach or in cord keepers.

___ ___ Safety latches and locks are on cabinets and drawers in kitchens, bathrooms, and elsewhere.

___ ___ Fans and air conditioners are out of reach.

Plastic wrappers, plastic bags and balloons are kept from your children.

Rooms are checked for potential choking hazards like toys, decorations, and foods.

I check my child’s toys for safety hazards.

Spring-loaded lid-support devices are on toy chest lids. These prevent a lid from falling on a child’s neck or from closing and trapping a child inside.

Climbing equipment is placed outside on mats, mulch, or sand to prevent dangerous falls.

My child does not wear a pacifier or jewelry around his or her neck.

Does anyone in your home ever smoke?

I have a plan of escape from my home in the event of a fire.

I have working smoke alarms in my home.

I know how to test and replace a smoke detector battery.

I do not ever drink or carry hot liquids when holding my baby.

Paint is not chipping or peeling off the walls or woodwork.

My babysitter is older than 13 and mature enough to handle common emergencies.

I know how to prevent my child from choking.

Guns are unloaded and locked up in my home and the homes of frequently visited friends or relatives. Ammunition is stored separately from guns.

Bookshelves, dressers, TVs and other heavy furniture is bolted or anchored to a wall.

Bedroom/Sleeping

Yes          No

___ ___ My infant/toddler sleeps alone in a crib or bassinette.

___ ___ My infant does not sleep in his or her crib with toys, stuffed animals or pillows.

___ ___ My infant is always placed on his or her back to sleep.

___ ___ I do not have a drop side crib.

___ ___ My baby’s crib is not near a window or curtain/blinds.
### Windows and Doors

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

- Loops are cut on window blind cords or blind cord safety kits installed.
- Windows are securely closed and screens in good shape.
- I have safety measures so my child cannot fall out if windows are opened.

### Bathroom

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Non-slip mat or strips are in tub or shower.
- Items like razors and shampoo are stored out of reach (not left on edge of tub).
- Children are always watched while in tub or bath seat.
- I use safety precautions when using electrical appliances in the bathroom.

### Kitchen and Laundry

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Pot handles are always turned away from stove edges.
- Grease, water, and bits of food are wiped up immediately if spilled.
- Knives/sharp objects are out of reach.
- Trash cans are out of reach or covered.
- Safety latches and locks are on low kitchen cabinets.

### Cars

<table>
<thead>
<tr>
<th>Yes</th>
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- My family has and uses car seats and booster seats. I never leave my child unattended in an automobile.

### Basement, Garage, Attic and Storage Areas

<table>
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- Yard tools and other power tools are put away after use.
- Garage door openers are kept out of reach.
- Oily rags and other flammable trash are discarded.
- Stairs are kept clear of tripping hazards.

### What are your safety concerns?

My family’s home safety action plan is: