



Keeping Children Safe at Child Care

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In Iowa, 75 percent of families with working parents have children under the age of six in child care. Many of these children spend up to 10 hours per day in care and families rely on child care providers for keeping their children healthy and safe.

On November 19, 2014, the Child Care and Development Block Grant (CCDBG) Act was signed into federal law. This law:

- Reauthorized the Child Care and Development Fund program for the first time since 1996;
- Represented a historic re-envisioning of the program;
- Included health and safety training requirements (new for Iowa child care providers);
- Increased quality spending; and
- Included a provision for improving access for underserved populations (including children with special needs and food allergies).

In 2016, states were required to initiate the health and safety training requirements. The Iowa Department of Public Health, in partnership with Iowa State University Extension and Outreach, developed for the Iowa Department of Human Services the “Essentials” Health and Safety Series. In the past year approximately 20,000 Iowa child care providers have received 12 hours of “Essentials” training on the following topics:

1. Safety in the Child Care Environment
2. Emergency Preparedness
3. Transportation in Child Care
4. Prevention and Control of Infectious Disease
5. Handling and Storage of Hazardous Materials
6. Medication in Child Care
7. Managing Food Allergies
8. Safe Sleep
9. Prevention of Shaken Baby Syndrome
10. Understanding Cultural Diversity
11. Understanding Homelessness
12. Child Development

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Keeping Children Safe at Child Care

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Exclusion from Child Care Due to Illness

Due in part to this training, Iowa child care providers have gained knowledge in controlling the spread of infectious diseases through effective exclusion policies. Understanding the American Academy of Pediatrics (AAP) child care exclusion recommendations is helpful for both child care providers and health care providers.

As a rule, a child should be temporarily excluded from child care when the child's illness causes one or more of the following:

- The illness prevents the child from participating comfortably in activities;
- The need for care is greater than the staff can provide without compromising the health and safety of other children;
- The child has an acute change in behavior: lethargy, lack of responsiveness, irritability, persistent crying, difficult breathing, or a quickly spreading rash;
- The child has a fever with behavior change or other signs and symptoms: sore throat, rash, vomiting, diarrhea, etc., in children older than two months of age; and
- For infants younger than two months of age, a fever with or without a behavior change or other signs and symptoms.

AAP recently changed the definition of fever:

- For an infant or child older than two months, a fever is a temperature that is above 101 degrees F [38.3 degrees C] by any method;
- For infants younger than two months of age, a fever is a temperature above 100.4 degrees F [38 degrees C] by any method;
- Temperature readings do not require adjustment for the location where the temperature is taken. Caregivers should document the location of the reading.

***Note:** Any infant younger than two months with an unexplained fever should get medical attention within an hour.

For additional exclusion criteria see pages 5-6, or go to Healthy Child Care Iowa's *Common Child Care Illnesses and Exclusion Criteria* at: https://idph.iowa.gov/Portals/1/userfiles/128/Common%20Child%20Care%20Illnesses%20and%20Exclusion%20Criteria_5_2017.pdf

Food Allergies

- Food allergy affects 8 percent of children in the United States, and food allergies are the leading cause of anaphylaxis—a life-threatening allergic reaction that affects the entire body.
- Many foods can produce an allergic reaction from mild to severe.
- Forty percent of children with a food allergy have experienced a severe allergic reaction.
- Twenty-five percent of first-time anaphylactic reactions occur at child care/school.

The eight most common foods associated with food allergy include:

- | | |
|---------------|--------------|
| 1. Cow's Milk | 5. Soy |
| 2. Egg | 6. Wheat |
| 3. Peanut | 7. Fish |
| 4. Tree nut | 8. Shellfish |

The Americans with Disabilities Act (ADA) recognizes severe food allergies as a disability. Child care providers must be prepared to care for children with food allergies and manage allergic reactions, including anaphylaxis. Safe medication administration is important to ensure high-quality care and compliance with ADA law.

There are two forms that a health care provider may be asked to complete (and sign) for a child who has food allergies: *Food Allergy and Anaphylaxis Emergency Care Plan* and *Diet Modification Request Form*, if the child care program participates in the Child and Adult Care Food Program.





Food Allergy and Anaphylaxis Emergency Care Plan

The Food Allergy and Anaphylaxis Emergency Care Plan provides information about what to do in the event of a reaction or emergency. The plan includes the child's food allergy diagnosis, symptoms, triggers, medication to be given, including epinephrine, parent/physician notification, and emergency care.

Diet Modification Request Form

The Diet Modification Request Form includes special dietary needs/allergies and food substitutions allowed (e.g., soy milk instead of dairy milk).

Food Allergy and Anaphylaxis Emergency Care Plan available at:

<https://idph.iowa.gov/Portals/1/userfiles/128/Food%20Allergy%20Action%20Plan.pdf> (English)

<https://idph.iowa.gov/Portals/1/userfiles/128/Food%20Allergy%20Action%20Plan%20Spanish.pdf> (Spanish)

Diet Modification Request Form available at:

https://idph.iowa.gov/Portals/1/userfiles/128/Diet%20Modification%20Request%20Form%202018_v2.pdf

Iowa Child Care Nurse Consultants (CCNCs) are available to assist with care planning to assure a child's needs are met while in care. CCNCs also are available for child care staff training on a child's special needs care plan (i.e., Food Allergy Care Plan, Asthma Action Plan, Seizure Action Plan, Diabetic Care Plan, etc.). To find your local CCNC go to: www.idph.iowa.gov/hcci/consultants

For more information or specific questions regarding Iowa child care health requirements go to Healthy Child Care Iowa, www.idph.iowa.gov/hcci, or email Heidi Hotvedt, RN, HCCI Coordinator at: heidi.hotvedt@idph.iowa.gov, or call: (515) 321-8137.



References:

1. Child Care Resource & Referral (CCR&R) State of Iowa Annual Report 2017 <https://iowaccrr.org/resources/files/Data/FY17/FY17%20Annual%20Report.pdf>
2. American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education, 2011. *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs*. 3rd edition. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association. Also available at: <http://nrckids.org>
3. Food Allergy Research and Education (FARE) www.foodallergy.org/

Introducing Peanuts to Infants

Ana Cary, MD, FAAP, Stead Family Department of Pediatrics, University of Iowa Stead Family Children's Hospital

The American Academy of Pediatrics (AAP) has endorsed guidelines and is now recommending early introduction of peanut protein to infants at increased risk of developing a peanut allergy. There are various ways of safely introducing an infant to peanuts. It is recommended that if an infant is classified as having either severe eczema or an egg allergy that a serum level of peanut specific IgE be obtained, or the infant should be referred to an allergist prior to introducing peanut-containing foods. If sIgE for peanut is obtained and the level is ≥ 0.35 kU/L, this patient should continue to refrain from peanut introduction until evaluated by an allergist. If the infant does not have severe eczema, an egg allergy, or sIgE for peanut returns ≤ 0.35 kU/L, it is recommended to initiate peanut-containing foods. Severe eczema is defined as persistent or frequently

Guidelines for Early Introduction of Peanut Protein to Infants

Addendum guideline	Infant criteria	Recommendations	Earliest age of peanut introduction
1	Severe eczema, egg allergy, or both	Strongly consider evaluation by sIgE measurement and/or SPT and, if necessary, an OFC. Based on test results, introduce peanut-containing foods.	4-6 months
2	Mild-to-moderate eczema	Introduce peanut-containing foods	Around 6 months
3	No eczema or any food allergy	Introduce peanut-containing foods	Age appropriate and in accordance with family preferences and cultural practices

recurring eczema requiring frequent need for prescription-strength topical corticosteroids, calcineurin inhibitors, or other anti-inflammatory agents despite appropriate use of emollients. Remember that obtaining a food allergy panel for other foods besides peanuts is not recommended due to the poor positive predictive value of this test.^{1, 2, 3}

Starting Peanut Foods³

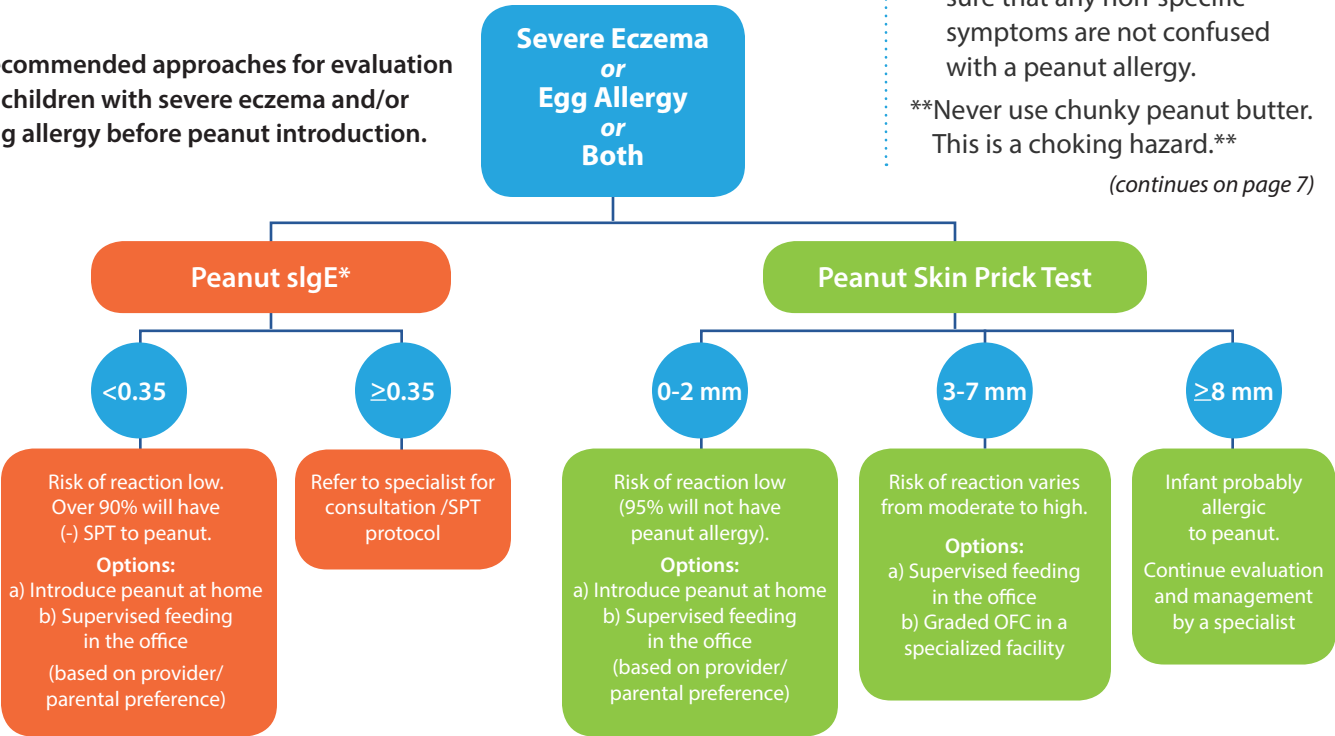
First remember to recommend to parents to continue breastfeeding or formula feeding as appropriate for the infant's age.

- Peanut foods should be offered only after other solid foods have been introduced to ensure the infant is developmentally ready for solids and to make sure that any non-specific symptoms are not confused with a peanut allergy.

****Never use chunky peanut butter. This is a choking hazard.****

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Recommended approaches for evaluation of children with severe eczema and/or egg allergy before peanut introduction.



*To minimize a delay in peanut introduction for children who may test negative, testing for peanut-specific IgE may be the preferred initial approach in certain health settings. Food allergen panel testing or the addition of sIgE testing for foods other than peanut is not recommended due to poor positive predictive value.



Common Child Care Illnesses and Exclusion Criteria

*A child should be temporarily excluded from care when the child's illness causes one or more of the following:

- Prevents the child from participating comfortably in activities.
- A need for care that is greater than the staff can provide without compromising the health and safety of other children.
- An acute change in behavior: lethargy, lack of responsiveness, irritability, persistent crying, difficult breathing, or a quickly spreading rash.
- Fever and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea) in infants older than 2 months of age.
- For infants younger than 2 months of age, a fever with or without a behavior change or other signs and symptoms.
- **Any infant younger than 2 months with an unexplained fever should get medical attention within an hour.**

A fever is defined as:

- For an infant or child older than 2 months, a fever is a temperature that is above 101 degrees F [38.3 degrees C] by any method.
- For infants younger than 2 months of age a fever is a temperature above 100.4 degrees F [38 degrees C] by any method.
- Temperature readings do not require adjustment for the location where the temperature is taken.

ILLNESS	EXCLUDE*	RETURN TO CHILD CARE
Chicken Pox	Yes.	When all blisters are crusted with no oozing (usually 6 days) and resolution of exclusion criteria.
Diarrhea (infectious)	Yes (there are special exclusion rules for E.coli 0157.H7, Shigella and cryptosporidiosis).	When diarrhea stops and health care provider or public health official states the child may return.
Diarrhea (non-infectious)	Yes, if stool can not be contained in the diaper, or if toiletied child has 2 or more loose stools in 24 hours, or blood in stool.	When diarrhea stops and resolution of exclusion criteria.
Fifth Disease	No. Unless child meets other exclusion criteria.*	If excluded due to presence of other exclusion criteria, resolution of exclusion criteria.
Hand Foot and Mouth Disease	No. Unless child meets other exclusion criteria.* Or is excessively drooling with mouth sores.	If excluded due to presence of other exclusion criteria, resolution of exclusion
Head Lice (Pediculosis)	No. Unless child meets other exclusion criteria.*	Treatment of an active lice infestation may be delayed until the end of the day. Children do not need to miss school or child care due to head lice. The Iowa Department of Public Health & Healthy Child Care Iowa recommend a 14 day treatment protocol .
Impetigo	Yes, exclude at the end of the day if blisters can be covered.	After child has been seen by the doctor, after 24 hours on antibiotic, and blisters are covered.
Influenza	Yes.	When child is fever free for 24 hours and resolution of exclusion criteria.



Molluscum Contagiosum	No. Unless child meets other exclusion criteria.*	Skin disease similar to warts. Do not share towels or clothing and use good hand hygiene.
MRSA	No. Unless child meets other exclusion criteria.*	Wounds should be kept covered and gloves worn during bandage changes. Do not share towels or clothing and use good hand hygiene.
Otitis Media (ear infection)	No. Unless child meets other exclusion criteria.*	If excluded due to presence of other exclusion criteria, resolution of exclusion criteria.
Pertussis (Whooping Cough)	Yes.	Child may return after 5 days of antibiotics and resolution of exclusion criteria.
Pink Eye (Conjunctivitis)	No. Unless child meets other exclusion criteria.*	Child does not need to be excluded unless health care provider or public health official recommends exclusion. Resolution of all exclusion criteria.
Ringworm	No. Unless child meets other exclusion criteria.*	Treatment of ringworm infection may be delayed to the end of the day. Child may be readmitted after treatment has begun. Cover lesion(s) if possible. Do not share clothing, bedding or personal items.
Strep Throat	Yes.	When resolution of exclusion criteria and after 24 hours of antibiotic.
Vomiting	Yes.	When vomiting has resolved and resolution of exclusion criteria.

Please refer to [Caring for Our Children: National Health and Safety Performance Standards \(third edition\)](#) or the [Iowa Department of Public Health EPI Manual](#) for guidance on specific diseases not included in this list. Contact your local [Child Care Nurse Consultant](#) for additional information.

References: American Academy Of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. 2011. *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs. 3rd edition.* Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association. Also available at <http://nrckids.org>.

Center for Acute Disease Epidemiology. Guide to Surveillance, Investigation, and Reporting. Iowa Department of Public Health, January, 2014

Iowa Department of Public Health Head Lice brochure, updated 09062016 http://www.idph.iowa.gov/Portals/1/userfiles/128/UPDATED_LiceBrochure_962016%20english.pdf

5/2017

TABLE S-I. Typical peanut-containing foods, their peanut protein content, and feeding tips for infants

	Bamba	Peanut butter	Peanuts	Peanut flour or peanut butter powder
Amount containing approximately 2 g of peanut protein	A. 17 g B. $\frac{2}{3}$ of a 28-g (1-oz) bag C. 21 sticks	A. 9-10 g B. 2 teaspoons	A. 8 g B. 10 whole peanuts (2½ teaspoons of grounded peanuts)	A. 4 g B. 2 teaspoons
Typical serving size	1 bag (28 g)	Spread on a slice of bread or toast (16 g)	2½ teaspoons of ground peanuts (8 g)	No typical serving size
Peanut protein per typical	3.2 g	3.4 g	2.1 g	No typical serving size
Feeding tips	For a smooth texture, mix with warm water (then let cool) or breast milk or infant formula and mash well. Pureed or mashed fruit or vegetables can be added. Older children can be offered sticks of Bamba.	For a smooth texture, mix with warm water (then let cool) or breast milk or infant formula and mash well. For older children, mix with pureed or mashed fruit or vegetable or any suitable family foods, such as yogurt or mashed potatoes.	Use blender to make a powder or paste. 2-2 ½ teaspoons of ground peanuts can be added to a portion of yogurt or pureed fruit or savory meal.	Mix with yogurt or apple sauce.

Notes: Bamba (Osem, Israel) is named because it was the product used in the LEAP trial and therefore has known peanut protein content and proven efficacy and safety. Other peanut puff products with similar peanut protein content can be substituted for Bamba.

Reference: [http://www.jacionline.org/article/S0091-6749\(16\)31222-2/fulltext](http://www.jacionline.org/article/S0091-6749(16)31222-2/fulltext)



How Much Peanut to Offer

- The infant should be offered 6-7 grams of peanut protein per week divided over three or more feedings.
- Two grams of peanut protein is equivalent to:
 - 2 teaspoons (10 mL) of smooth peanut butter (9-10 grams);
 - 10 whole peanuts ground into fine powder/paste (8 grams of peanuts or 2.5 teaspoons of ground peanuts);
 - 2 teaspoons of peanut flour or peanut butter flour; or
 - 21 sticks of Bamba (peanut product made in Israel, readily available at retail sites such as Amazon).

Peanut Recipes for Parents to Consider

- Thinned, smooth peanut butter - Made by mixing 2 level teaspoons of smooth (not chunky) peanut butter with 2-3 teaspoons of hot water. Mix this until dissolved and thin. The consistency can be changed to match consistencies previously tolerated by the infant. Make this thinner by adding more water or thicker by adding a thicker pureed food the infant has previously tolerated. Allow it to cool and then serve.

- Smooth peanut butter puree (Remember, never use chunky peanut butter.) - Mix 2 level teaspoons of smooth peanut butter with 2-3 tablespoons (60-90 mL) of a previously tolerated pureed fruit or vegetable. Mix well. Make thinner or thicker by adding more or less pureed fruit/vegetable.
- Peanut flour or peanut butter powder - Measure 2 level teaspoons of peanut flour or peanut butter powder with 2 tablespoons (60 mL) of a previously tolerated pureed fruit or vegetable. Mix well. Again, add more or less pureed fruit/vegetable to obtain a consistency desirable to the infant.
- Bamba - Serve 21 pieces to infant as is. However, if your infant is less than seven months old or unable to manage dissolvable textures, then mix the 21 pieces with 4-6 teaspoons of water. Allow pieces to soften and serve. Monitor infant closely to ensure that they are able to tolerate this preparation.



First Feeding Instructions

- The infant should be healthy and well so if there is a reaction it is not confused with an illness; do not feed to the infant if they have a cold, recent emesis, or diarrhea, etc.
- The first feeding should be performed at home and not at a restaurant or child care. At least one adult should be present to watch the infant for a minimum of two hours without other distractions or responsibilities to

monitor for allergic symptoms. It is helpful to have most of the infant's skin easily visible.

- Symptoms of an allergic reaction most commonly occur within minutes of eating the food and can include hives or red itchy skin, stuffy/itchy/sneezing nose, itchy/watery eyes, vomiting, stomach cramps, diarrhea, angioedema, or swelling. Signs of anaphylaxis include hoarse/tight throat, wheezing, difficulty breathing, or tingling hands, feet, lips, and scalp.⁴

References:

1. Addendum guidelines for the prevention of peanut allergy in the United States: Report of the National Institute of Allergy and Infectious Diseases–Sponsored expert panel. *Annals of Asthma, Allergy and Immunology*. January 4, 2017.
2. Du Toit G, Katz Y, Sasieni P, Mesher D, Maleki SJ, Fisher HR, Fox AT, Turcanu V, Amir T, Zadik-Mnuhin G, Cohen A, Livne I, and Lack G. Early consumption of peanuts in infancy is associated with a low prevalence of peanut allergy. *J Allergy Clin Immunol*. 2008 Nov;122(5):984-91. doi: 10.1016/j.jaci.2008.08.039.
3. D'Alessandro D. How Much Peanut Butter Should He Take? May 22, 2017. <https://pediatriceducation.org/2017/05/22/how-much-peanut-butter-should-he-take/>
4. www.aaaai.org/conditions-and-treatments/allergies/food-allergies



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