4.E.06	I-T-P-K	Random	FS, TS, PP
The program staff provide families with information about the choice, use, scoring, and interpretation of screening and assessment methods that includes			
a	the purpose and use for which an assessment is designed and its programmatic purpose and use,		
b	the interpretations of the results and their meaning in terms of future learning opportunities for their child,		
c	the way teaching staff or others have been trained to use assessment procedures and interpret results as well as the conditions under which the child will be assessed (e.g., group size, time constraints, familiarity with adults involved), and		
d	access to or information about the specific instruments used.		
Evidence may include written policies, relevant information from family/staff handbook, orientation materials, and parent tip sheets.			

4.E.07	I-T-P-K	Emerging	FS, TS, PP
The program staff provide families with a full explanation of confidentiality by			
a	listing the categories of individuals who will have access to individual child screening and assessment results as well as the reasons for their access.		
b	sharing regulations governing access to files and familial rights.		
	Programs should consult their licensing or regulating body for regulations pertaining to their program. Information may be shared as part of children's enrollment information, in the parent handbook, etc.		
c	describing the procedures used to keep individual child records confidential.		
d	explaining how and why children's individual screening results and assessment information will be represented, used, and interpreted.		
	Look for evidence of how the individual screening results will be used.		

Standard 5 – Health

5.A. – Promoting and Protecting Children's Health and Controlling Infectious Disease

5.A.01	I-T-P-K	Random	PP
The program maintains current health records for each child:			
a	Within six weeks after a child begins the program, and as age-appropriate thereafter, health records document the dates of services to show that the child is current for routine screening tests and immunizations according to the schedule recommended, published in print, and posted on the Web sites of the American Academy of Pediatrics, the Centers for Disease Control of the United States Public Health Service (CDC-USPHS), and the Academy of Family Practice.		
	Rate as 'Yes' if program portfolio provides evidence that child health records include evidence of immunizations. It is not necessary to establish whether all immunizations were performed as scheduled. *In addition to immunization confirmation at enrollment, evidence should address how often your program reviews children's health and safety files to update for age-appropriate immunizations, screenings, and well-baby checks. Current recommended screening tests and immunizations can be found on the web sites of the American Academy of Pediatrics, the Centers for Disease Control of the United States Public Health Service [CDC-USPHS], and the Academy of Family Practice, available here: (http://www2.aap.org/immunization/izschedule.html).*		
b	When a child is overdue for any routine health services, parents, legal guardians, or both provide evidence of an appointment for those services before the child's entry into the program and as a condition of remaining enrolled in the program, except for any immunization for which parents are using religious exemption.		
	The following guidance represents current best practices regarding this criterion. It should be used to guide program improvement and in preparation for assessment. If assessed, NAEYC Assessors will use this guidance to rate the criterion during the assessment visit. *In addition to religious exemptions, parents/guardians may opt to not have their children immunized due to philosophical beliefs.*		
Child health records include			

5.A.01	I-T-P-K	Random	PP
c	Current information about any health insurance coverage required for treatment in an emergency;		
	Current information regarding the child's health insurance coverage should include the insurance carrier, policy number, and name of insured. This information may sometimes be required in non-life-threatening emergencies.		
d	Results of health examinations, showing up-to-date immunizations and screening tests with an indication of normal or abnormal results and any follow-up required for abnormal results;		
	Rate as 'Yes' if the Program Portfolio includes evidence of how the program gathers information on immunizations for individual children. Evidence should also include the procedure for capturing information on screening tests including the follow-up procedure with families to ensure any abnormal results are addressed.		
e	Current emergency contact information for each child, which is kept up to date by a specified method during the year;		
f	Names of individuals authorized by the family to have access to health information about the child;		
	A place for parent/guardian signature must always appear for this indicator to be met. This indicator concerns programs' obligations with reference to HIPAA -- the federal Health Insurance Portability and Accountability Act of 1996. Health care providers are required to safeguard the confidentiality of health records. Therefore, health records should somewhere include a signed authorization from parents or legal guardians for the health care provider to share information (about health exams, immunizations, illness visits) with the program. This is most often seen on a state's health exam form required for admission to group care. However, implementation varies from state to state, so location and wording may differ.		
g	Instructions for any of the child's special health needs such as allergies or chronic illness (e.g., asthma, hearing or vision impairments, feeding needs, neuromuscular conditions, urinary or other ongoing health problems, seizures, diabetes);		
h	Supporting evidence for cases in which a child is under-immunized because of a medical condition (documented by a licensed health professional) or the family's beliefs. Staff implement a plan to exclude the child promptly if a vaccine-preventable disease to which children are susceptible occurs in the program.		
	The following guidance represents current best practices regarding this criterion. It should be used to guide program improvement and in preparation for assessment. If assessed, NAEYC Assessors will use this guidance to rate the criterion during the assessment visit. *'Family's beliefs' include religious or philosophical beliefs.* *Evidence could include a written policy stating that (1) if a child is under-immunized, his or her health records document this and explain why; and (2) Under-immunized children may be excluded from care if a vaccine-preventable disease occurs to which children are susceptible.* *Under-immunized: A person who has not received the recommended number or types of vaccines for his/her age according to the current national and local immunization schedules (AAP). see http://www.cdc.gov/vaccines/ for current national immunization schedule.*		

5.A.02	I-T-P-K	Emerging	PP
The program has and implements a written agreement with a health consultant who is either a licensed pediatric health professional or a health professional with specific training in health consultation for early childhood programs.			
a	The health consultant visits at least two times a year and as needed. Where infants and toddler/twos are in care, the health consultant visits the program at least four times a year and as needed.		
b	The health consultant observes program practices and reviews and makes recommendations about the program's practices and written health policies to ensure health promotion and prevention of infection and injury. The consultation addresses physical, social-emotional, nutritional, and oral health, including the care and exclusion of ill children.		
a-b	*Licensed pediatric health professionals include (but are not limited to) pediatricians, family practice physicians, pediatric nurses, or pediatric nurse practitioners. Child care health consultation is a growing specialty for which training is available.*		
c	Unless the program participates in the United States Department of Agriculture's Child and Adult Care Food Program, at least two times a year a registered dietitian or pediatric public health nutritionist evaluates the menus for nutritional content; portion sizes; nationally recommended limits on juice, sugar, sodium, and saturated fats; food service operations; special feeding needs to be met by the program; and procedures used for food brought from home.		

5.A.02	I-T-P-K	Emerging	PP
	Rate as 'N/A' if the program participates in the US Dept of Agriculture's CACFP. An individual with a degree in nutrition and/or a Dietetic Technician are examples of a "registered dietitian or pediatric public health nutritionist."		
d	The program documents compliance and implements corrections according to the recommendations of the consultant (or consultants).		

A growing number of states require visits by a health consultant as part of their licensing regulations. The Healthy Child Care America (HCCA) Campaign website (http://www.healthychildcare.org/) maintains a list of state HCCA and American Academy of Pediatrics (AAP) contacts that may be useful in locating a consultant. Other sources are other early childhood education programs that use consultants, local regulatory agencies, local health agencies, clinics and pediatric hospitals, the state chapter of AAP or local Head Start programs that have a health consultant. Some programs have also used pediatric health professionals who are parents of enrolled children. However, it is important to make sure that the consultant has knowledge of health issues specific to program and school settings, a public health perspective, and knowledge of confidentiality issues related to children, families, and staff.

An early childhood professional certified as a trained child care health consultant is acceptable as a health consultant.

A written agreement with a health care provider should include the details of the relationship. Evidence could include a copy of the contract with the provider or the plan for consultation. The qualifications of the provider (e.g., provider resume or documentation of training/certification) must also be provided as outlined in the criteria.

5.A.03	I-T-P-K	Required	TS, PP, [O]
a	At least one staff member who has a certificate showing satisfactory completion of pediatric first-aid training and satisfactory completion of pediatric CPR is always present with each group of children.		

At least one staff member who meets both components of criterion 5.A.03 must be present throughout the entire observation. Take note of all staff members who are present with children throughout each group observation. During the Program Portfolio review, review documentation of appropriate training for 5.A.03 for those staff members who were present with children throughout (each of) the group observation(s).

Use the 5.A.03 Worksheet and the list of staff members present during each observation to rate this criterion. Look for evidence:

1. *That a first-aid course has been completed, and*
2. *That the staff member is currently certified in CPR (including a pediatric or infant and/or child component).*

If the documentation does not include this information, programs must supply additional documentation indicating that these topics were covered in the training. The documentation must be issued from the course or course instructor and can include an agenda, course description, letter from the trainer or issuing organization, etc.

Documentation must be specific to individuals and could be in the form of individual cards or certificates, documentation of an individual's successful completion of an online training course, or a record of staff that attended and successfully completed a suitable training course. A blanket policy that all staff are required to hold current trainings that meet 5.A.03 is not sufficient.

Ideal evidence would include classroom staffing patterns, in conjunction with staff first-aid and CPR training records, to document compliance with this required criterion.

This criterion does not specify how frequently the training would occur but the certification must be current. If the certificate indicates that the certification has expired, then the training(s) would not meet this criterion.

A first aid course and a CPR self-learning program for infants and/or children (i.e., kit with practice manikin or online course) followed by a demonstration skills assessment by a qualified instructor meets this criterion if the program provides documentation that the staff member successfully passed the assessment. For criterion 5.A.03 to be met, a staff member who has appropriate training for criterion 5.A.03 is always present with each group of children. Exceptions are noted below:

- *A group of children can be left in the care of an adult who does not have appropriate training for criterion 5.A.03 for no more than five minutes. For example, if the adult with appropriate training for criterion 5.A.03 needed to step into the hallway to speak privately to a parent or leave the group to use the restroom, the adult must return within five minutes or another adult with appropriate training for criterion 5.A.03 must join the group within five minutes.*
- *When a teaching staff member who meets 5.A.03 must leave the group, an "other adult" who meets 5.A.03 may cover for that teaching staff member for up to 20 minutes. During that 20 minute period, the group would still meet 5.A.03.*
- *Teacher/student one-on-one pairings (for purposes such as occupational therapy, physical therapy, or speech therapy) do not constitute a group; the adult does not need to have appropriate training for criterion 5.A.03.therapy) do not constitute a group; the adult does not need to have appropriate training for criterion 5.A.03.*

5.A.03	I-T-P-K	Required	TS, PP, [O]
This is a required criterion. If a child is in immediate danger, assessors must immediately notify the program administrator and contact the NAEYC Academy. If the assessor determines that this criterion is not fully met during the observation, Assessors MUST list it on the Missing Evidence Request Form (MERF) for the Program Portfolio Source of Evidence. If the criterion is still not fully met after the program responds to the MERF, assessors must note this on the Required Criterion Report Form. This form is shared with the program administrator at the Closing Meeting, at which point the Program Administrator will be given a chance to respond in writing directly on the Required Criterion Report Form; OR choose not to respond during the site visit by checking the appropriate box on the form; AND/OR provide additional contextual information to the NAEYC Academy within 30 business days of the site visit.			

5.A.04	I-T-P-K	Not Currently Assessed: Best Practice
The program follows these practices in the event of illness:		
a	If an illness prevents the child from participating comfortably in activities or creates a greater need for care than the staff can provide without compromising the health and safety of other children or if a child's condition is suspected to be contagious and requires exclusion as identified by public health authorities, then the child is made comfortable in a location where she or he is supervised by a familiar caregiver. If the child is suspected of having a contagious disease, then until she or he can be picked up by the family, the child is located where new individuals will not be exposed.	
b	The program immediately notifies the parent, legal guardian, or other person authorized by the parent when a child has any sign or symptom that requires exclusion from the program.	
A program that allows ill children or staff to remain in the program implements plans that have been reviewed by a health professional about		
c	what level and types of illness require exclusion;	
d	how care is provided for those who are ill but who are not excluded; and	
e	when it is necessary to require consultation and documentation from a health care provider for an ill child or staff member.	

5.A.05	I-T-P-K	Not Currently Assessed: Best Practice
a	Staff and teachers provide information to families verbally and in writing about any unusual level or type of communicable disease to which their child was exposed, signs and symptoms of the disease, mode of transmission, period of communicability, and control measures that are being implemented at the program and that families should implement at home.	
b	The program has documentation that it has cooperative arrangements with local health authorities and has, at least annually, made contact with those authorities to keep current on relevant health information and to arrange for obtaining advice when outbreaks of communicable disease occur.	
	Examples of cooperative arrangements may include documented visits or communications with local health authorities, reports of communicable illnesses reported to local health authorities, and reports received from the local or state health authority (e.g., downloaded press releases).	

5.A.06	I-T-P-K	Random	O, TS, PP
a	Children of all ages have daily opportunities for outdoor play (when weather, air quality, and environmental safety conditions do not pose a health risk).		
	If children do not go outside to play during the observation, posted daily schedules or other material evidence may be used to rate this indicator. If you see no outside play AND no schedule or other evidence that the children get fresh air, rate 'No'.		
b	When outdoor opportunities for large-motor activities are not possible because of conditions, the program provides similar activities inside.		
	Evidence could include an indoor gross motor space, schedule, posted policy, handbook and memos. Rate 'NoOpp' if the group goes outside during observation and there is not a dedicated indoor gross motor space.		
c	Indoor equipment for large-motor activities meets national safety standards and is supervised at the same level as outdoor equipment.		

5.A.06	I-T-P-K	Random	O, TS, PP
	Rate 'N/A' if there is no indoor equipment. *Indoor equipment should be arranged in a way that provides for the safety of the children, including spacing and flooring (e.g., climbers not on hard floor).* *Written evidence should include evidence that the stationary indoor play equipment meets national safety standards as recommended by Caring for our Children (CFOC). Programs should follow manufacturers' instructions regarding the installation, use, care, and maintenance of any large motor play structures including a supervision plan for indoor gross motor play.*		
	Examples of Weather Conditions: winds, temperature extremes, precipitation, pollution, pollen, high UV Index.		

5.A.07	I-T-P-K	Random	PP
To protect against cold, heat, sun injury, and insect-borne disease, the program ensures that:			
a	Children wear clothing that is dry and layered for warmth in cold weather.		
	Rate 'N/A' if written evidence indicates that the program is located in an area that does not have cold weather.		
b	Children have the opportunity to play in the shade. When in the sun, they wear sun-protective clothing, applied skin protection, or both. Applied skin protection will be either sunscreen or sun block with UVB and UVA protection of SPF 15 or higher that is applied to exposed skin (only with written parental permission to do so).		
	Shaded areas are not required during the winter months (November through March) when and if children wear clothing, including hats and gloves, to cover their skin. *Evidence could include your program's sun safety policies and procedures reflecting these best practices.* *Sun-protective clothing: clothing made with fabrics rated for ultraviolet protection, or clothing that protects skin areas most prone to sun damage.* *Examples of sun-protective clothing: broad-brim hats, long sleeve shirts, full-length pants/skirts.* *Sunscreen that protects against both UVA and UVB radiation and is SPF 15 or higher is also referred to as 'broad-spectrum' sunscreen. See* http://www.fda.gov/downloads/ForConsumers/ConsumerUpdates/UCM258910.pdf		
c	When public health authorities recommend use of insect repellents due to a high risk of insect-borne disease, only repellents containing DEET are used, and these are applied only on children over 2 months of age. Staff apply insect repellent no more than once a day and only with written parental permission.		
	Rate 'N/A' if portfolio contains evidence that public health authority does NOT recommend use of insect repellents. *Rate as 'Yes' only if portfolio contains evidence supporting ALL aspects of the policy: (1) only DEET or an acceptable alternative approved by the public health authority; (2) only over 2 months of age; (3) no more than 1x/day; and (4) need written parental permission. Evidence for (2) is not needed if the program does not serve infants.* *When using an alternative to DEET, include documentation in the PP of what is being used as well as documentation that the alternative has been approved and is applicable for the age of the child(ren) it is being used.*		

5.A.08	I-T-P-K	Random/Emerging	O, PP
During observations, rate 'N/A' if all children in the group are able to use the toilet consistently. *When assessing the Program Portfolio, rate 'N/A' if the program serves only Preschool and/or Kindergarten children and does not address the criterion.*			
For children who are unable to use the toilet consistently, the program makes sure that:			
a	*Indicator 'a' has been permanently removed from this criterion to reflect current best practice.*		
b	For children who require cloth diapers, the diaper has an absorbent inner lining completely contained within an outer covering made of waterproof material that prevents the escape of feces and urine. Both the diaper and the outer covering are changed as a unit.		
	Rate 'N/A' if NO children use cloth diapers, if the program indicates that it does not permit the use of cloth diapers, or if the program does not serve children who are not toilet-trained; otherwise rate 'NoOpp" unless you directly observe diapering using cloth diapers. *For evidence, programs could provide their diapering policy that addresses all components of this indicator.*		
c	Cloth diapers and clothing that are soiled by urine or feces are immediately placed in a plastic bag (without rinsing or avoidable handling) and sent home that day for laundering.		

5.A.08	I-T-P-K	Random/Emerging	O, PP

	Rate 'NoOpp" unless you directly observe changing of clothing AND/OR cloth diapers soiled by urine or feces.
Staff check children for signs that diapers or pull-ups are wet or contain feces	
d	at least every two hours when children are awake and
e	when children awaken.
	Evidence may include direct observation of regular diaper checks OR written or posted evidence that such checks occur. Rate 'NoOpp' if no sleeping infants or toddler/twos awaken, even in part day programs. Rate 'N/A' for part-day preschool and kindergarten groups if diapers/pull-ups are used.
f	Diapers are changed when wet or soiled.
	Children wearing cloth or disposable training pants and children who have accidents in underwear are also changed when wet or soiled. *Changing should be initiated within 5 minutes of discovery that they are wet or soiled, unless circumstances clearly make it difficult to do so. Rate as 'Yes' if a cycle of group changing in initiated, even if it takes longer to get to a particular diaper.*
g	**Staff change children's diapers or soiled underwear in the designated changing areas and not elsewhere** in the facility.
h	Each changing area is separated by a partial wall or is located at least three feet from other areas that children use and is used exclusively for one designated group of children. For kindergartners, the program may use an underclothing changing area designated for and used only by this age group. **(This indicator only is an Emerging Practice.)**
	A partial wall is designed to keep children from entering the changing area and would begin at floor level. The 3 feet separation from other areas used by children means that, for example, activity areas, shelves with materials from which children choose, and tables at which children sit, are not located within 3 feet of the changing area. *Designated Changing Area: An area of space prepared for the purpose of changing soiled diapers, training pants, or underwear and in which all changing related materials are readily available.*
i	At all times, caregivers have a hand on the child when the child is being changed on an elevated surface.
	Rate as 'N/A' if all children are potty training and using pull-ups. *Rate as 'No' if a caregiver steps out of arm's length at any time while a child is on an elevated changing surface.*
In the changing area, staff	
j	post changing procedures and
	Rate if there is a changing area, even if no diapering takes place during the observation.
k	follow changing procedures
	Rate 'No Opp' if no diapering takes place during the observation.
j-k	*Changing procedures outline the basic procedures for organizing the changing area; placing children on the changing table; cleaning the child; disposing of the soiled diaper and materials; applying the clean diaper and redressing the child; hand hygiene; and cleaning of the changing table. All elements must be included in posted changing procedures.*
l	These procedures are used to evaluate teaching staff who change diapers.
	Rate as 'NoOpp' unless staff are evaluated in how to change diapers during the observation. Rate 'N/A' if the program indicates that it does not serve children who are not toilet-trained. *Evidence should show or describe how the program trains and evaluates staff on correct diapering procedures.*
m	Surfaces used for changing and on which changing materials are placed are not used for other purposes, including temporary placement of other objects, and especially not for any object involved with food or feeding.
n	Containers that hold soiled diapers and diapering materials have a lid that opens and closes tightly by using a hands-free device (e.g., a step can).
	Rate 'N/A' if the program indicates that it does not serve children who are not toilet-trained. *Diaper disposal systems are acceptable receptacles for storing soiled diapers only when they are designed to be used in a hands-free manner.*
o	Containers are kept closed and
p	are not accessible to children.

5.A.08	I-T-P-K	Random/Emerging	O, PP
	Rate 'N/A' if the program indicates that it does not serve children who are not toilet-trained. *In order to be considered inaccessible, the containers shall be placed in an area that children cannot enter without close adult supervision. For example, if the container were in a bathroom that children only enter when accompanied by an adult, then it would be considered inaccessible. However, if the diaper changing area is in the classroom, then the container would need to be positioned or placed in such a way that it is inaccessible to children.*		
q	Staff members whose primary function is preparing food do not change diapers until their food preparation duties are completed for the day.		
	The indicator refers specifically to staff whose primary function is to prepare food. Rate as 'N/A' if the program does not have a cook or other individual whose primary responsibility is to prepare food or if the individual does not change diapers. Rate 'NoOpp' if the program has a staff member whose primary function is to prepare food but who is not present during the observation.		

5.A.09	I-T-P-K	Random	O, PP
The program follows these practices regarding hand washing:			
a	Staff members and those children who are developmentally able to learn personal hygiene are taught hand-washing procedures and are periodically monitored.		
b	Hand washing is required by all staff, volunteers, and children when hand washing would reduce the risk of transmission of infectious diseases to themselves and to others.		
c	Staff assist children with hand washing as needed to successfully complete the task. Children wash either independently or with staff assistance.		
	Rate 'NoOpp' for infant groups if wet wipes are being used.		
d-p	*Rate as 'Yes' if the indicators are positively observed in children and adults MOST of the time.*		
Children and adults wash their hands:			
d	on arrival for the day;		
	Do not include parents unless they are staying -- not dropping off.		
e	after diapering or using the toilet (use of wet wipes is acceptable for infants);		
	Toddlers' hands should be washed at a sink following proper procedures, with adult assistance as needed. Infants who can be safely held in one arm should be assisted in washing their hands at a sink. The use of wet wipes should be reserved for situations in which hand washing is not possible or practical.		
f	after handling body fluids (e.g., blowing or wiping a nose, coughing on a hand, or touching any mucus, blood, or vomit);		
g	before meals and snacks, before preparing or serving food, or after handling any raw food that requires cooking (e.g., meat, eggs, poultry);		
h	after playing in water that is shared by two or more people;		
i	After handling pets and other animals or any materials such as sand, dirt, or surfaces that might be contaminated by contact with animals; and		
	Rate 'N/A' if they have no pets or have no sources of animal contamination. If sandboxes have covers, assume they are not a source of animal contamination. *DO NOT rate this indicator automatically when groups come in from outside.*		
j	When moving from one group to another (e.g., visiting) that involves contact with infants and toddlers/twos		
	Refers to situations when older children visit and interact with groups of infants and/or toddlers (or vice versa). Rate 'N/A' only if the program does not have infant and/or toddler/twos groups.		
Adults also wash their hands:			
k	before and after feeding a child,		
	This indicator refers to feeding an individual child, not serving food to a group.		
l	before and after administering medication,		
m	after assisting a child with toileting, and		
	Rate whenever an adult touches a child's clothing or body, or touches any part of the toilet, while assisting the child with toileting. Rate hand washing related to diapering on Indicator e.		
n	after handling garbage or cleaning.		

5.A.09	I-T-P-K	Random	O, PP

	This indicator refers to the handling of contaminated materials or the use of cleaning, sanitizing, and/or disinfecting chemicals (for example, while cleaning tables after meal or snack). This does not include putting materials and equipment away after an activity, or "clean-up time" when materials are uncontaminated and no cleaning agents/chemicals are used.
Proper hand-washing procedures are followed by adults and children and include:	
o	using liquid soap and running water;
o-p	*Children's hands should be washed at a sink following proper procedures, with adult assistance as needed whenever possible. Infants who can safely be held in one arm should be assisted in washing their hands at a sink. When hand washing at a sink with soap and running water is not possible (e.g., during neighborhood walks at local parks) children under the age of 24 months may use wet wipes. Children age 24 months and older may use alcohol-based sanitizers as described in additional guidance below. Rate 'Yes' when hand washing at a sink (with soap and running water) is not possible AND wet wipes or alcohol-based sanitizers are used appropriately.*
p	rubbing hands vigorously for at least 20 seconds including back of hands, wrists, between fingers under and around any jewelry, and under fingernails; rinsing well; drying hands with a paper towel, a single-use towel, or a dryer; and avoiding touching the faucet with just-washed hands (e.g., by using a paper towel to turn off water).
	ALL elements must be observed (in MOST of the adults and children MOST of the time) to rate as 'Yes' for this indicator. *The following guidance represents the current best practices regarding this criterion. It should be used to guide program improvement and in preparation for assessment. If assessed, NAEYC Assessors will use this guidance to rate the criterion during the assessment visit.* *Hands should be vigorously rubbed for at least 20 seconds.*
Except when handling blood or body fluids that might contain blood (when wearing gloves is required), wearing gloves is an optional supplement, but not a substitute for, hand washing in any required hand-washing situation listed above.	
q	Staff wear gloves when contamination with blood may occur.
r	Staff do not use hand-washing sinks for bathing children or for removing smeared fecal material.
	Rate indicator as 'NoOpp' unless you see bathing or the removal of smeared fecal material.
s	In situations where sinks are used for both food preparation and other purposes, staff clean and sanitize the sinks before using them to prepare food.
	Rate as 'N/A' if sinks used for food prep are not used for other purposes.
t	Hand hygiene with an alcohol-based sanitizer with 60% to 95% alcohol is an alternative to traditional hand-washing (for children over 24 months and adults) with soap and water when visible soiling is not present.
	If alcohol-based sanitizers are used, the manufacturer's instructions must be followed. For visibly dirty hands, rinsing under running water or wiping with a water-saturated towel should be used to remove as much dirt as possible before using a hand sanitizer. Supervision of children is required to monitor effective use and to avoid potential ingestion or inadvertent contact of hand sanitizers with eyes and mucous membranes. If hand sanitizers are used, assume children are 24 months or older unless children are clearly younger than 24 months. *For children 24 months and under, soap and water should be used and alcohol-based hand sanitizers should not be used.* *Since the alcohol-based hand sanitizers are toxic and flammable, they must be stored and used according to the manufacturer's instructions. In small quantities hand sanitizers do not need to be stored off-site, but must be kept out of reach of children.* *Rate 'N/A' if no hand sanitizer is seen during the observation. Rate 'NoOpp' if there is hand sanitizer available, but it is not used. Rate 'No' if hand sanitizer is used on children under 24 months, or used on children of any age when hands are visibly soiled. Do not consider the percentage of alcohol in hand sanitizer when rating this indicator in an observation.* *When assessing the Program Portfolio, rate 'N/A' if the program indicates that they do not use hand sanitizer.*
	When hand-washing is not possible (e.g., during neighborhood walks at local parks), wet wipes may be used. *Evidence should include a hand-hygiene policy that includes all of the above indicators (if applicable).*

5.A.10	I-T-P-K	Emerging	O, PP
a	Precautions are taken to ensure that communal water play does not spread infectious disease. No child drinks the water. Children with sores on their hands are not permitted to participate in communal water play. Fresh potable water is used, and the water is changed before a new group of children comes to participate in the water play activity. When the activity period is completed with each group of children, the water is drained. Alternatively, fresh potable water flows freely through the water play table and out through a drain in the table.		
All elements of this criterion must be present/met to rate as 'Yes' for the criterion. *Rate 'N/A' only if the program states in Program Portfolio that it NEVER does communal water play. If water play policy is not referenced in Program Portfolio, assume the program DOES do water play and the policy is missing. Rate as 'NoOpp' if no communal water play occurred during the observation, even if a water table is seen.* *"Potable" water is water of sufficient quality to serve as drinking water. Water must be "fresh" (recently obtained from its source) to remain potable, as harmful germs can easily multiply in exposed or standing water.* *"A new group of children" is a different group of children in the room (for example, an afternoon class versus the morning class), NOT a new subgroup of children within the existing group. See the ratio/group size chart notes for the definition of "group."* *"The activity period" is defined by the program but may not exceed one day.*			

5.A.11	I-T-P-K	Random	O, TS, PP
Rate 'N/A' for all indicators if the program's policy states they never administer any medications (neither prescription nor OTC). *Rate indicators "NoOpp" if no medication is administered and no written evidence is observed during the observation.* *Rate an indicator as 'Yes' if written evidence of its medication practice is seen in the classroom during the observation, or if the practice is actually observed.* *Rate an indicator as 'No' only if observation or written evidence clearly contradicts it.*			
Safeguards are used with all medications for children:			
a	Staff administer both prescription and over-the counter medications to a child only if the child's record documents that the parent or legal guardian has given the program written permission.		
	Over the Counter (OTC) medications may include pain reliever and treatments for allergies. If medication and/or sunscreen administration is observed, rate 'Yes' if clear evidence of permission is seen. A physician's authorization is required to use OTC medications. *Rate as 'N/A' if the program shows that they do not administer any prescription medications.*		
b	The child's record includes instructions from the licensed health provider who has prescribed or recommended medication for that child; alternatively, the licensed health provider's office may give instructions by telephone to the program staff.		
	Licensed health providers include any health professional licensed to practice and prescribe or recommend medications in that state. Health professionals who evaluate medication administration may include but are not necessarily limited to physicians, physician assistants, nurses (including school nurses), and nurse practitioners. *Written instructions for prescribed medications may be limited to the information included on the prescription label. The program may have a standing order from a licensed health care provider to guide the use of a specific over the counter (OTC) medication with a specific child in the program when the order details specific circumstances and gives specific instructions for individual dosing of the medication (i.e. epi-pen for allergic reaction or inhaler for asthma). Cough and cold medication is not recommended for children under the age of 6, but can be administered if the program has written orders from a health care provider and parent/guardian.* *If instructions from the health care provider are given over the phone, the conversation must be documented in writing.* *The program must document BOTH written permission from the parent/legal guardian AND instructions from the licensed health provider (for example a doctor's note or a care plan form) for prescription AND OTC medication and treatments (for example, rehydration fluids to treat diarrhea and/or vomiting; hydrocortisone creams to treat eczema).*		

5.A.11	I-T-P-K	Random	O, TS, PP
c	Any administrator or teaching staff who administers medication has (a) specific training and (b) a written performance evaluation updated annually by a health professional on the practice of the five right practices of medication administration: (1) verifying that the right child receives the (2) right medication (3) in the right dose (4) at the right time (5) by the right method with documentation of each right each time the medication is given. The person giving the medication signs documentation of items (1) through (5) above. Teaching staff who are required to administer special medical procedures have demonstrated to a health professional that they are competent in the procedures and are guided in writing about how to perform the procedure by the prescribing health care provider.		
	Rate ''NoOpp' if not observed. *Rate as 'N/A' if the program shows that they do not administer any prescription medications.* *Prescription diaper creams and/or ointments would require all steps to be followed.* *The Program Portfolio should include a list of all individuals who are trained to administer medications as well as evidence of the content of the training. Training and evaluation of medication administration should be completed annually, unless documentation clearly states that the training received by staff is valid for a defined time period (e.g. training certificate with clear expiration date).*		
d	Medications are labeled with the child's first and last names, the date that either the prescription was filled or the recommendation was obtained from the child's licensed health care provider, the name of the licensed health care provider, the expiration date of the medication or the period of use of the medication, the manufacturer's instructions or the original prescription label that details the name and strength of the medication, and instructions on how to administer and store it.		
	For OTC medications (including sunscreen), rate 'Yes' if labeled with only child's first and last names. If the same container of OTC medication (e.g., sunscreen or insect repellent) is used by more than one child in the group, a list of children's first and last names is required; rate 'Yes' only if this list is visible.		
e	All medications are kept in a locked container.		
	Medications that must be readily available at all times per a physician's orders (i.e., emergency medication such as an EpiPen) should be stored in a safe manner, inaccessible to children, while allowing for quick access to staff in an emergency. Examples of acceptable ways to store emergency medications include a fanny pack or backpack carried by an adult or an unlocked container that is out of the reach of children. A fanny pack or backpack that is not on a staff member's person and is also in reach of children is an unacceptable way of storing emergency medications. Sunscreen, special soaps, lotion, and diaper creams do not need to be kept in a locked cabinet but must be inaccessible to children.		
Non-prescription preventatives such as sunscreen, insect repellent, non-medicated diaper cream, lotion, lip balm, and toothpaste are not considered medications and only require parental/guardian consent. Staff do not need to be trained or evaluated in their use.			

5.A.12	I	Required/Always	O, PP
Rate 'NoOpp' if there are no infants sleeping AND no infants are laid down to sleep during the observation.			
To reduce the risk of Sudden Infant Death Syndrome (SIDS):			
a	Infants, unless otherwise ordered by a physician, are placed on their backs to sleep on a firm surface manufactured for sale as infant sleeping equipment that meets the standards of the United States Consumer Product Safety Commission.		
	This is a required indicator. Rating of this indicator takes into account: • *Observed infant sleep practices,* • *Program policies regarding infant sleep practice, and* • *Other written documentation to support some aspects of compliance.* *Observed Infant Sleep Practices:* *Rate 'No Opp' if both conditions are true:* *1) No infants are placed to sleep during the observation and* *2) No infants are observed to be sleeping with sleep positioners during the observation.* *Infant sleep positioners may be used only with a doctor's authorization. If applicable, documentary evidence of compliance, such as a doctor's note, should be seen. Infant sleep positioners are devices intended to keep a baby in a desired position while sleeping. Examples include: sleeping bolsters, wedge-style positioners, and/or rolled*		

5.A.12	I	Required/Always	O, PP

up blankets or quilts placed under the baby or under the crib mattress. Do not rate infant sleep positioners in unoccupied cribs when rating indicator 'a'.

If the Assessor(s) observes any person employed by or volunteering for the program placing an infant to sleep in a position other than on his/her back, placing an infant to sleep with an infant sleep positioner, or observes any sleeping infants with an infant sleep positioner , the Assessor(s) will confirm the name and age of the child at the end of the observation and, for any child 12 months and younger, will ask for a doctor's note allowing the child to be placed to sleep in an alternate position on the MERF (unless the Doctor's note has already been provided). If a child younger than 12 months is observed being placed in a position other than on his/her back, observed being placed to sleep with an infant sleep positioner, or observed to be sleeping with an infant sleep positioner, and the program does not provide a doctor's note after the administration of the MERF, the required indicator is not met and the Assessor(s) will note this rating on the Required Criterion Report Form.

If an infant arrives to the program asleep, or falls asleep at the program, in equipment not specifically designed for infant sleep (example: car safety seat, bouncy seat, infant seat, swing, jumping chair, stroller, or highchair) the infant is removed and placed on their back on infant sleep equipment that conforms to the requirements of this indicator. ***The infant should be moved within a reasonable timeframe at the teaching staff's earliest opportunity.*** *Program policies regarding infant sleep practices should include this information.*

If a child is in immediate danger due to observed infant sleep practices, the Assessor(s) are instructed to immediately notify the program administrator and to contact the NAEYC Academy.

For Program Portfolio: Rate 'Not Age' if only infants one year and older are served.

Policies should state that infants 12 months and younger are placed on their backs to sleep without the use of infant sleep positioners unless ordered by a physician. If cribs are used for infant sleep, the cribs must meet CPSC Crib Standard # CPSC 16 CFR 1219 or 1220. All "other sleep equipment" (such as play yards or floor beds) must meet the applicable CPSC standards. All programs serving infants must sign the "Infant Sleep Equipment Acknowledgement Form" to meet this indicator.

Policies should also state that infants are not left asleep in swings, car seats, high chairs or other equipment not certified for infant sleep.

If the Assessor(s) determines that this indicator is not fully met during the Program Portfolio review, the Assessor(s) MUST list it on the Missing Evidence Request Form (MERF). If the criterion is still not fully met after the program responds to the MERF, the Assessor(s) must rate Indicator 'a' as not met, and note this on the Required Criterion Report Form.

b	Pillows, quilts, comforters, sheepskins, stuffed toys, and other soft items are not allowed in cribs or rest equipment for infants younger than twelve months.

Rating 'Yes' indicates that these items are not in cribs. A sleep positioner may be used only with a doctor's authorization. Rate the observed use of infant sleep positioners in indicator 'a'.
Rate 'Not Age' if only infants 12 months and older are served.
A sleep environment includes a firmly fitting sheet (i.e. such that the mattress does not curl up on the ends) and the infant in comfortable, safe garments (no hoods, bibs, necklaces, or ties/strings), but nothing else, not even firm bumper pads. If a mattress cover is used to protect the mattress from wetness, it should be tightly fitting and thin.

c	Blankets are not allowed in cribs or rest equipment for infants younger than twelve months.

Rate as 'No' if there is no stated policy about the use of blankets, or if stated policy is not consistent with the indicator. Infant clothing sacks or other clothing designed for sleep may be used as an alternative to blankets and should be lightweight to avoid overheating.

d	The infant's head remains uncovered during sleep.

After being placed down for sleep on their backs, infants may then be allowed to assume any comfortable sleep position when they can easily turn themselves from the back position.

Programs must include their policies regarding infant sleep positioning and safe sleep practices in their Program Portfolio. Swaddling is not recommended, but is not prohibited by this criterion. The following conditions should be met: programs may use light-weight swaddling material wrapped securely and no higher than the child's shoulders.

5.A.13	I	Emerging	O
a	After each feeding, infant's teeth and gums are wiped with a disposable tissue (or clean soft cloth used only for one child and laundered daily) to remove liquid that coats the teeth and gums.		
Rate 'NoOpp' if infants are not fed during the observation. For infants who have at least one tooth, an alternative to wiping gums with a cloth is to brush the tooth/teeth with a soft toothbrush. Rate 'Yes' if wiping or brushing is observed.			

5.A.14	I-T	Random	O,PP
a	Infants younger than 12 months are held for bottle-feeding. All others sit or are held to be fed.		
	Rate 'Not Age' for toddlers. Rate as 'NoOpp' if feeding does not occur during observation.		
b	Infants and toddler/twos do not have bottles while in a crib or bed and		
	Rate as 'NoOpp' if feeding does not occur during observation.		
c	do not eat from propped bottles at any time.		
	Rate as 'NoOpp' if feeding does not occur during observation. *Propped bottles include using items such as blankets or boppy pillows to hold the infant's bottle.*		
d	Toddler/twos do not carry bottles, sippy cups, or regular cups with them while crawling or walking.		
	Rate 'Not Age' for infants. If there is no evidence that children carry bottles or cups throughout the classroom, rate 'Yes'.		
e	Teaching staff offer children fluids from a cup as soon as the families and teachers decide together that a child is developmentally ready to use a cup.		
	Rate as 'NoOpp' if feeding does not occur during observation.		
The manner in which food is given to infants should be conducive to the development of sound eating habits for life. Written evidence may include information from the parent or staff handbook on feeding policies, and staff training on feeding infants and/or toddler/twos.			

5.A.15	I-T	Not Currently Assessed: Best Practice
a	Infants and toddlers/twos do not have access to large buckets that contain liquid.	
If buckets of liquid are in areas separated from infants by barriers (e.g., in a hallway separated by a closed door), then they do NOT have access.		

5.A.16	T-P-K	Random	O, PP
a	At least once daily in a program where children older than one year receive two or more meals, teaching staff provide an opportunity for tooth brushing and gum cleaning to remove food and plaque. (The use of toothpaste is not required.)		
Rate the criterion 'N/A' if the program provides evidence that children do not receive 2 or more meals daily in the program. However, give credit if evidence of tooth brushing and gum cleaning is seen. *Programs that serve two or more meals must provide at least one opportunity daily for children older than one year for tooth brushing and teeth cleaning. The timing of this opportunity is not specified in the criteria. The program defines whether the food it serves constitutes a meal or snack.* *If the observation is not taking place after a meal time, look for evidence of tooth brushing equipment and supplies, time on the daily schedule, etc. On the Program Portfolio, assessors rate this criterion as 'Yes' if the program provides evidence of this practice.* *If toothpaste is used, it should be labeled with the child's first and last name.*			

5.B. – Ensuring Children's Nutritional Well-being

5.B.01	I-T-P-K	Not Currently Assessed: Best Practice
a	If the program provides food for meals and snacks (whether catered or prepared on-site), the food is prepared, served, and stored in accordance with the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP) guidelines.	
CACFP regulations, policies, and guidance materials on meal requirements provide the basic guidelines for good nutrition, food storage, preparation, service and sanitation practices. Meals and snacks offered to young children should provide a variety of nourishing foods on a frequent basis to meet the nutritional needs of young children, as well as be stored, served and prepared in accordance with the USDA and CACFP guidelines. Programs not eligible for reimbursement under the regulations of CACFP are encouraged to use the CACFP food guidance.		

5.B.02	I-T-P-K	Not Currently Assessed: Best Practice
Staff take steps to ensure the safety of food brought from home:		
a	They work with families to ensure that foods brought from home meet the USDA's CACFP food guidelines.	
b	All foods and beverages brought from home are labeled with the child's name and the date.	
c	Staff make sure that food requiring refrigeration stays cold until served.	
d	Food is provided to supplement food brought from home if necessary.	
e	Food that comes from home for sharing among the children must be either whole fruits or commercially prepared packaged foods in factory-sealed containers. **(This indicator only is an Emerging Practice.)**	
CACFP regulations, policies, and guidance materials on meal requirements provide the basic guidelines for good nutrition, food storage, preparation, service and sanitation practices. Meals and snacks offered to young children should provide a variety of nourishing foods on a frequent basis to meet the nutritional needs of young children, as well as be stored, served and prepared in accordance with the USDA and CACFP guidelines. Programs not eligible for reimbursement under the regulations of CACFP are encouraged to use the CACFP food guidance.		

5.B.03	I-T-P-K	Random	PP
If the program does not provide food to children, then the criterion would be N/A.			
The program takes steps to ensure food safety in its provision of meals and snacks.			
a	Staff discard foods with expired dates.		
b	The program documents compliance and any corrections that it has made according to the recommendations of the program's health consultant, nutrition consultant, or a sanitarian that reflect consideration of federal and other applicable food safety standards.		
	Definition: A sanitarian is a specialist in public sanitation and health. *An individual with a degree in nutrition could also meet this indicator. The health consultant, nutrition consultant, or sanitarian should be should be incorporating federal (U.S. Food and Drug Administration) and all applicable state and local food safety standards.* *Rate this indicator "No" if the program does not have a health consultant, nutrition consultant or sanitarian.*		
Evidence in the Program Portfolio could include a policy about food safety, a checklist for maintaining food safety, a consultant agreement, etc.			

5.B.04	I-T-P-K	Random	O, FS, PP
a	For all infants and for children with disabilities who have special feeding needs, program staff keep a daily record documenting the type and quantity of food a child consumes and provide families with that information.		
This criterion MUST be rated for infant groups. Also rate when the group or program includes older children diagnosed with identified special needs that require special feeding; for example, a child who requires assistance feeding him/herself due to a medical condition. This criterion does not apply to children with food allergies only. *Rate 'N/A' only for toddler/two, preschooler, and kindergartener groups without diagnosed special feeding needs.*			

5.B.05	I-T-P-K	Not Currently Assessed: Best Practice
a	For each child with special health care needs or food allergies or special nutrition needs, the child's health care provider gives the program an individualized care plan that is prepared in consultation with family members and specialists involved in the child's care.	
	Children with special health care needs are defined as "...those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."(1) *Reference: McPherson, M., P. Arango, H. Fox, C. Lauver, M. McManus, P. Newacheck, J. Perrin, J. Shonkoff, and B. Strickland. 1998. A new definition of children with special health care needs. Pediatrics 102:137--40*	
b	The program protects children with food allergies from contact with the problem food. The program asks families of a child with food allergies to give consent for posting information about that child's food allergy and, if consent is given, then posts that information in the food preparation area and in the areas of the facility the child uses so it is a visual reminder to all those who interact with the child during the program day.	

5.B.05	I-T-P-K	Not Currently Assessed: Best Practice
This criterion refers specifically to children with diagnosed food allergies or special nutritional needs because of medical conditions. A program may choose to honor family preferences regarding food (for example, vegetarian or kosher diet) in the absence of a diagnosed food allergy or medical condition without obtaining an individualized care plan by the physician as long as the request conforms with the nutritional guidelines of the US Department of Agriculture's Child and Adult Care Food Program.		

5.B.06		I-T-P-K	Random	O
a	Clean sanitary drinking water is made available to children throughout the day. (Infants who are fed only human milk do not need to be offered water.)			
Look for evidence that water is readily available (such as cups by sink, drinking fountain or a pitcher of water and/or cups is available or children are offered or are drinking water during the observation).				

5.B.07		I-T-P-K	Not Currently Assessed: Best Practice
a	Liquids and foods that are hotter than 110 degrees Fahrenheit are kept out of children's reach.		
This criterion is intended to protect children from burns from hot coffee, tea, soups, and other foods that adults may have brought into a classroom. Children can participate in well-supervised cooking experiences. *Although the USDA cites specific temperatures for cooking and holding food, cooking and holding temperatures are different than recommended temperatures for food served to young children.* *Look for evidence that hot liquids are not brought into the classroom or are inaccessible to children.*			

5.B.08		I	Random	FS, PP
a	If the program provides food to infants, then the program staff work with families (who are informed by their child's health care provider) to ensure that the food is based on the infants' individual nutritional needs and developmental stage.			
Communicating with families about infant nutrition ensures that the program is aware of any individual nutritional needs (such as allergies or special dietary needs) and also allows programs to be aware of nutritional decisions that families are making in conjunction with health care providers, such as when to begin serving solid foods. *Examples of evidence may include parent intake forms that ask questions about a child's nutritional needs, daily notes home informing families of what the infant ate that day, and/or program policy information on how information about is obtained from families about infant nutrition.*				

5.B.09		I	Random	FS, TS, PP
The program supports breastfeeding by				
a	accepting, storing, and serving expressed human milk for feedings			
accepting human milk in ready-to-feed sanitary containers				
b	labeled with the infant's full name, date and time the milk was expressed. The bottle or container should immediately be stored in the refrigerator on arrival and			
	While best practice states that bottles or containers of expressed milk should immediately be stored in the refrigerator on arrival, freshly expressed milk can remain at room temperature for up to 4 hours.			
c	stored at the following temperatures and for the following duration times according to the date that the milk was expressed: • Refrigerator at 39 degrees F: 5 days • Freezer at 5 degrees F: 2 weeks • Freezer compartment with separate doors at 0 degrees F: 3-6 months • Chest or upright deep freezer at -4 degrees: 6-12 months			
d	ensuring that staff gently mix, not shake, the milk before feeding to preserve special infection-fighting and nutritional components in human milk; and			
e	providing a comfortable place for breastfeeding and			
f	coordinating feedings with the infant's mother.			
Freezer bags are considered ready-to-feed sanitary containers and meet the criterion as long as they are stored according to the stated guidelines.				

5.B.10	I	Random/Emerging	O, TS, PP
a	If formula is served, staff serve only formula that comes to the facility in factory- sealed containers (e.g., ready-to-feed powder or concentrate formulas and baby food jars) prepared according to the manufacturer's instructions. If solid food is served, parents may bring solid food prepared at home for use by their child or the program may prepare solid infant food in the facility. **(This indicator only is an Emerging Practice.)**		
	If parents bring manufactured formula for their child from home, it should be sent in unopened, factory-sealed containers. Rate 'No' if program's policies expressly prohibit parents from bringing solid food prepared at home.		
b	Bottle feedings do not contain solid foods unless the child's health care provider supplies written instructions and a medical reason for this practice.		
	Evidence in the Program Portfolio should include policy statements or directives to staff and/or families. Solid foods include cereals, fruits or vegetables. Adding solids to bottles increases risks of choking, food allergies, and obesity. Rate as 'NoOpp' unless documentation from a health provider is observed.		
c	Staff discard after one hour any formula or human milk that is served but not completely consumed or is not refrigerated.		
	Formula or human milk left unrefrigerated for one hour or more must be discarded, even if it was not served. Over the course of an hour, an infant may continue to drink the formula or milk between burping or breaks.		
d	If staff warm formula or human milk, the milk is warmed in water at no more than 120 degrees Fahrenheit for no more than five minutes.		
	The U.S. Consumer Product Safety Commission recommends that hot water heaters be set at no more than 120 degrees. Bottles may be warmed in warm tap water when the hot water heater is set at this level.		
e	No milk, including human milk, and no other infant foods are warmed in a microwave oven.		

5.B.11	I	Random	O, PP
Rate NoOpp if no food or beverages are provided for infants.			
a	Teaching staff do not offer solid foods to infants younger than **four** months, unless that practice is approved by families.		
	*Rate 'N/A' if the program does not serve infants younger than **4 months** of age.*		
b	Sweetened beverages are avoided.		
	Rate 'No' if sweetened beverages are provided. Examples of sweetened beverages: 'juice beverages', 'juice drinks', or 'juice cocktails' of less than 100% juice; sweetened iced- tea; carbonated soft drinks; powdered drink mixes. Do not count 100% fruit juice as a "sweetened beverage".		
c	If juice (only 100% fruit juice is recommended) is served, it is served only to infants twelve months and older, and the amount is limited to no more than four ounces per child daily.		
Written or photographic evidence may include policies, staff and/or parent handbooks, menus, memos, or posted notices. Solid foods include cereals, fruits or vegetables. Solid foods must be introduced separately, not included in a bottle feeding because of increased risks of choking, food allergies, and obesity. This criterion is based on the American Academy of Pediatrics recommendations.			

5.B.12	I	Random	O
a	Teaching staff who are familiar with the infant feed him or her whenever the infant seems hungry.		
b	Feeding is not used in lieu of other forms of comfort.		
The intent of the criterion is to ensure that infants are fed by regular caregivers that children are fed when hungry, and they are not over- or under-fed. *Rate as 'No' if the teaching staff member seems unfamiliar with the infant's meal pattern, feeds the infant whenever she/he is upset or does not respond to cues that the infant is hungry.*			

5.B.13	I-T	Random	PP
a	The program does not feed cow's milk to infants younger than 12 months. The program serves whole or reduced-fat cow's milk to children of ages 12 months to 24 months.		
Rate as 'Yes' if no cow's milk is served to infants younger than 12 months. Children older than 12 months may still be given breast milk. *Whole milk is generally recommended for children between the ages of 12 and 24 months; these children need some fats for growth and development, including of the brain. However, the American Academy of Pediatrics issued a policy revision in July 2008 which states, "For children between 12 months and 2 years of age for whom overweight or obesity is a concern or who have a family history of obesity, dyslipidemia, or CVD, the use of reduced-fat milk would be appropriate" (PEDIATRICS Vol. 122, No. 1, July 2008, pp. 198-208).*			

5.B.14	I-T-P	Random	O, PP
Rate the criterion 'N/A' if the program does not serve food.			
a	Staff do not offer children younger than four years these foods: hot dogs, whole or sliced into rounds; whole grapes; nuts; popcorn; raw peas and hard pretzels; spoonfuls of peanut butter; or chunks of raw carrots or meat larger than can be swallowed whole.		
	This criterion is applicable to both food provided by the program, as well as food brought from home. Rate as 'Yes' if no instances of any of these foods being provided are observed. Hard pretzel sticks and hard, small, traditionally shaped pretzels are high- risk foods for choking incidents. Rate as 'Not Age' if four years old and older.		
b	Staff cut foods into pieces no larger than ¼-inch square for infants and ½-inch square for toddler/ twos, according to each child's chewing and swallowing capability.		
	Rate as 'Not Age' for preschool and kindergarten age categories. Infants and toddlers often swallow pieces of food without chewing. Chicken tenders, fish sticks and other foods should be cut to the age group requirements. If this cannot be done, these foods should not be served regardless if the program provides the food or if it is brought from home. Staff should err on the side of safety regardless of whether a child has had problems chewing or swallowing.		
For mixed age groups, apply the practice that is appropriate to the youngest age present. *Evidence may include a policy from the staff and/or parent handbook, memo, posted notice, email, and staff meetings notes or minutes.*			

5.B.15	T-P-K	Random	O, PP
a	The program prepares written menus, posts them where families can see them, and has copies available for families. Menus are kept on file for review by the consultant described in criterion 5.A.02.		
Rate 'N/A' if no meals or snacks are served by the program. When assessing written documentation, menus kept on file must include enough to demonstrate the pattern of meals served and include some that are current within one year of the site visit. Rate 'Yes' if written menus are posted where families can see the menu. Written evidence may also include a policy (in a staff and/or parent handbook) or a licensing requirement.			

5.B.16	T-P-K	Random	PP
a	The program serves meals and snacks at regularly established times.		
b	Meals and snacks are at least two hours apart but not more than three hours apart.		
	The time span is measured from the ending time of the previous meal or snack and the beginning time of the next meal or snack.		

5.C. – Maintaining a Healthful Environment

5.C.01	I-T-P-K	Random	O, PP
a	The routine frequency of cleaning and sanitizing all surfaces in the facility is as indicated in the Cleaning and Sanitation Frequency Table.		
	Rate 'Yes' if classroom space overall (floors, walls, restroom and kitchen surfaces) appears clean. *A contract with a cleaning service documenting the responsibilities and frequencies for cleaning, sanitizing, and disinfecting is acceptable to demonstrate that some of the components on the table are met including some of the weekly and daily tasks. Responsibilities not covered by the contract should be documented as well.* *Refer to the Cleaning, Sanitizing and Disinfecting Frequency Table (Revised October 2015).* *In order to meet this indicator, all items on the Cleaning, Sanitizing, and Disinfecting Frequency Table must be complete.* *Cleaning is physically removing all dirt and contamination, oftentimes using soap and water. Sanitizing is reducing germs on inanimate surfaces to levels considered safe by public health codes or regulations.* *Disinfecting is destroying or inactivating most germs on any inanimate object, but not bacterial spores. Carpet cleaning must be consistent with local health regulations. Check with the local health department or licensing agency to determine what regulations, if any, apply in your community.*		
b	Ventilation and sanitation, rather than sprays, air freshening chemicals, or deodorizers, control odors in inhabited areas of the facility and in custodial closets.		
	Give credit for proper ventilation if no odors are detected and there is no evidence of sprays.		

5.C.02	I-T-P-K	Random	O, PP
Procedures for standard precautions are used and include the following:			
a	Surfaces that may come in contact with potentially infectious body fluids must be disposable or made of a material that can be sanitized.		
	Refer to the Cleaning, Sanitizing and Disinfecting Frequency Table (Revised October 2015). References to 'sanitized' are now generally 'disinfected'.		
b	Staff use barriers and techniques that minimize contact of mucous membranes or of openings in skin with potentially infectious body fluids and that reduce the spread of infectious disease.		
	Barriers include gloves, moisture-resistant disposable diaper paper, and eye protection. The intent of this indicator is that infectious body fluids do not get into staff member's eyes, nose, or mouth.		
c	When spills of body fluids occur, staff clean them up immediately with detergent followed by water rinsing.		
d	After cleaning, staff sanitize nonporous surfaces by using the procedure for sanitizing designated changing surfaces described in the Cleaning and Sanitation Frequency Table.		
	Refer to the Cleaning, Sanitizing and Disinfecting Frequency Table (Revised October 2015). References to 'sanitized' are now generally 'disinfected'.		
e	Staff clean rugs and carpeting by blotting, spot cleaning with a detergent-disinfectant, and shampooing or steam cleaning.		
	A contract with a cleaning service documenting the responsibilities and frequencies for cleaning, sanitizing, and disinfecting is an acceptable form of evidence.		
f	Staff dispose of contaminated materials and diapers in a plastic bag with a secure tie that is placed in a closed container.		
	Diapers do not need to be placed in a separate bag and tied before they are placed in a lidded, hands-free container. Soiled diapers should be handled as little as possible to avoid contamination. This indicator refers to the disposal of waste that includes diapers.		
Rate 'NoOpp' if no body fluid spills occur. Written evidence may include training agendas, policies, or staff handbooks. The intent of this criterion is that staff disinfect and clean up potentially infectious areas from bodily spills safely. "Standard Precautions" are work practices recommended by the Centers for Disease Control and Prevention that are required for a basic level of infection control. They are "standard" because you do these practices all the time, not just for children who might be sick. Standard precautions apply to (1) blood; (2) all body fluids, secretions, and excretions except sweat; (3) broken skin; and (4) mucous membranes (eyes, nose, mouth). Standard precautions include good hygiene practices (particularly washing and drying hands before and after contact), the use of protective barriers (such as gloves, masks or eye shields), and appropriate handling and disposal of infectious waste.			

5.C.03	I-T-P-K	Random	O, PP
a	A toy that a child has placed in his or her mouth or that is otherwise contaminated by body secretion or excretion is either to be washed by hand using water and detergent, then rinsed, sanitized, and air dried **or** washed and dried in a mechanical dishwasher before it can be used by another child.		
Rate 'NoOpp' if a child does not place a toy in his/her mouth during the observation and there is no other evidence that the program washes toys according to the criterion. Rate 'No' if a toy soiled with bodily excretions or secretions is not removed from the environment or is touched by another child. *Definitions of key words: "Body secretion or excretion" may include blood, saliva, urine, feces, vomit, or mucous. Teaching staff should be aware of toys that are being mouthed by children or otherwise exposed to bodily excretions or secretions. Teaching staff may either remove the toy for immediate cleaning and sanitation or may set the toy aside in an area inaccessible to children (such as a basket or net bag for soiled toys) for cleaning and sanitation at a later time.*			

5.C.04	I-T-P-K	Random	PP
a	Staff maintain areas used by staff or children who have allergies or any other special environmental health needs according to the recommendations of health professionals.		
Rate 'N/A' if program provides evidence that there are no allergies and/or special environmental health needs among staff and children in the program that require environmental adaptations to be safely managed. Evidence could include examples of forms used to collect information from staff and families about allergies and/ or, special environmental health needs; evidence may also include documentation that necessary changes or precautions are made in accordance with the recommendations of health professionals.			

5.C.05	I-T-P-K	Not Currently Assessed: Best Practice
a	Classroom pets or visiting animals appear to be in good health.	
b	Pets or visiting animals have documentation from a veterinarian or an animal shelter to show that the animals are fully immunized (if the animal should be so protected) and that the animal is suitable for contact with children.	
c	Teaching staff supervise all interactions between children and animals and instruct children on safe behavior when in close proximity to animals.	
d	Program staff make sure that any child who is allergic to a type of animal is not exposed to that animal.	
e	Reptiles are not allowed as classroom pets because of the risk for salmonella infection.	
	Examples of reptiles include lizards, turtles, snakes, iguanas, and geckoes.	

5.C.06	I	Random	O, PP
a	Before walking on surfaces that infants use specifically for play, adults and children remove, replace, or cover with clean foot coverings any shoes they have worn outside that play area. If children or staff are barefoot in such areas, their feet are visibly clean.		
Rate 'No' if children or staff are barefoot and have dirty feet. Examples of foot coverings would include booties, shoes, socks, etc.			

Standard 6 – Teachers

6.A. – Preparation, Knowledge, and Skills of Teaching Staff

6.A.01	I-T-P-K	Random	PP
a	All teaching staff know and use ethical guidelines in their conduct as members of the early childhood profession. (For NAEYC's Code of Ethical Conduct, please visit: http://www.naeyc.org/positionstatements/ethical_conduct)		
The intent is that teaching staff are informed of, and follow, the program's expectation of ethical conduct. It is not required that the program follows NAEYC's Code of Ethical Conduct, but would be acceptable. Evidence in the Program Portfolio must demonstrate that teaching staff are made aware of the ethical guidelines used by the program and may include a written policy, be a component of employee orientation/training, staff handbook, etc.			