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CARING FOR CHILDREN WITH HIV OR AIDS IN CHILD CARE

By the Staff of the Child Care Law Center

Acknowledgements

Research and printing of this publication was made possible thanks to a grant from the David and Lucile Packard Foundation.

Special thanks to Karen Sokal-Gutierrez, M.D., Susan Aaronson, M.D., Ann Petru, M.D., Judy Calder, R.N., Shelley Kodimer, and Abby J. Cohen, J.D. for their help with this publication; any errors are strictly those of the authors.

Originally published in 1993, last revision 2005
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PN: 9302

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Caring for Children with HIV or AIDS in Child Care:

CONTENTS

Introduction.....	1
Background Information on HIV and AIDS.....	2
What Are HIV and AIDS, and How Do They Differ?	2
How Many Children Are Infected with AIDS?	2
What Symptoms Are Associated With HIV and AIDS?	3
How Is the Virus Transmitted?	3
What Are Standard Precautions or Universal Infection Control Measures?	4
How Do I Handle Fears or Misinformation About HIV from Staff or Parents?	5
AIDS Discrimination: Legal Issues	6
Is It Illegal to Discriminate Against People with AIDS?.....	6
Whom Does the ADA Protect from Discrimination?.....	7
Who Must Comply with the Laws Protecting People with Disabilities?.....	7
May I Require that a Child Be Tested for HIV Infection and the Test Results Disclosed to Me?	7
If I Know a Child Has HIV or AIDS, Whom May I Tell?	9
If I Know or Believe that a Child Has HIV or AIDS, Is It Appropriate to Exclude that Child from My Program?.....	10
How Do I Determine Whether My Child Care Program Is an Appropriate Environment for a Child with HIV or AIDS?.....	11
Does a Child with HIV or AIDS Need Any Special Immunizations?.....	12
How Is the HIV-Infected Child Entitled to Be Treated While Attending Child Care?	13
Do I Need to Provide Special Toys or Accommodations for a Child with HIV or AIDS?	14
How Do I Determine Whether a Child with HIV or AIDS Poses a Direct Threat to the Health or Safety of Others?.....	15
What Should I Do if a Child Exhibits Aggressive Behavior?	17
What Is the Best Way to Prepare for Potential Illness in Children?.....	18
Standard or Universal Precautions and OSHA Regulations	19
Who is Required to Establish Universal Precautions?.....	19
When is Hand-Washing Necessary?.....	19
What is the Proper Method of Hand-Washing?	20
Do I Ever Need to Wear Gloves?	20
Should I Wear Gloves While Diapering a Child?.....	21
Should I Wear Gloves if a Child is Injured?.....	22
What Cleaning Procedures Should I Follow? What Cleaning Supplies Do I Need?....	22

Do I Need to Clean Toys that the Children Are Sharing? What if the Children Are Mouthing the Toy?.....	24
What Precautions Should I Take in Waste Disposal?.....	24
What Do I Do if I Think Someone in the Program Has Been Exposed to Contaminated Body Fluids? Do I Need to Report this Information?.....	26
Conclusion	26
Appendix A: Biohazardous Waste Symbol	27
Appendix B: Regional OSHA Offices.....	28
Appendix C: Other Resources Directory of National Organizations.....	30

INTRODUCTION

The number of children in this country who test positive for HIV has decreased in recent years, due in part to the use of antiretroviral medications for pregnant women.¹ “With no intervention, the likelihood that an infected mother will pass H.I.V. to her child is 20 to 25 percent, according to the Centers for Disease Control. A year after the introduction of AZT treatment, the risk had dropped to 8 percent . . .” according to an expert quoted in the New York Times.² These new drug treatments are also being used on the children who do test positive, enabling more children with HIV to function normally in classroom settings for long periods of time.³ Thus, despite the decreased numbers, some child care providers will inevitably need to be prepared to care for children with HIV. This is especially true in areas with high immigration rates, as many children coming here from other countries may not have had the same opportunities to be diagnosed and treated. How does one prepare? To be ready to care for children with HIV/AIDS, providers must deal with their fears and ignorance about the disease, learn about confidentiality requirements and how to ensure a safe environment for all children in child care, regardless of HIV status. For the most part, preventive care and knowledge will go a long way.

All children need loving care, nurturing, guidance, and a safe environment in which to thrive. Children with HIV have exceptional needs for these elements of care. Although the medical profession has established that transmission of the HIV virus does not occur through casual contact like preparing food, sharing eating utensils, hugging, kissing, or diapering,⁴ a great deal of unwarranted fear and anxiety still remain about transmission of the virus. Regrettably, people with HIV or AIDS are the ones who suffer most as a consequence of this public fear. It is not uncommon for children with HIV to be isolated from casual contact and stigmatized because of the mistaken belief that they pose a threat to others. When this happens, these children can lose out on much of the loving care, nurturing, social contact, and early education that they need and deserve in order to thrive.

With the passage, in 1990, of the law known as the Americans with Disabilities Act⁵ (the “ADA”), child care providers may not deny care to children with HIV or AIDS just because the children have the virus. Due to the medical advancements in treatment for individuals living with HIV infection and AIDS’ providers could be asked to care for children with HIV or AIDS. In all likelihood, any provider who is asked to do so will be required by law not to deny care solely on the basis of the child’s HIV infection. It is important that you, as a child care provider, understand what your legal obligations are under the ADA, and that you have the chance to think through some of the difficult issues that are bound to arise before you actually face the issues. This publication will help you to anticipate some of the questions you, your caregiver staff, or the parents of the children for whom you care may have about HIV transmission and prevention, your legal responsibilities under the ADA to admit and care for a child with HIV/AIDS, and issues of confidentiality regarding a child’s HIV status.

BACKGROUND INFORMATION ON HIV AND AIDS

WHAT ARE HIV AND AIDS, AND HOW DO THEY DIFFER?

HIV (Human Immunodeficiency Virus) is a virus that weakens the immune system by depleting the supply of specialized white blood cells (T-cells) that help the body fight infection. The virus can also cause illness by directly infecting the brain, intestines, kidney, heart or other organs. As HIV weakens the immune system, the individual becomes susceptible to secondary infections typical of AIDS. The onset of AIDS is usually diagnosed by the presence of opportunistic infections or other specific conditions. Pneumocystic Carinii Pneumonia (PCP) is a common opportunistic infection affecting children. PCP occurs in about 40 percent of children with AIDS and is a major cause of death among these children. It is the presence of these so called “opportunistic” infections that indicates the presence of Acquired Immune Deficiency Syndrome, or AIDS.⁶ Hepatitis and renal disease are other complications occurring in children with AIDS.⁷ Diseases like TB also occur more commonly in children with HIV. The most common complications for children with HIV/AIDS are common bacterial and viral infections including bacterial pneumonia, thrush and sinus and ear infections. These are very common and NOT highly transmissible. There is no greater risk of transmission of these conditions when children with HIV/AIDS have them than when children without HIV get them.

HOW MANY CHILDREN ARE INFECTED WITH AIDS?

In 2003, 152 children born with AIDS were reported to the CDC. This was a slight decrease from the 158 cases reported in 2002.⁸ Infants of HIV positive women acquire antibodies through the placenta and will therefore test seropositive at the time of birth.⁹ However, most children who test positive at birth for HIV infection will convert spontaneously to negative HIV status within their first year of life and will never develop a full blown case of AIDS.¹⁰

More than ninety percent of HIV infected children acquired the virus from their mothers.¹¹ According to the American Academy of Pediatrics, 80 percent of women with AIDS (approximately 80,000 women) are in their childbearing years, and more than 25% of women with AIDS are from smaller cities or rural areas of the United States.¹² Although declining in numbers in the United States, children with HIV or AIDS comprise an important concern for child care providers. Children with HIV are living longer and healthier lives, and as a result more will be entering child care.¹³ Moreover, the mothers of children with HIV or AIDS are also likely to have the virus, thus making child care for these children vitally important, particularly if the mother’s health is declining. In some cases the mother’s health may have become so poor that it altogether prevents her from continuing to care for her child, or a child’s mother may have already died. As a result, it is not unusual for children with HIV to be cared for by their father, other relative, or a

non-relative guardian who may be the one seeking child care and making legal decisions on behalf of the child. Even if the mother is still caring for her child, the increased likelihood that she may encounter serious health problems will heighten the important role that child care can play in the child's growth and development. Finally, pediatric AIDS continues in epidemic proportions in other parts of the world, and immigration of families will continue the presence of the disease here in the U.S. Consequently, it is important for all providers to be prepared.

WHAT SYMPTOMS ARE ASSOCIATED WITH HIV AND AIDS?

A person infected with HIV may not show any symptoms for many years after becoming infected and they may not even know they are infected. During this time, the person with HIV may look and feel very healthy and may not need any special care or accommodations. If a child with HIV has no symptoms, the child care setting, including exposure to common childhood illnesses, will pose little risk to her or his health. However, "[b]ecause the immune systems of children born with HIV [have] not fully developed, they many begin to show the symptoms of infection much more quickly than adults do."¹⁴ When the HIV infection becomes symptomatic, it can manifest itself through many types of symptoms, including ear infections; frequent and persistent diarrhea; joint infections; inability to gain weight and to thrive normally; gland, spleen, or liver enlargement; or developmental delays.¹⁵

The onset of AIDS is usually diagnosed by the presence of opportunistic infections or other specific conditions. Pneumocystic Carinii Pneumonia (PCP) is a common opportunistic infection affecting children. PCP occurs in about 40 percent of children with AIDS and is a major cause of death among these children. Hepatitis and renal disease are other complications occurring in children with AIDS.¹⁶

HOW IS THE VIRUS TRANSMITTED?

By far, the most common way for children to become infected with HIV is through congenital or perinatal transmission.¹⁷ This is when the virus is passed from an infected mother to her child during pregnancy, labor, or delivery. Mothers with HIV do not always pass the virus to their unborn children. Transmission rates have dropped dramatically in recent years, due in part to HIV testing of pregnant women, counseling of HIV positive women in the US not to breastfeed, antiretroviral drugs and elective cesarean delivery before the onset of labor, but perinatal exposure still occurs. And, of those, the HIV-blood test of many of the children born with the virus converts spontaneously to a healthy blood test within the first year of life.¹⁸

In the past, some children also became infected through blood transfusions. According to the American Red Cross, today the risk of receiving an HIV positive unit of blood through a blood transfusion is 1 in 1.5 million.¹⁹

HIV can only be transmitted through the exchange of certain body fluids. Many body fluids do not pose a problem unless they contain visible blood. Saliva, sweat, tears, vomit, urine, feces, nasal secretions, and breast milk all pose virtually no risk of transmission of the virus with casual contact, unless they contain visible blood.²⁰ In the child care setting, blood will be the main type of body fluid which will require use of standard or universal precautions.

There are no known cases of children (or adults) having become infected with HIV through casual household contact, like food preparation, eating, hugging, kissing, diapering, or other forms of contact commonly occurring in the same household or in child care. Even biting has never resulted in transmission of the virus in the child care setting. A child with HIV or AIDS poses virtually no risk to the health of the other children or staff in a child care setting. This is particularly true when standard precautions or universal infection control measures are taken on a regular basis for all children. Taking these simple precautions on a routine and uniform basis (such as regular hand-washing) when caring for all children can protect both children and staff from transmission of HIV and other infections which are far more common, such as Hepatitis B and Hepatitis C.

WHAT ARE STANDARD PRECAUTIONS OR UNIVERSAL INFECTION CONTROL MEASURES?

Universal infection control measures also known as “standard precautions” (which has become the favored term), are a set of simple hygiene, social, and behavioral guidelines recommended by the Centers for Disease Control and the American Academy of Pediatrics to prevent the spread of infections, including HIV.²¹ Since 1992, most child care providers have been required by law²² to establish and practice a set of infection control guidelines for their programs. The best way to control the spread of any infection in a child care setting is to implement and adhere strictly to these guidelines in a uniform manner. While these universal precautions are designed to prevent the transmission of HIV, HBV (hepatitis B virus), and HCV (hepatitis C)²³, as well as other infections, **they will only be effective if they are practiced consistently**, regardless of whether a particular child or adult is known to test HIV, HBV, or HCV positive. All child care programs, whether required by law to do so or not, should follow the uniform guidelines. Implementing standard precautions or infection control measures will greatly reduce the risk of transmission of any infectious disease in your child care program and will also serve to protect you from liability should a child under your care contract an infectious disease.

Generally, universal precautions entail relatively simple precautions that many child care providers already practice. Moreover, most recommended and required precautions are neither expensive nor difficult to implement in a child care setting. These precautions include regular hand-washing, daily cleaning of surfaces, use of disposable gloves when coming into contact with blood, and proper disposal of items that can potentially carry infectious material. To ensure uniformity in your universal precautions, each program should formally adopt a set of written guidelines that becomes standard procedure. To

determine whether your program is required by law to comply with universal precautions, and for a detailed description of the universal precautions required by law and recommended by the CDC, see the section titled *Standard Precautions or Universal Precautions and OSHA Regulations* later in this publication.

HOW DO I HANDLE FEARS OR MISINFORMATION ABOUT HIV FROM STAFF OR PARENTS?

Education is the best way to deal with ignorance or fear about HIV or AIDS. Training of parents and staff will also likely save you from future difficulties by opening the topic for discussion and education before a concrete situation arises. You should conduct trainings for your staff and workshops for parents using local experts on HIV as presenters. Smaller programs may be able to combine efforts with other programs. Because the issues and fears that staff and parents hold can differ significantly, it is always a good idea to provide separate trainings for each group. And, while the training for parents is optional, OSHA regulations, if applicable, require you to train all of your staff (including substitutes and possibly volunteers), at the time of hire and annually thereafter.²⁴

If outside health experts are not available, review and present objective information about the virus yourself. Extensive information on pediatric HIV/AIDS is available on the Centers for Disease Control website at www.cdc.gov; click on “Diseases and Conditions” and then click on HIV/AIDS. Disseminating printed literature on transmission of the virus will always be useful, regardless of the size of your training. No matter how simple or elaborate your training is, your efforts are likely to reach at least some, whether staff or parents, who will benefit from further education on the topic. In educating staff and parents, be sure to:

- Discuss the limited ways in which HIV and other blood borne diseases could be transmitted in the child care setting, and emphasize to parents and staff that there have been no cases of HIV transmission in the child care setting.
- Let parents know that both prevalence and transmission of HIV in young children is extremely low, and that a strictly followed uniform hygiene policy is the best method of infection control.²⁵
- Present your policies for infection control, handling aggressive behavior,²⁶ health assessment,²⁷ and confidentiality to parents and staff. These policies should be applied uniformly and involve all children.
- Be certain that all staff members (including substitutes and, if they participate in your program, parents) understand and follow your standard precautions or universal infection control guidelines.

- Discuss universal precautions and HIV/AIDS education as a community response to prevention and discuss the importance of adhering to the prevention principles in our personal lives as well as in the child care setting.
- Discuss how to use supplies for infection control such as gloves, disinfectants, and plastic disposable bags.
- Discuss the types of aggressive behaviors you are watching for from any child and the types of action you take to prevent such behaviors as well as how you address them when they do occur.
- Discuss your policy to exclude children who are too ill to attend child care, and the importance of the parents notifying you if their child has any infectious disease from which other children (especially children with HIV) should be protected.
- Discuss your policy and legal obligation to protect the confidentiality of all medical information pertaining to each child, including information concerning a child's HIV status. Be clear with parents that you will maintain this confidentiality.

AIDS DISCRIMINATION: LEGAL ISSUES

IS IT ILLEGAL TO DISCRIMINATE AGAINST PEOPLE WITH AIDS?

In 1990, Congress passed the Americans with Disabilities Act (the "ADA"), a comprehensive federal law that prohibits discrimination on the basis of disability (including HIV and AIDS).²⁸ Generally, you may not discriminate against people who have HIV, AIDS, or other blood borne diseases such as Hepatitis B or Hepatitis C simply because of the existence of the condition. This means that you may neither refuse to admit a child into your program if the only reason for refusal is that that child tests positive for HIV or has AIDS, nor refuse to employ an otherwise qualified person who tests positive for HIV or who has AIDS.²⁹ The ADA, and other state anti-discrimination laws which parallel the ADA, do not focus on the name of the disease or the impairment. Instead, if a person has a physical or mental impairment which substantially limits one or more major life activities, they are covered as a person with disabilities and are entitled to receive reasonable accommodations to enable their participation in "public accommodations." Public accommodations include almost any kind of privately owned business that opens its doors to the public, and very clearly include child care providers of all sizes.³⁰ Under the ADA, both child care centers and family child care homes are considered to be "public accommodations."

WHOM DOES THE ADA PROTECT FROM DISCRIMINATION?

In addition to people with other types of disabilities, **the ADA protects people with HIV and AIDS** from discrimination in employment and public accommodations. The ADA also protects **people who are regarded as having HIV or AIDS** (refusing admission of a child into your program cannot be based on the belief that the child has HIV/AIDS, regardless of whether that child does in fact have HIV or AIDS), **people who have a record of HIV** (even if they are currently asymptomatic), and **people who are associated with people who have HIV or AIDS**. This latter category means that a child cannot be refused care simply because the child's mother, father, caretaker, brother, sister, or other person closely associated with the child—even if a non-relative has HIV or AIDS.

WHO MUST COMPLY WITH THE LAWS PROTECTING PEOPLE WITH DISABILITIES?

As noted above, all public accommodations of any size must comply with the ADA. This includes all child care providers, regardless of whether the program is based in a center or a family home. This means that no child care provider may refuse to admit or care for a child simply because that child has HIV or AIDS, nor may a child be discriminated against simply because she or he has a family member who has HIV or AIDS. Case law has established that children with HIV/AIDS who are vulnerable to other opportunistic conditions and are moderately symptomatic are substantially limited in their ability to care for themselves.³¹

The only significant exception to compliance with the ADA is for religiously-operated child care programs, which are exempt from the ADA. Secular programs, housed in places of worship are not exempt. Remember, though, that state and local laws may also apply, some of which are now more comprehensive than the ADA. California anti-discrimination law, known as the Unruh Civil Rights Law, prohibits discrimination by "business establishments."³² There are currently no cases which directly address how California courts will treat child care programs operated by religious entities, but to the extent that they operate as business establishments—open to the public, charging fees and including more than religious instruction, it is likely that they will be required to comply with state anti-discrimination law. In California, the Department of Fair Employment and Housing (DFEH) is responsible for enforcing this law. You can contact them for further information,³³ or if you are from another state and are unsure of what state and local laws apply to your program, contact the Attorney General's office in your state.³⁴

MAY I REQUIRE THAT A CHILD BE TESTED FOR HIV INFECTION AND THE TEST RESULTS DISCLOSED TO ME?

The simple answer to both questions is "No." Generally, child care providers do not have the right to require information about a child's HIV status. Because casual contact

has never resulted in the transmission of the virus, a child's HIV status, in and of itself, poses virtually no threat to the health and safety of the other children or staff in the child care setting, particularly if your program routinely practices standard precautions or universal infection control procedures, which in most instances is required and in all other instances is "best practice."

More specifically, the ADA clearly forbids HIV testing as a requirement of admission to a child care program. "Screening" children out of your program who test positive for the virus is strictly forbidden. This means that you may neither require a child to be tested for HIV infection, nor may you require the disclosure of the information if the child has been tested.

The information about a child's HIV status is confidential and very private information. Because of public fear and misinformation on the subject, careless disclosure of this information can be very damaging and stigmatizing to the child and his or her family. Consequently, many parents and guardians with HIV-infected children may never feel safe in disclosing their child's HIV status to their child care provider, and it is well within their rights not to disclose this information. **In practice, therefore, you should always assume that you may be caring for a child who is HIV infected and take the appropriate precautions to prevent exposure to the virus.** Routinely taking proper precautions will eliminate any need on your part to know the HIV status of children in your care and will help keep all the children protected from the spread of disease. While you may not require information about a child's HIV status, the parents or guardian of a child with HIV or AIDS may voluntarily disclose this information to you. And while the HIV status of a child will never be information that is *necessary* for you to obtain, having this information may make you better equipped to care for the child and to help the parents or guardian detect symptoms of infections early. The parents or guardian are likely to disclose this information only if you have established an environment of trust with them, and if they do volunteer information about their child's HIV status, it is vitally important that you maintain the information in the strictest of confidence (see the section titled *If I know a child has HIV/AIDS, who may I tell?* in this publication for a more thorough discussion of confidentiality).

The best way to engender a feeling of trust with the parents or guardian of any child with a disability is to follow these guidelines:

- 1) Assure all parents and guardians that all health related information will be held strictly confidential and will not be disclosed to other parents, to other staff, or to the public without the written consent of the parents or guardian.
- 2) Do not ask parents or guardians to disclose the HIV status of their child; if they choose to do so, allow them to approach you.
- 3) Assure parents and guardians that any information they give about a child's HIV status will be used only to determine the best care possible for

the child; it will not be used to screen the child out of your program or to separate or isolate the child from the other children or staff.

- 4) Develop a written policy about the confidentiality of the children's personal health information, and enforce and maintain these rules of confidentiality (particularly HIV status) very strictly with your staff and others;
- 5) Distribute your policy and rules of confidentiality to all parents and guardians.

Following these guidelines will make the parents or guardian of any child with a disability more likely to feel safe in confiding details about the child's condition that may help you care for the child. But, remember, parents and guardians *never have to* disclose their child's HIV status; while some do, there is a good chance that you may find yourself caring for a child who, unbeknownst to you, has HIV. **Practicing appropriate infection control precautions on a routine basis is the best way to eliminate any need to know.**

A child with an infectious condition can be excluded from child care if the condition poses a direct threat to the health or safety of other children or staff in the child care setting (see the section titled *How do I determine whether a child with HIV or AIDS poses a direct threat to the health or safety of others?* in this publication for a more thorough discussion of *direct threat*). However, a child's HIV-positive status alone will never constitute a direct threat, because HIV is not actively infectious through casual contact, particularly if universal infection control measures are practiced. Any absolute exclusion of children with HIV/AIDS or other condition which do not pose direct threats would violate the ADA. Acute, temporary illnesses, such as measles, are not considered disabilities under the ADA, and regulations that require exclusion of children with these illnesses do not violate the ADA. The ADA does permit you to exclude adults with active infectious diseases such as tuberculosis (TB), when the basis for exclusion is limited to conditions such as TB that pose a *direct threat* to others. Note however that *children* cannot be excluded for TB because they do not tend to transmit the disease before puberty and therefore do not pose a threat to others.

IF I KNOW A CHILD HAS HIV OR AIDS, WHOM MAY I TELL?

Most states have confidentiality laws that prohibit the disclosure of health information without written permission.³⁵ Information about HIV status is especially sensitive and so may be protected by specific state laws. Where laws governing release of HIV-related information exist, they tend to be stricter than laws limiting release of general medical information. Some HIV-specific confidentiality laws require written permission from the person with HIV (or, for children, from a parent or legal guardian) before disclosing even to other staff or board members within your program. California child care center licensing regulations, for example, prohibit child care providers and their employees from revealing or making available confidential information, such as a child's HIV status.³⁶ While family child care homes do not have the same explicit regulatory provision, best

practice and general confidentiality laws would suggest that the same should be practiced by family child care providers. Whether or not your state has HIV-specific confidentiality laws, it is a good idea to refrain from disclosing this information to anyone, even within your program, unless you have obtained written permission for each disclosure from the child's parent or guardian. Information or rumor about a child's HIV status can be very volatile and can take on a life of its own very quickly if confidentiality is not carefully maintained. Once you have shared the information with one other person, you no longer have control over the information. Remember, the parents or guardian of a child with HIV, alone, own this information, and they, alone, have the right to decide who else may know.

If you disclose the HIV status of a child to another person, even a staff member, and the news spreads to other staff or parents, to the press, or to anyone else, your program may be indirectly or directly responsible for the ignorance, fear, discrimination, or hostility that the child may face as a consequence. If the information spreads beyond those who were granted explicit permission to know, your program may become liable for violating the medical records and/or HIV confidentiality laws of your state. Fortunately, it is within your power to prevent this from happening by exercising strict rules of confidentiality.

It is also important to impress upon all of your staff members that a child's HIV status is extremely sensitive and legally protected information. If the parents or guardian of a child with HIV permit disclosure to staff, or if staff believe that a child for whom they are caring has HIV, the importance of refraining from disclosing this information should be underscored. Under no circumstances may staff members disclose or discuss this information with other staff, parents, or others without written permission from the parents or guardian of the child with HIV and unless instructed by the director of the program to do so. Be sure to include your strict policy on confidentiality and information about staff responsibility in maintaining confidentiality in all training about HIV or AIDS as well as in your initial staff orientations.

IF I KNOW OR BELIEVE THAT A CHILD HAS HIV OR AIDS, IS IT APPROPRIATE TO EXCLUDE THAT CHILD FROM MY PROGRAM?

Just as you may not require information about a child's HIV status, you may never refuse to care for a child simply because you know the child has tested positive for HIV. The fact that a child has the virus poses virtually no risk to the other children or staff in your program. You may not refuse to admit or discontinue care for a child based simply on the fact that the child has HIV.

A child with AIDS may be excluded from care only if the child has a secondary infection that poses a direct threat to others and the child's individual condition requires accommodations that would impose an undue burden on program resources or would fundamentally alter the nature of the program.³⁷ A child excluded from care for this reason may be excluded only for the duration of the direct threat. For a more detailed

discussion, see the section in this publication titled *How do I determine whether a child with HIV or AIDS poses a direct threat to the health or safety of others?*

HOW DO I DETERMINE WHETHER MY CHILD CARE PROGRAM IS AN APPROPRIATE ENVIRONMENT FOR A CHILD WITH HIV OR AIDS?

The ADA prohibits child care programs from denying a child admission based on the child's status as an individual with HIV. Children with HIV who are admitted into child care programs are entitled to participate equally with the other children in *the most integrated setting appropriate to the needs of the individual*.³⁸

For the most part, children with HIV, particularly those who are asymptomatic, will be unlikely to need any special accommodations in order to be integrated into your program. You may not even be aware that you are caring for any children with HIV. However, some children with HIV may tire more easily or may have additional disabilities that may require some accommodations from you. When a child's disability is brought to your attention, you should follow a standard procedure to determine what reasonable accommodations can be made to facilitate the child's participation. For larger programs, it is recommended that you assemble a panel of experts, including the **child's physician, and family members or guardian** to discuss the considerations in caring for the child with HIV or AIDS, and that you review these considerations periodically. If appropriate, consideration may also be given to incorporating the input of a local public health official. For smaller programs it may be impractical to assemble a formal panel of experts, but it is still a good idea to consult with the parents or guardian, the child's physician, and as appropriate, a local health official. **Remember, you will need written permission from the parents or guardian to discuss the child's health concerns with anyone, even consultants who are on a formally organized panel.**³⁹

In considering what to discuss with your program's consultants, keep in mind the following:

- Understand the child's individual needs and condition; engage in a discussion with the family or guardian, the family physician, and as appropriate, the local public health official, keeping in mind the particular needs of this child. Given the child's current condition, are any measures necessary to minimize the child's exposure to infections in the child care environment? Are there any activities the child should not participate in, given her or his current health?
- Assess the child's immune status. Determine whether, at this particular stage, the child can tolerate an environment such as the one at your program. Remember that children who are immuno-deficient may experience serious complications from chicken pox, CMV (cytomegalovirus), tuberculosis, and the measles virus. As a result, notification of contagious illnesses to parents and public health officials is essential and are also likely to be required by your licensing

regulations⁴⁰ thereby posing no additional burden on the program to notify all parents of children who have been exposed to these diseases/conditions.

- Make every reasonable attempt to accommodate the child's condition and needs. For instance, a very ill child may require having a place in your program held open during an absence or series of absences, or the child may need medication administered at the program site. The ADA permits you to maintain uniform policies on payment for absences, as long as the same policy is applied to all children, regardless of the reason for the absence. Be clear with parents and guardians about your payment policies. By contrast, uniform policies which prohibit the administering of medication generally are considered to be a violation of ADA since, according to case law, such a policy neither fundamentally alters the program nor presents an undue burden.⁴¹

With a parent's or legal guardian's consent, child care providers may contact Department of Public Health personnel, child care health consultants, and/or health care professionals when making these assessments about a particular child. All persons consulted and findings made in this process should be documented and the records should be maintained in the child's confidential records.

If the request is only for general information not related to a particular child, child care providers may ask these professionals for general health/medical information without the consent of the parents.

Obviously, this process is possible only when a child's parents or guardian volunteer information about the child's HIV status and consent to your having access to health professionals. While you may feel that you can be of more help to the child and the family if you know this information, it is entirely up to the parents or guardian to decide whether to disclose the information to you. The best you can do as a provider is to establish and maintain open and confidential communication with the child's parents or guardian. Foster an environment of trust through parent and staff education. In this environment, parents and guardians can more easily discuss health problems openly and honestly, knowing that any needs will be dealt with in a fair and confidential manner and that no one will be discriminated against because of an illness.

DOES A CHILD WITH HIV OR AIDS NEED ANY SPECIAL IMMUNIZATIONS?

Many children with HIV infection cannot tolerate the standard immunizations against childhood diseases and, consequently, are medically exempt from state licensing requirements for these immunizations.⁴² But, because HIV infection attacks a child's immune system, leaving the child more vulnerable to these common infections, it is vitally important for these children to be protected from infectious diseases whenever possible.

Fortunately, the Centers for Disease Control (CDC) has developed alternative immunization recommendations that can be tolerated by children with HIV. Contact the Centers for Disease Control (www.cdc.gov) or the child's pediatrician for the most current information. See Appendix C for additional resources. While these alternative immunizations are optional for children with HIV, you should raise the option in your discussions with the child's parents or guardian and your program's consultants as a possible means of preserving and safeguarding the child's health, considering the likelihood of the child's exposure to many contagious illnesses in the child care setting. If immunizations are not required by state law, it is still a good idea to inform all parents at the time they enroll their child about the standard and alternative immunizations, and where to get additional information. It will then be up to the parents or guardian to decide whether to discuss them further with you.

A child with HIV has a compromised immune system that will not adequately protect her or him from some common childhood illnesses, such as chicken pox or measles. Exposure to these illnesses may lead to serious health complications for children with HIV and should be avoided whenever possible by simply enforcing a policy of routinely posting exposure notices and excluding all children with any acute illness during the illness' actively infectious stage, the risks from exposure can be reduced, thus allowing the child with HIV to remain in child care. This policy, of course, will benefit everyone, because it will also help to prevent the spread of the acute illness to the other children or staff in the program.

HOW IS THE HIV-INFECTED CHILD ENTITLED TO BE TREATED WHILE ATTENDING CHILD CARE?

The ADA makes it very clear that a child with HIV has the right to participate fully, equally, and not separately from the other children, unless the child's condition poses a direct threat to the health and safety of the others. A child's HIV status alone will not pose a risk through touching and normal play. Consequently, the law requires that a child with HIV be allowed to engage in normal activities with other children *in the most integrated setting appropriate to the needs of the child.*⁴³

Of course, if the parents or guardian of the child with HIV request certain accommodations for the child that result in some unequal or separate treatment of the child, you may accommodate the parents' request. But you may not *require* different treatment of a child with HIV who does not pose a direct threat, nor may you treat the child differently or separately at the request of parents of the *other* children. While a child can be excluded from a program if they pose a direct threat there have been no cases in which such a direct threat has been identified in the child care setting. Since HIV/AIDS alone does not pose a direct threat, and the secondary infections children with HIV/AIDS experience rarely are ones which would constitute a direct threat, this situation would rarely apply. (As noted earlier, an adult staff member on the other hand, who had HIV/AIDS and developed active infectious tuberculosis might be excludable because active infectious tuberculosis could pose a direct threat if no reasonable accommodation to eliminate the direct threat is available.)⁴⁴ The condition of an

asymptomatic child with HIV, or one whose symptoms are not actively infectious, will most likely *not* pose a direct threat to others, and that child is entitled to be fully integrated into your child care program.

DO I NEED TO PROVIDE SPECIAL TOYS OR ACCOMMODATIONS FOR A CHILD WITH HIV OR AIDS?

Providing special toys for a child who has HIV is unnecessary, since any risk in sharing toys with other children is virtually non-existent. Absent an objective medical reason or unless you routinely provide separate toys for all children,⁴⁵ you may be violating the ADA if you do have separate toys for a child known to have HIV, since this would likely necessitate in separating the child with HIV from the other children. Depending on the condition of a child with HIV, she or he may need some accommodations to make it possible to be integrated comfortably and safely into your program. The types of accommodations will, no doubt, vary greatly depending on the child's individual needs and the progression of the disease. To help you determine the type of accommodations needed by a child under your care, you should consult with the child's parents or guardian and physician, and if appropriate, a local public health official (see *How do I determine whether my child care program is an appropriate environment for a child with HIV/AIDS?* in this publication). Remember that the law requires you to make reasonable modifications to your policies, practices and procedures for the child only when the accommodations do not **fundamentally alter the nature of your program**. Remember, also, that if you are unaware that a child has HIV or if the child's parents or guardian have not indicated a need for accommodations for the child's condition and the need is not self evident, you are under no legal obligation to provide accommodations until the need is brought to your attention. It is the legal responsibility of the child's family to inform you of the need for reasonable accommodations for any disability.

If a preferred accommodation will fundamentally alter the nature of your program, you must look for **reasonable alternatives** that will not do so. Remember, too, that you may not pass the costs of accommodating the child on to that child's family, alone.⁴⁶ Costs of accommodating the child will have to be borne by your program's existing budget, through outside funding, or by increasing rates to all parents. The resources your program has from any of these sources will become the primary basis for you to use in evaluating whether accommodating a child's particular needs will impose an undue burden on your program. For a much more detailed discussion of *undue burden and fundamental alteration of the nature of the program*, and how to handle the increased costs of caring for a child with disabilities, see CCLC's publication, *Caring for a Child with Special Needs: The Americans with Disabilities Act and Child Care*.

HOW DO I DETERMINE WHETHER A CHILD WITH HIV OR AIDS POSES A DIRECT THREAT TO THE HEALTH OR SAFETY OF OTHERS?

The fact that a child is infected with HIV or AIDS virtually never poses a *direct threat* to the health or safety of others in a child care program, particularly if standard precautions or universal infection control measures are practiced.⁴⁷ While rare, it is conceivable that other, secondary infectious conditions, whether related to the HIV infection or not, could pose a direct threat. As one example, an adult with active infectious tuberculosis (which is more commonly existent in persons with HIV/AIDS than in the general public) might be excludable from a contact position in a program because adults with active infectious tuberculosis may be considered to pose a direct threat when there is not reasonable accommodation available to eliminate the direct threat. However, children with HIV/AIDS who also have tuberculosis generally are not excluded because children with TB do not actively transmit the disease until they reach puberty. In sum, exclusions may only occur if it can be objectively established that admitting the child would pose a direct threat to the health or safety of other children or staff in the program.

A determination of direct threat must never be based on personal or public fears and biases, stereotypes, or general misinformation.⁴⁸ You must always have objective medical, scientific, or public health information upon which to base a decision of this nature, and you should document the information and keep it in the child's confidential permanent file. The process of determining a direct threat and assessing potential accommodations should include records of consultation with the child's parents or guardian, physician, and a local health official (see *CCLC's publication Caring for Children with Special Needs: The Americans with Disabilities Act and Child Care* for resources from which to obtain objective medical information).

You should consider the following criteria in determining whether a specific chronic infectious condition poses a direct threat to others:

- the symptoms the child has;
- the risk to the infected child if she or he remains in the child care setting;
- how the infectious condition is transmitted;
- the likelihood that the infectious condition will be transmitted to others;
- the duration of the risk of transmission;
- the severity of the risk to others;
- the probability that the infectious condition will be transmitted to others; and
- any reasonable accommodations that would enable the child to remain in the child care setting.⁴⁹

In assessing these criteria, a provider must examine objective medical information about the child's condition, facts about the particular child's condition, and whether the provider is able to offer a safe environment by altering some policies or practices of the

program. While it is often not possible to eliminate the direct threat of an infectious condition through accommodations, exploring the options is nonetheless required. In some cases it may actually be possible to eliminate the threat by taking some very simple and common sense measures.

Again, consultation with the child's doctor and/or public health officials about whether the direct threat to the other children can realistically be eliminated, given the particular circumstances, is strongly recommended. Your objective observations of the children's behavior, as well as the parents' objective observations of the children, can also be taken into account in assessing the likelihood of success of removing the threat to the other children.

If a **direct threat** can be eliminated through **reasonable accommodations** such as **changes in policy or practices** that do not **fundamentally alter the nature of the program**, then the ADA requires the provider to care for the child until or unless the child's condition progresses to the point where it will pose a direct threat to others and cannot be reasonably accommodated. If there is no reasonable way to eliminate the threat, the law will not require you to care for that child. Remember, though, that before you conclude that a direct threat cannot be reasonably eliminated, you must explore whether any **reasonable alternatives** exist that will eliminate the direct threat without isolating the child from the other children.

The ADA requires you to take steps to minimize the possibility of a direct threat from a child's condition. The following steps are recommended:

- 1) Maintain close contact with all of the parents. Let them know that you need to be kept informed of any condition any child has that is, or could be, contagious. Do not expect to be able to diagnose the condition of a child with HIV or AIDS.
- 2) Do not permit children to attend the program during the contagious period of a specified communicable disease, such as when they have chicken pox.⁵⁰
- 3) When a child is known to have HIV and/or known to have a contagious illness, monitor the progress of the disease with the parents or guardian and the physician.
- 4) Provide on-going staff education that addresses topics such as health, sanitation, child guidance, developmentally appropriate activities, and other topics to help prepare your staff with the proper tools to accommodate a child with HIV or AIDS.
- 5) Post exposure notices for all communicable infectious diseases that could be, or could have been, transmitted at child care. Inform newly enrolling parents of infectious diseases which have had outbreaks in the past year,

an issue of particular importance for those who enroll who have not been vaccinated either because of a medical condition or personal belief.

A good summation of the law is found in a letter from the Department of Justice to the Honorable Frank S. Turner, Maryland House of Delegates who wrote the DOJ on behalf of the Howard County Family Care Association. The letter noted the following: "A direct threat is a significant risk to others that cannot be eliminated or reduced to an acceptable level by reasonable modifications to the public accommodation's policies, practices, or procedures or by the provision of appropriate auxiliary aids or services. The determination that someone poses a direct threat should be based on the best available objective evidence rather than generalizations or stereotypes. Based on the CDC's findings. . . , private and public child care and educational institutions cannot exclude from their programs children who are living with HIV or AIDS, because abundant scientific evidence suggests that there is almost no risk that the disease will be transmitted through the types of contact that occur in these settings."⁵¹

WHAT SHOULD I DO IF A CHILD EXHIBITS AGGRESSIVE BEHAVIOR?

HIV has never been transmitted casually in a child care setting, even through a bite or a scratch.⁵² Children who demonstrate aggressive behavior should be treated no differently if they are known to have HIV. Aggressive behavior by any child should be promptly dealt with by the staff to prevent injury to children and to protect children from behavior that could lead to infection or infectious disease.

To control aggressive behavior, such as biting or scratching, the child may require added supervision, and the provider should adopt a policy of positive child guidance techniques to deal uniformly with such behavior. For example, persistent biters may require separation from the group until the behavior subsides. If the level of supervision required for a child with aggressive behavior would fundamentally alter the nature of your program, then you may not be able to care for the child unless you are able to come up with reasonable alternatives that remove the risk to other children.⁵³ To determine how to care for an aggressive child, or whether you are able to do so, consult with the child's parents or guardian, physician, or a public health or mental health official to assist you in evaluating the situation (see the section titled *How do I determine whether my child care program is an appropriate environment for a child with HIV or AIDS*, in this publication, for a more thorough discussion on the use of consultants). Those with the greatest knowledge concerning behavior issues would include mental health consultants and behaviorists. There are also a number of excellent written resources in the child care field concerning challenging behaviors.⁵⁴

If injuries that require first aid or medical attention occur, notify the parents or guardians of both children. Remember, if you know that either of the children involved has HIV, you may not disclose this information to the other family without first obtaining written permission from the parent or legal guardian of the child with HIV.⁵⁵ This information is confidential, and you do not have the right to disclose it without consent.

WHAT IS THE BEST WAY TO PREPARE FOR POTENTIAL ILLNESS IN CHILDREN?

Any child, not just children with HIV, may become ill in your program with little or no notice. Therefore, it is vitally important to establish procedures and safeguards ahead of time, so that you will respond to an emergency or severe condition promptly and smoothly. The following steps are suggested:

- ***Establish clear lines of communication between your program's staff and the parents.***

For all children, it is important that you know how to reach a parent or legal guardian during child care hours in case of emergency. You should have this information, as well as the phone number for the child's physician, on file for all children. For children who are known to have HIV and who are symptomatic, it is especially important that you know where to reach a parent or guardian at all times, and that you have permission to call the family physician if you are unable to reach the parent or guardian.

- ***Monitor the health and behavior of the children and prepare progress reports.***

You or someone on your staff should evaluate any significant changes in children's behavior, and any indications of illness. A simple morning health check on all children is a good practice and may be required by your licensing regulations. This information is important to any parent or guardian but can be particularly important to a parent or guardian of a child with HIV. Review and discuss the recorded information with the child's parent or legal guardian with an eye towards the significance of any changes over time. Sudden changes should be immediately reported to the parent or legal guardian. When any child enrolls in your program, it is a good idea to ask the parent or legal guardian at that time to identify any particular changes staff should watch for. This information should remain in the child's confidential file.

- ***Notify the parents or guardian of any significant changes in the child and of contagious illnesses and infections in the child care program.***

The child who has HIV may be more susceptible to ordinary infections, such as chickenpox, fifth disease (parvovirus 19), diarrheal disease, and measles. The child's health status may also vary over time and the child may have increased susceptibility to infection at particular times. As a uniform policy, exposure notices should always be prominently posted.⁵⁶

- ***Be prepared to dispense medication to children.***

Under the ADA, child care providers may be required to dispense medications to children with HIV and other disabilities. Administering simple medications will likely be considered a reasonable accommodation

for the child and not a fundamental alteration of the program. Dispensing some medications may require training, and programs should adopt policies concerning the training of staff with responsibility for dispensing medication. Safety should be a primary concern. The child's parents or guardian and the physician are good sources of information about the child's health needs, how to dispense the medication properly, and what adverse reactions to look for after the child has been medicated. All medications should be clearly labeled with the child's name, the type of medication, how often the medication is to be dispensed, and any special administration procedures. Documentation is critically important as children with HIV/AIDS may be taking at least 2 to 3 and sometimes 4 to 5 different medications with as many as 24-35 pills per day. If there are any side effects to the medication that are important to keep in mind, you may want to put those on the label as well. Alert the parents immediately if you notice signs of side effects to the medication. For more information regarding dispensing medication in the child care setting, see CCLC's publication *Caring for Sick and Injured Children*.

STANDARD OR UNIVERSAL PRECAUTIONS AND OSHA REGULATIONS

WHO IS REQUIRED TO ESTABLISH UNIVERSAL PRECAUTIONS?

Providers who employ any permanent or temporary, full-time or part-time staff or substitutes, or who use volunteers who receive free meals or other in-kind compensation, are required by law to adopt a written policy for standard or universal precautions that conforms at least minimally to the guidelines set forth in this publication. Even small family day care providers who are exempt from this law because they do not have any employees or volunteers, should make serious efforts to adopt guidelines and practices that conform minimally with these recommendations, as a means of protecting your program legally and protecting the health of the children and staff. Aside from the instructions and guidelines you can obtain from OSHA, your local child care resource and referral agency, if available, may have resources helpful to you in developing your infection control guidelines. Other resources that may help you can be found at the conclusion of this publication.

WHEN IS HAND-WASHING NECESSARY?

Whether or not gloves are used, hands should always be washed immediately after handling body fluids. If any other body part (like bare arms) comes into direct contact with blood or a blood-containing body fluid, that skin should also be washed immediately after contact. The washing, of course, will also help to prevent the transmission of many other infections, and should be done regardless of whether the body fluids handled contained blood.

Hand-washing is critically important. It is the best method for preventing the spread of many infections — not just HIV and HBV — in the child care setting. Hand-washing should always be done under the following circumstances:

By adults:

- after diapering a child,
- after wiping a child's nose,
- before preparing or eating food,
- after using toilet facilities,
- after coughing, sneezing, or blowing their own nose,
- before and after treating and/or bandaging a cut,
- after being in contact with any other body fluids from another person,
- after cleaning toys, wiping down surfaces, cleaning spills, or any other
- housekeeping, and before and after administering medication.

By children:

- before preparing or eating food,
- after using toilet facilities,
- after being in contact with any other body fluids from another person,
- after blowing their own nose,
- before doing group projects involving contact with food.

Frequent hand-washing may cause dry and chapped skin. In order to prevent new breaks in the skin due to dryness, it is a good idea to provide hand lotion near the hand-washing area. Cuts and breaks in the skin increase the risk of HIV and HBV transmission if they come into direct contact with infected blood or blood-containing body fluids.

WHAT IS THE PROPER METHOD OF HAND-WASHING?

The proper method for hand-washing is to turn on the faucet, wet, and then lather the hands well using water and bar or liquid soap.⁵⁷ Rub your hands together for ten to fifteen seconds, cleaning the palms, tops of the hands, between the fingers, the wrists, and under the nails. Rinse hands well under running water, and dry with a disposable paper towel. Use a paper towel to shut off the faucet.

DO I EVER NEED TO WEAR GLOVES?

Child care providers should take two main precautions to prevent the transmission of HIV, and Hepatitis B (HBV).⁵⁸

- avoid direct contact with any blood, regardless of its source; and
- adopt hand-washing as a regular habit after handling any body fluids.

Direct contact with blood can be avoided under most circumstances by using disposable gloves (latex or for those with latex allergies, non-latex) when handling any blood-containing body fluid. Remember, using gloves will not only protect you from the virus, but also will prevent the spread of the virus from child to child through you or the gloves. Always dispose of gloves immediately after use, and never use them for handling more than one child. If gloves become torn or punctured while in use, dispose of them immediately. After you wash your hands, put new gloves on before continuing to handle blood or blood-containing body fluids.

Proper disposal of gloves means ensuring that no child or adult comes into direct contact with them. Gloves should be disposed of in a container with a firmly closing lid. Because used gloves that came into contact with blood or blood-containing body fluids are generally considered regulated waste under OSHA regulations, the disposal container should be red, lined with a red plastic bag, or labeled with the words or symbol for BIOHAZARDOUS WASTE (see Appendix A for a reproduction of the biohazardous waste symbol). Using a red container or liner is called color coding under the OSHA regulations. Some states, like California, require both color coding and labeling. Federal law allows you to choose between color coding or labeling. Check your state OSHA office to find out the waste management requirements for bloodborne pathogens in your state. If the state regulation requires more than the federal regulation, like it does in California, you must comply fully with the state regulation.

You must use a liner in your regulated trash receptacles, regardless of the liner's color, and the entire liner should be removed each time you empty the receptacle. Check with medical supply stores or your local hospital on how and where to obtain the red garbage bags or receptacles. See section titled *What Precautions Should I Take in Waste Disposal?* below for a more extensive discussion of disposal of regulated waste.

Individuals with latex allergies or sensitivities to latex should not use or be exposed to latex gloves. A variety of non-latex gloves now available on the market are just as effective and should be used instead.

SHOULD I WEAR GLOVES WHILE DIAPERING A CHILD?

According to the CDC, gloves are not generally necessary when changing diapers. Although trace amounts of HIV or HBV may be present in urine and feces, those body fluids have never been known to transmit the virus.

However, gloves should be worn under certain circumstances:

- if the child is experiencing bloody diarrhea;
- if the child's stool is bloody;
- if the child has a bloody diaper rash; or
- if the provider has open lesions, cuts, or breaks in the skin on her or his hands.

Whether or not you use gloves, you should wash your hands, and the child's hands, after each diapering, according to the hand-washing policies outlined above.

Once a dirty disposable diaper is removed from a child, it should be placed immediately in a diaper receptacle. Diaper receptacles should be plastic garbage cans with tightly closing lids that are lined with disposable plastic bags (red bags or red receptacles with liners, or ones labeled with the words or symbol⁵⁹ for BIOHAZARDOUS WASTE (See Appendix A) should always be used for diapers that have blood on them. Check your state regulations for the exact requirements for color coding or labeling applicable for you). Place dirty cloth diapers first in a plastic bag designed for diaper disposal that can be securely tied, and then place the bag in a diaper receptacle. Use separate diaper receptacles for disposable and cloth diapers. To empty the disposable diaper receptacle, remove the entire plastic liner and fasten it securely. Send dirty cloth diapers home, in their plastic bags, with each parent or guardian at the end of the day.

Locate diaper receptacles away from the children's play areas and away from food preparation and serving areas. Clean them on a daily basis, and, if blood-containing body fluids come into contact with any receptacle, clean it immediately with bleach solution while wearing gloves.

SHOULD I WEAR GLOVES IF A CHILD IS INJURED?

If a child under your care is injured and the injury involves a bleeding wound, you should wear gloves when caring for the injury, particularly if you have open sores, wounds, or chapped skin on your hands. Once the wound has been dressed, you should remove and dispose of the gloves and wash your hands as outlined above.

If a child or staff member is injured badly and is bleeding profusely, you may not have the time or opportunity to put on additional protective clothing. In that case, if blood soaks through any of your clothing, remove it as soon as possible, place it in a red garbage bag, and launder it separately from other clothes. Treat any blood soaked towels or other cloth items the same way. Wear disposable gloves when laundering blood soaked clothing or bandages. Of course, all skin that comes into contact with the blood, either directly or through clothing, should be washed immediately.

WHAT CLEANING PROCEDURES SHOULD I FOLLOW? WHAT CLEANING SUPPLIES DO I NEED?

Because we know that HIV and HBV can be inactivated easily with diluted solutions of household bleach, experts recommend using a bleach solution as an economical disinfectant. It is a good idea to always have some pre-mixed bleach solution on hand, so that accidents and spills can be cleaned up right away. Mixing the solution in a spray bottle will simplify the cleaning process, allowing you to spray the solution on surfaces as needed.

The basic solution that experts generally recommend consists of one part chlorine bleach to sixty-four parts water. You may make the solution stronger than this if you choose, or if your state law requires it, although this solution will generally be strong enough under most circumstances. Some state laws, though, may have very specific disinfectant requirements. You will need to check with your state OSHA office to find out if this basic bleach solution is sufficient, or if your state law requires a different or stronger solution. If you use a bleach solution, it must be prepared daily to retain its disinfectant power, so you should not prepare a great deal more than you anticipate needing for a day's cleaning. Depending on how much of the solution you choose to prepare, the following measurements are a basic guideline:

One quart of solution:

Add one tablespoon of bleach to one quart of water.

One half gallon of solution:

Add one eighth cup bleach to two quarts of water.

Regular housekeeping should include daily cleaning of all surfaces and the children's play areas by spraying on the basic bleach solution and scrubbing the area well with a cloth or mop. Rinse the surfaces well (optional) and allow them to air dry. All mops and cloth towels used in cleaning should be disinfected in a bleach solution or laundered. Store and wash laundry that has come into contact with potentially infectious body fluids separately from the other laundry, and only handle it if you are wearing gloves. Store these items in a red, closable garbage bag or receptacle until you can wash them.

Clean the diapering area after each diapering. Use a paper towel to clear the surface of any urine or feces with a paper towel; then spray with the bleach solution. Allow the area to air dry or wait two minutes before wiping dry.

A surface that has had body fluids on it (blood, urine, feces, saliva, nasal fluid, etc.) should be wiped off as soon as possible with disposable towels. If the body fluid contained blood, you should put on gloves before you begin to clean. Once the fluid has been wiped up, you should cover the surface with the bleach disinfectant and let the surface air dry.

All trash containing items that may have come into contact with potentially infectious body fluids, like bloody diapers, dirty disposable gloves, and paper towels used for cleaning and spills, should be securely tied in the plastic bags that are used as liners for your indoor trash receptacles (receptacles containing these items should have securely closing lids). Federal regulations require either that the bag or the trash receptacle be red, or that the trash receptacle be labeled with the words or symbol for BIOHAZARDOUS WASTE (see Appendix A for a reproduction of the symbol). Check with medical supply stores or your local hospital on how and where to obtain the red garbage bags or

receptacles. California regulations require both color coding of the bag or receptacle and labeling of the receptacle. Check your state regulations, if applicable, for possible variations on this requirement.

DO I NEED TO CLEAN TOYS THAT THE CHILDREN ARE SHARING? WHAT IF THE CHILDREN ARE MOUTHING THE TOY?

It is recommended that toys used by infants and toddlers be washed daily. If children are drooling on or mouthing the toy, it should either be used by only one child or washed before it is given to another child to play with. While this recommendation may not always be realistic, you should make particular efforts to follow this guideline if you know that a child has open sores in her or his mouth, is teething, or is bleeding for some other reason. In some cases, you may find it helpful to start off the day using a limited number of toys that you can replace later in the day when the original toys become mouthed and dirty.

The most effective method of cleaning a toy is to submerge it in a bleach solution and then submerge and agitate it in clean water to rinse (rinsing is optional). Toys may be dried in the open air (in a net bag) or with paper towels. Many toys can also be washed in a dishwasher.

WHAT PRECAUTIONS SHOULD I TAKE IN WASTE DISPOSAL?

It is important to emphasize proper waste disposal. While HIV or HBV infection is extremely unlikely to occur in a household or child care setting, remember that these precautions will serve to shield you, your staff, and the children you care for from a vast array of possible infections. While wearing gloves, hand-washing, and regular cleaning practices are vital first steps in reducing the likelihood of infection, waste disposal is the remaining part of the formula, and just as vital as the other steps. It is important to protect not only the person who is doing the housekeeping, but also the children who may be tempted to explore the garbage. In addition to the guidelines set out above for waste disposal, the following steps are important:

- If blood prick testing is done, and one has the sharps, these should be disposed of immediately after use in a closeable, puncture resistant, leakproof, red container (usually the parents can obtain these containers from the treating physician or a pharmacy). Store the container out of the reach of the children, but make it easily accessible to the staff who administer the blood prick testing. None of the materials placed in the container should ever be removed manually and the container must be discarded intact. Close the container securely when you discard it. To discard it is preferable to have the parent return the intact container to the treating physician or pharmacy and pick up a replacement container for you.

- Waste receptacles in bathrooms should be plastic, lined with plastic garbage bags, and have a securely closing lid if you use them to dispose of any blood-containing articles or any cleaning towels. Remove the garbage bags each time you empty the receptacles, and replace the bags with new liners. Close bags securely before discarding. Sanitary napkins and tampons should be discarded only in this type of receptacle. The liners or the receptacles should be color coded red or labeled with the words or symbol for BIOHAZARDOUS WASTE (or both, depending on state law).
- Every day, clean garbage cans, diaper receptacles, bathroom wastebaskets, or other containers that are reasonably likely to come into contact with blood or blood-containing body fluids; also clean them immediately after contact with a potentially infectious body fluid.
- Line all receptacles likely to contain articles with squeezable or caked on blood with plastic bags, and empty them only by removing the entire liner. The liners or receptacles should be color coded red, or labeled with the words or symbol for BIOHAZARDOUS WASTE. In some states, including California, both color coding and labeling are required. Check with medical supply stores or your local hospital on how and where to obtain the red garbage bags or receptacles.
- Depending on state or local laws, you may not be able to dispose of the red bags through your regular garbage pick-up. California has special laws limiting how and by whom red color coded bags may be removed, and these laws prevent most trash collectors from removing them with the unregulated waste. Check with your waste disposal company, and if the law does not permit them to pick up the red bags, find out from them, a child's treating physician, a child care health consultant, or a local hospital how to dispose of the red garbage bags containing biohazardous waste. Unfortunately, in most places, you will have to arrange a special pick-up for the red plastic bags. In states where you have a choice, the advantage to using red plastic liners is that you do not have to color code your trash receptacles. The clear disadvantage is the added expense of purchasing and disposing of the red liners. In states where you have to both color code and label, you may still be able to avoid using the red liners by color coding your receptacle, rather than the liners.
- Broken glassware or other materials that caused a child or staff member to bleed must not be picked up manually. Use a dustpan and broom or brush, or tongs to pick up broken glass.

WHAT DO I DO IF I THINK SOMEONE IN THE PROGRAM HAS BEEN EXPOSED TO CONTAMINATED BODY FLUIDS? DO I NEED TO REPORT THIS INFORMATION?

Directors of child care centers and large family child care homes must offer hepatitis B immunizations to all staff that are at risk of exposure to blood or blood-containing fluids in the workplace. Staff must also receive training on Standard Precautions. Since first aid is often provided in the child care setting, where contact with blood or body fluids containing blood may be a common situation, all staff must be trained under OSHA guidelines. Contact your local OSHA office for more details (See Appendix B). If contact with blood occurs in the child care setting, the person exposed to the blood should be offered the Hepatitis B vaccine within 24 hours of exposure and at the expense of the employer.⁶⁰ Also, accidental ingestion of breast milk by another child should be considered an accidental exposure to potential HIV-containing body fluid and the child's parent should be informed.⁶¹ Staff should be trained and informed that the "exposure plan" should include reporting the incident to his/her employer before the end of their work shift of the day of exposure.⁶²

CONCLUSION

Coping with HIV and AIDS in the child care setting requires compassion for the child and family who are living with a chronic illness. It also requires discipline in maintaining proper infection control measures, uniformity in your treatment of the children, and a tight lid on confidential information. But, by complying with the requirements and the spirit of the ADA and the OSHA requirements, the benefits can be abundant. You will be maintaining a safer environment for all the people who work at and attend your program, providing a source of support for parents and guardians of children with HIV, and helping to educate other parents about HIV. There will, of course, also be tremendous personal rewards that come from successfully running your program, reducing the risk of infection among individuals in that program, and giving support to the children with HIV who attend your program and their families.

APPENDIX A: BIOHAZARDOUS WASTE SYMBOL



APPENDIX B: REGIONAL OSHA OFFICES

U.S. Department of Labor
Occupational Safety and Health Administration
Regional Offices
Region I
(CT,* MA, ME, NH, RI, VT*)
JFK Federal Building, Room E340
Boston, Massachusetts 02203
Tel: (617) 565-9860

Region II
(NJ, NY,* PR,* VI*)
201 Varick Street
Room 670
New York, NY 10014
Tel: (212)337-2378

Region III
(DC, DE, MD,* PA, VA, WV)
U.S. Department of Labor/OSHA
The Curtis Center-Suite 740 West
170 S. Independence Mall West
Philadelphia, PA 19106-3309
Tel: (215) 861-4900

Region IV
(AL, FL, GA, KY,* MS, NC,* SC,* TN*)
61 Forsyth Street, SW
Atlanta, Georgia 30303
Tel: (404) 562-2300

Region V
(IL, IN,* MI,* OH, WI)
230 South Dearborn Street
Room 3244
Chicago, IL 60604
Tel: (312)353-2220

Region VI
(AR, LA, NM,* OK, TX)
525 Griffin Street
Room 602
Dallas, TX 75202
Tel: (214)767-4731

Region VII

(IA,* KS, MO, NE)

City Center Square

1100 Main Street, Suite 800

Kansas City, Missouri 64105

Tel: (816) 426-5861

Region VIII

(CO, MT, ND, SD, UT,* WY*)

1999 Broadway, Suite 1690

P.O. Box 46550

Denver, Colorado 80201-6550

Tel: (303) 844-1600

Region IX

(American Samoa, AZ*, CA,* Guam, HI,* NV,* Trust Territories of the Pacific)

71 Stevenson Street

Room 420

San Francisco, CA 94105

Tel: (415) 975-4310

Region X

(AK,* ID, OR,* WA*)

111 Third Avenue

Suite 715

Seattle, WA 98101-3212

Tel: (206)553-5930

* These states and territories operate their own OSHA-approved job safety and health programs (Connecticut and New York plans cover public employees only.) States with approved programs must have a standard that is identical to, or at least as effective as, the federal standard.

APPENDIX C: OTHER RESOURCES DIRECTORY OF NATIONAL ORGANIZATIONS

These groups can direct providers to helpful articles and printed resources, as well as identifying local organizations for the provider for more specialized service.

American Public Health Association

Publication Sales

P.O. Box 753

Waldorf, MD 20604-0753

Tel: (301) 893-1894

Fax: (301) 843-0159

www.apha.org

CDC National Prevention Information Network (CDC NPIN) (Formerly known as the National AIDS Information Clearinghouse)

P.O. Box 6003

Rockville, MD 20850

Tel: (800)458-5231

Equal Employment Opportunity Commission (ADA Information)

Tel: (800)669-4000

National AIDS Hotline - CDC

Tel: (800)342-AIDS

National Association of People with AIDS

1413 K Street, NW

Washington, D.C., 20005

Tel: (202)898-0414

National Minority AIDS Council

1931 13th Street, N.W.

Washington, DC 20009

Tel: 202-483-6622

Centers for Disease Control

1600 Clifton Road N.E.

Atlanta, GA 30333

Tel: (404)639-3311 or (800)311-3435

www.cdc.gov

American Academy of Pediatrics
Task Force on Pediatric AIDS
141 N.W. Point Blvd.
Elk Grove Village, IL 60009
Tel: (847) 434-4000
www.aap.org

National Resource Center for Health and Safety in Child Care
<http://nrc.uchsc.edu>

National Pediatric and Family HIV Resource Center
University of Medicine & Dentistry of New Jersey
30 Bergen Street - ADMC #4
Newark, NJ 07103
Tel: (973) 972-0410, (800) 362-0071

¹ “Perinatally Acquired AIDS Cases, by year of Diagnosis, 1985-2000, United States”, L262 Slide prepared by Division of HIV/AIDS Prevention, National Center for HIV, STD and TB Prevention, Centers for Disease Control, available at <http://www.cdc.gov/hiv/graphics/images/1262/1262-3.htm> (website visited August 5, 2003).

² New York Times, Jan. 30, 2005, p. 1, *U.S. is Close to Eliminating AIDS in Infants, Officials Say.*”

³ American Academy of Pediatrics Policy Statement, Volume 105, Number 6, June 2000, pp 1358-1360, “Education of Children with Human Immunodeficiency Virus”.

⁴ HIV and Its Transmission, Centers for Disease Control fact sheet, available at <http://www.cdc.gov/hiv/pubs/facts/transmission.htm> (website visited August 5, 2003).

⁵ 42 U.S.C. §§12101 *et seq.*

⁶ National Institute of Health (NIH) Fact sheet, June 2003. Available at <http://www.niaid.nih.gov/factsheets/hivinf.htm>. (website visited August 5, 2003).

⁷ National Institute of Health (NIH) Fact sheet, June 2003. Available at <http://www.niaid.nih.gov/factsheets/hivinf.htm>. (website visited August 5, 2003).

⁸ Pediatric HIV/AIDS Surveillance Slide #5, from the Centers for Disease Control, <http://www.cdc.gov/hiv/graphics/images/1262/1262-5.htm>

⁹ American Academy of Pediatrics. Section 3: Summaries of Infectious Diseases. In: Pickering LK, ed. *Red Book: 2003 Report of the Committee on Infectious Diseases*. 26th ed. Elk Grove Village, IL: American Academy of Pediatrics: 2003: p. 366. *Hereinafter: AAP Red Book of Infectious Diseases.*

¹⁰ AAP Red Book of Infectious Diseases, pp. 366, 375.

¹¹ AAP Red Book of Infectious Diseases, p. 365.

¹² American Academy of Pediatrics Policy Statement, Volume 104, Number 2, August 1999, pp. 318-319, “Issues Related to Human Immunodeficiency Virus Transmission in Schools, Child Care, Medical Settings, the Home and Community”.

¹³ American Academy of Pediatrics Policy Statement, Volume 105, Number 6, June 2000, pp. 1358-1360, “Education of Children with Human Immunodeficiency Virus”.

¹⁴ See www.thebody.com/bp/fed98/kid.html (website visited May 25, 2005).

¹⁵ AAP Red Book of Infectious Diseases, pp. 360-63.

¹⁶ National Institute of Health (NIH) Fact sheet, June 2003. Available at <http://www.niaid.nih.gov/factsheets/hivinf.htm>. (website visited August 5, 2003).

¹⁷ In 2001, of the 175 reported cases of children with AIDS, 150 of them had acquired it perinatally. “Perinatally Acquired AIDS Cases, by year of Diagnosis, 1985-2000, United States”, L262 Slide prepared by Division of HIV/AIDS Prevention, National Center for HIV, STD and TB Prevention, Centers for Disease Control, available at <http://www.cdc.gov/hiv/graphics/images/1262/1262-3.htm> (website visited August 5, 2003).

¹⁸ AAP Red Book of Infectious Diseases, pp. 360-63, 366, 375.

¹⁹ American Red Cross, Biomedical Frequently Asked Questions, available at <http://www.redcross.org/faq/blood.html> (website visited August 5, 2003).

²⁰ HIV and Its Transmission, Centers for Disease Control fact sheet, available at <http://www.cdc.gov/hiv/pubs/facts/transmission.htm> (website visited August 5, 2003).

²¹ MMWR Perspectives in Disease Prevention and Health Promotion Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health-Care Settings, 1988 Jun 24; 37(24); pp. 377-388

²² The laws that require the practice of universal infection control measures in child care are commonly referred to as the *OSHA regulations (29 CFR 1910.1030)*. See the section titled *Who is required to establish universal precautions?* for details on what the OSHA regulations are, and to whom the regulations apply.

²³ The hepatitis B and C viruses are transmitted virtually the same way as HIV, but are more contagious viruses than HIV. In the child care setting, the only risk of transmission of these viruses are through blood, and universal precautions practiced in the child care setting are designed to prevent all three viruses from spreading. While, like HIV, the overall incidence of HBV and HCV among children is extremely low, universal precautions should always be practiced uniformly in every child care program as a means of ensuring a safe environment for everyone. For more information on the transmission risk of HCV and HBV contact the Centers for Disease Control and Prevention (www.cdc.gov/hepatitis), the American Academy of Pediatrics (www.aap.org) or AAP's Red Book of Infectious Diseases.

²⁴ OSHA Regulations (29 CFR 1910.1030). For California residents, see also <http://www.dir.ca.gov/dosh/EmployerResponsibilities.htm>

²⁵ American Academy of Pediatrics Policy Statement, Volume 104, Number 2, August 1999, pp 318-319, "Issues Related to Human Immunodeficiency Virus Transmission in Schools, Child Care, Medical Settings, the Home and Community".

²⁶ See the section titled *What should I do if a child exhibits aggressive behavior?* in this publication for information about establishing a policy on aggressive behavior.

²⁷ See the sections titled *How do I determine whether a child with HIV or AIDS poses a direct threat to the health or safety of others?* and *What is the best way to prepare for potential illness in children?* in this publication, for information about establishing a health assessment policy.

²⁸ 28 CFR §36.104(1)(iii) (1991).

²⁹ Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 56 Fed. Reg. 35,544 (July 26, 1991) (to be codified at 28 CFR pt. 36.104).

³⁰ 28 CFR §36.207 (1991).

³¹ U.S. v. Happy Time Day Care Center, 6 F. Supp.1073,1081 (1998).

³² Cal. Civil Code Section 51 et seq.

³³ Go to www.dfeh.ca.gov for further information. Under "contact us" there is information on office locations.

³⁴ To find your state's Attorney General's Office, contact the National Association of Attorneys General by phone at 202-326-6000 or on the web at www.naag.org.

³⁵ To find out more about the confidentiality laws in your state, see "Legislative Survey of State Confidentiality Laws, with Specific Emphasis on HIV and Immunization" available at http://www.epic.org/privacy/medical/cdc_survey.html.

³⁶ 22 California Code of Regulations Section 101221(c).

³⁷ For a more thorough explanation of how to determine whether an accommodation might impose an undue burden on your program, see the section titled *Do I need to Provide Special Toys or Accommodations for a Child with HIV or AIDS?* on page 17 in this publication, and, see also, CCLC's publication *Caring for Children with Special Needs: The Americans with Disabilities Act and Child Care*.

³⁸ Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 56 Fed. Reg. 35,547 (July 26, 1991) (to be codified at 28 CFR pt. 36.203).

³⁹ See your state and local laws for confidentiality and privacy. In California: CA. CONST. art. I, § 1 and 22 California Code of Regulations § 101221(c).

⁴⁰ California Code of Regulations Section 101212(g) specifies reporting requirements for centers.

⁴¹ *Alvarez v. Fountainhead, Inc.* 55 F. Supp. 1048 (1999).

⁴² AAP Red Book of Infectious Diseases, pp. 73, 78-80.

⁴³ Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 56 Fed. Reg. 35,547 (July 26, 1991) (to be codified at 28 CFR pt. 36.203).

⁴⁴ See *Arline v. School Board of Nassau County*, 692 F. Supp. 1286 (1988), which discusses tuberculosis in the context of “direct threat.” This is an opinion based on Section 504 of the Rehabilitation Act of 1973, but this is law generally used to interpret the ADA as well.

⁴⁵ See the section titled *Do I need to clean toys that the children are sharing? What if the children are mouthing the toy?* in this publication for guidelines on cleaning and separating toys.

⁴⁶ Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 56 Fed. Reg. 35,563 (July 26, 1991) (to be codified at 28 CFR pt. 36.301).

⁴⁷ American Academy of Pediatrics Policy Statement, Volume 104, Number 2, August 1999, pp 318-319, “Issues Related to Human Immunodeficiency Virus Transmission in Schools, Child Care, Medical Settings, the Home and Community”. “No need exists to restrict the placement of HIV-infected children in child care settings to protect personnel or other children.”

⁴⁸ Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 56 Fed. Reg. 35,560 (July 26, 1991) (to be codified at 28 CFR pt. 36.208).

⁴⁹ Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 56 Fed. Reg. 35,564 (July 26, 1991) (to be codified at 28 CFR pt. 36.302).

⁵⁰ Children who are immunodeficient may experience serious complications from chicken pox, CMV (cytomegalovirus), tuberculosis, and the measles virus. Check with local health officials for other communicable diseases that pose a direct threat to the children.

⁵¹ Letter to the Honorable Frank S. Turner, Maryland House of Delegates from the U.S. Department of Justice, November 29, 1995, available at www.usdoj.gov/crt/foia/tal653.txt.

⁵² American Academy of Pediatrics Policy Statement, Volume 104, Number 2, August 1999, pp 318-319, “Issues Related to Human Immunodeficiency Virus Transmission in Schools, Child Care, Medical Settings, the Home and Community”. “Although biting theoretically is a possible mode of transmission of blood-borne illness, such as HIV infection, the risk of such transmission is believed to be extremely low.”

⁵³ See the section titled *How do I determine whether a child with HIV or AIDS poses a direct threat to the health or safety of others?* in this publication for additional discussion on assessing undue burden

⁵⁴ See Linda Brault and Tom Brault, *Children with Challenging Behavior: Strategies for Reflective Thinking*, San Diego: CA, CPG Publishing Company, 2005, and Barbara Kaiser and Judy Sklar Rasminsky, *Meeting the Challenge: Effective Strategies for Challenging Behaviors in Early Childhood Environments* Washington, DC: NAEYC, 1999.

⁵⁵ See your state and local laws for confidentiality and privacy. In California: CA. CONST. art. I, § 1 and California Code of Regulations § 101221(c)

⁵⁶ American Academy of Pediatrics Policy Statement, Volume 104, Number 2, August 1999, pp 318-319, “Issues Related to Human Immunodeficiency Virus Transmission in Schools, Child Care, Medical Settings, the Home and Community”. “Children with HIV or other chronic illnesses may be immunodeficient, and thus, their caregivers should be informed of exposure to readily communicable illnesses in child care settings that might compromise their health, such as pneumococcal infections, varicella, or measles. The policy of child care programs should be to inform all families when such communicable diseases have been identified in any child.”

⁵⁷ Under federal regulations, any common household soap is sufficient. Anti-bacterial soap does not provide added protection. But check your state regulations, if applicable, to determine if particular soaps or disinfectants are required in your state.

⁵⁸ Hepatitis B virus.

⁵⁹ See Appendix A for a reproduction of the biohazardous waste symbol.

⁶⁰ OSHA Regulations (see 29 CFR §1910.1030 (f) *et. seq.*).

⁶¹ See *Caring for Our Children: National Health and Safety Performance Standards*, Chapter 3, Standard 3.027. American Academy of Pediatrics and National Resource Center for Health and Safety in Child Care, Second Edition, 2002. This publication is available through the American Academy of Pediatrics, American Public Health Association or National Resource Center for Health and Safety in Child Care – see Appendix C for contact information.

⁶² OSHA Regulations 29 CFR §1910.1030 (f). See also *Caring for Our Children: National Health and Safety Performance Standards*, Chapter 1, Standard 1.033. American Academy of Pediatrics and National Resource Center for Health and Safety in Child Care, Second Edition, 2002.