



## HEALTH CARE PROGRAM FOR CHILD CARE CENTERS

State Form 45877 (R8 / 2-15)

**IF THIS IS A PROPOSED (NEW SITE OR NEW OWNER) FACILITY, YOU MUST SUBMIT AN APPLICATION FOR LICENSURE PRIOR TO SUBMITTING THIS PROGRAM.**

### ***Instruction for completion: Health Programs***

*Health Program forms are to be used by Child Care Centers for the purpose of reporting the development of their written health program in compliance with the regulations for licensure. The health program must be completed in and approved prior to licensure or if there are any changes to the license that is listed under 470 IAC 3-4.7-84(c). The form incorporates the requirements of 470 IAC 3-4.7.84.*

*All items in the forms must be carefully studied and completed by the authorities responsible for the development of the health program. A number of attachments, which are identified in the health program forms, are required. The programs will be reviewed to determine compliance with licensing requirements.*

*The original completed forms and one (1) original set of attachments must be submitted to the Family and Social Services Administration, 402 West Washington Street, Room W361, Indianapolis, IN 46204.*

*If the health program is not in substantial compliance with regulations, both forms and attachments will be returned to the facility for corrections and resubmittal.*

### **STATEMENT OR EXPLANATION REGARDING HEALTH CARE CONSULTANT ACTIVITIES**

The health care consultant's responsibilities are to assist the Administrator or Director in developing the health policies and procedures and be available for telephone consultation as needed. The consultant may be an MD, DO, or APN with community, family, or pediatric experience or an RN or PA with five (5) years of pediatric experience.

The health care consultant's liability is limited only to direct care and advice they may render.

The rendering of direct care by the health care consultant is not required by Regulations.

It is expected that all children in child care centers will continue to receive direct medical care from their family physician or clinic.

If health care of children is rendered by the health care consultant, it would be an arrangement between the health care consultant and the child care facility's administration.

If the "First Aid Supply List" or the "Skin Care Procedure" contains any medications, including oral and topical over-the-counter items, only a health care consultant with prescriptive authority (MD, DO, NP) can authorize these forms.

## HEALTH PROGRAM HELPS

Experiences with health programs indicate the most frequent reasons for not approving submitted health programs are:

1. The lack of the health care consultant's **ORIGINAL** signature and date on the first page.
2. The lack of the health care consultant's **ORIGINAL** signature and date on the written first aid directives.
3. The lack of the health care consultant's **ORIGINAL** signature and date on the first aid supply list if the list contains any type of medications (e.g. *Mercurochrome, Bactine, Ointment, etc.*). Your physician must indicate in writing on the list why you are to give it, how often, how much and the date and sign the list. The signature of the MD, DO, or NP on the separate list constitutes a "written order".

If first aid supplies consist of only soap, water, band-aids, sunscreen, and insect repellent, just indicating it in the health program is adequate; no signature from an MD or DO is required.

4. A sample of the form used for the children's health examination must be submitted. The form must include all of 470 IAC 3-4.7-86 requirements. (*A recommended health form is attached.*)
5. A sample of the form used for employees' and volunteers' health examination must be submitted. The form must include all of 470 IAC 3-4.7-85 requirements. (*A recommended health form is attached.*)
6. All adults counted in the child-staff ratio must have basic first aid training within three (3) months of employment. All adults counted in the child-staff ratio for infants or toddlers must have basic first aid training prior to giving care.
7. All medications must be in a locked container and inaccessible to children. The only exceptions are those medications requiring refrigeration as indicated on the prescription label. Medications not requiring refrigeration are not to be kept in the kitchen or bathrooms.
8. There are only two (2) types of medications which may legally be given by the child care employee: those medications in a prescription container specifically ordered by an MD, DO, or NP for the individual child, and those medications for which you have a written order from an MD, DO, or NP for the individual child. This includes over-the-counter oral and topical items.
9. If providing care for children under two (2) years of age, the Supplement Health Programs for Infant/Toddler care must also be submitted.
10. One (1) copy of each of the required forms or policies must be attached to each health program.

The following have been included for your use:

1. Recommended Child Day Care Center Health Record form.
2. Recommended Adult Physician Examination Health Record form.
3. Suggested First Aid Directives (*must be approved and signed by your health consultant*).
4. Suggested Skin Care Procedures (*must be completed, approved and signed by your health consultant*).
5. Suggested First Aid Supply form
6. Medication Order form

Return completed forms to:

MS02  
Family and Social Services Administration  
402 W. Washington St., Rm. W361  
Indianapolis, IN 46204



**ATTACH A COPY OF THE FORM USED FOR THE CHILD'S HEALTH EXAMINATION.**

**Periodic Health Examination**

Periodic health examinations will be required as follows:

- 8.  Yes  No Annually for children two (2) years of age and younger.
- 9.  Yes  No More frequently if the child's general condition indicates.
- 10  Yes  No When the child has a condition which is potentially hazardous to others.
- 11.  Yes  No If a child frequently requires separation from the group and special observation for fatigue, illness or emotional upset, a report will be available to parents or guardians; and they will be asked to take the child to an MD, DO, or NP for evaluation.

**SECTION 3 470 IAC 3-4.1-7 (e)(2) - CHILD'S HEALTH RECORD**

Health and medical records are current, on file in the licensed facility for each child and contain the following information:

- 12.  Yes  No The prescriber's written instructions regarding any special dietary or other special health care the child may need.
- 13  Yes  No A record of all the medications and first aid given the child in the facility.
- 14.  Yes  No The record includes:
  - a.  Yes  No Prescription number or name of medication, amount, time and date given, name of prescriber and person who gave the medication.
  - b  Yes  No Description of injury, date and time of first aid treatment and who gave the treatment.
  - c.  Yes  No That parents were notified of all accidents.
- 15.  Yes  No Record of absences due to illness or injury.

**SECTION 4 470 IAC 3-4.1-8 - HEALTH EXAMINATIONS FOR PERSONS PERFORMING SERVICES**

- 16.  Yes  No Children are excluded if physical exam and immunizations are not documented within 30 days.
- 17.  Yes  No Employees will have a complete physical during the period 12 months prior to, or within 30 days, of employment.
- 18.  Yes  No Mantoux tuberculin skin test, or equivalent screening approved by the ISDH, date and results of the test.
- 19  Yes  No Diagnostic chest X-ray if Mantoux test is positive.
- 20.  Yes  No No person will be allowed to perform any services in the nursery until above is completed.

**ATTACH A COPY OF THE FORM USED FOR THE EMPLOYEES' HEALTH EXAMINATION. IT MUST PROVIDE AN AREA TO RECORD RESULTS OF MANTOUX TUBERCULIN TEST, HEALTH HISTORY, ALLERGIES AND CHRONIC HEALTH CONDITIONS.**

- 21  Yes  No Volunteers, substitutes, student aides and any other personnel having direct contact with the children or providing food service will have the same kind of examination as the employees.
- 22.  Yes  No Annual Mantoux tuberculin skin tests, or equivalent screening approved by the ISDH, shall be required of all adults having direct contact with children, including food service personnel.

**SECTION 5 470 IAC 3-4.1-11(a)(b) - CONTROL OF COMMUNICABLE DISEASES**

- 23.  Yes  No Staff members and other persons with an illness shall not be permitted to have contact with children nor be permitted to work in a capacity where illness could be transmitted. Ill staff are excluded.
- 24.  Yes  No Children who are ill upon arrival to the facility shall not be admitted.
- 25.  Yes  No Children who become ill while in attendance will be isolated, kept under direct supervision and parents notified to take the child home.
- 26.  Yes  No The isolation room is not used for any other purpose by children while being used as isolation quarters.
- 27  Yes  No The cot(s) and other furnishings of the isolation room can be easily sanitized.
- 28.  Yes  No Toilet and lavatory facilities are located within or near the isolation room  
Where is the isolation room located? \_\_\_\_\_

- 29.  Yes  No Arrangements have been made to consult a medical practitioner or the local health officer for instructions regarding control measures when exposure to a disease has occurred in the child care center.  
These measures include the following:
  - a  Yes  No Disinfection of toilet facilities, furnishings and toys or other articles used by the ill child.
  - b  Yes  No Proper disposal of body discharges.
  - c.  Yes  No The cot, facilities or articles that have been used by a child suspected of having a communicable disease, will not be used by any other person until properly disinfected or until it is established the child did not have a communicable disease.

**SECTION 5 470 IAC 3-4.1-11(a)(b) - CONTROL OF COMMUNICABLE DISEASES (continued)**

30.  Yes  No Arrangements have been made to notify all parents and staff members when a child is known to have a communicable disease.
31.  Yes  No Before readmission, the child care staff members will ascertain that the child does not have a condition which would prevent participation in center activities.
32.  Yes  No If pets are kept, they will be nonvicious, free from disease and shall be immunized against rabies, if indicated.
33.  Yes  No Animals will be housed in such a manner which prevents injury either to the children or the animals. Ferrets, turtles, reptiles, psittacine birds, or any wild animals will be prohibited.

**SECTION 6 470 IAC 3-4.1-11(c) - CARE OF ILLNESS AND INJURY**

**ATTACH A COPY OF THE HEALTH CONSULTANT'S WRITTEN DIRECTIVES WHICH THE HEALTH CONSULTANT HAS SIGNED AND DATED REGARDING FIRST AID TO BE GIVEN AT THE CENTER**

There must be directives for the treatment of hemorrhaging, choking, seizures, poisoning, artificial respiration. *(If licensed for children under 2 years of age, include directives for the treatment for shock in that age group)*

34.  Yes  No First aid directives are posted in every room occupied by children.
35.  Yes  No First aid policies provide for:
- a.  Yes  No All persons counted in the child/staff ratio to have training in basic first aid within three (3) months of providing care and a refresher course every two (2) years thereafter. *(Infant and toddler staff must be trained upon employment)*
  - b.  Yes  No A telephone is provided within the facility and immediately available telephone numbers that include consulting medical provider, nearest emergency facility, ambulance service, local fire department, dentist and poison control.
- It is recommended that an individual emergency card be kept for each child. The card should include the parent(s) name and telephone number, name and telephone number of a responsible person to call if the parent(s) cannot be reached as well as the child's allergies, doctor, hospital preference and a brief medical history.**
36.  Yes  No The Red Cross First Aid Manual or its equivalent is available.
- a. Give title: \_\_\_\_\_
  - b. List the first aid supplies the consulting medical provider has indicated you are to have on hand. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - c. If any medications such as acetaminophen, ointment, etc., are included in the first aid supplies, the consulting MD, DO, or NP original signature and date must be on the list, as well as why you should give the medication, how much, and how frequently.  
Where do you keep the supplies? \_\_\_\_\_

**SECTION 7 470 IAC 3-4.1-11(2)(d) - MEDICATION**

37.  Yes  No The health policies include the giving or the application of medication, providing dietary supplements, making special variations in diets and carrying out special medical procedures for any child and will be done only on the written order or prescription from a prescriber.
- Individual prescriptions:
- a.  Yes  No Are kept in the original containers.
  - b.  Yes  No Have the original pharmacy label showing prescription number or name of medication, date filled, prescriber's name, child's name and directions for use *(frequency and amount to be given)*.
38.  Yes  No Over-the-counter medications or sample medications have a prescriber's written order indicating child's name, name of medication, reason for giving, frequency of use, dosage to be given. *(The prescriber's original signature and date must appear on the written order.)*
39.  Yes  No All medications will be kept in a locked cabinet, drawer or box.
- Where is the locked cabinet, drawer or box for non-refrigerated medications located?  
*(This location is not to be in the kitchen or bathroom.)* \_\_\_\_\_

**SECTION 7 470 IAC 3-4.1-11(2)(d) - MEDICATION (continued)**

40.  Yes  No Medication requiring refrigeration will be stored in a lidded, plastic container, marked "medication".
41.  Yes  No All medication given in the facility will be recorded when medication is given and by whom it is administered.
42.  Yes  No Unused portions of any child's prescription will be correctly disposed of or returned to the child's family.

**SECTION 8 470 IAC 3-4.1-11(2)(e) - PERSONAL HYGIENE**

43.  Yes  No The facility's schedule provides for supervised washing of hands and face before meals and after using the toilet.
44.  Yes  No Soap is provided at every handwashing sink.
45.  Yes  No Disposable towels are used and are provided in a dispenser at every handwashing sink.
46.  Yes  No Toilet paper is provided in a dispenser at every toilet.
47.  Yes  No If toothbrushes are used, they are stored separately from one another and in a sanitary manner.

**SECTION 9 470 IAC 3-4.1-11(2) - GENERAL SAFETY**

48.  Yes  No All equipment, materials and furnishings whether for indoor or outdoor use, are sturdy, clean and in a safe condition.
49.  Yes  No All cleaning supplies and hazardous articles (labeled "Keep Away from Children" or "Keep out of Reach of Children") are inaccessible to children.
50.  Yes  No All poisons, chemicals and items labeled "Fatal if Swallowed" are in locked storage.

**SECTION 10 470 IAC 3-4.1-15 - DISASTER SAFETY**

51.  Yes  No Written, posted procedures for disaster evacuations and shelter within the buildings are posted in all child care areas.

**SECTION 11 470 IAC 3-4.1-14(a) - SPACE**

52.  Yes  No Clothes-hanging hooks are provided for each child and are spaced far enough apart so that one child's clothing does not touch that of another child. (*Hats and collars, hoods and shoulder area of coats must not touch*)

**SECTION 12 470 IAC 3-4.1-10(2) - PHYSICAL CARE**

53.  Yes  No Supervised nap periods are provided for preschool children after the noon meal.
54.  Yes  No A firm, portable, narrow, easily-sanitized cot, whose sleeping surface is off the floor, is provided for each preschool child.
55.  Yes  No Cots are maintained in a good state of repair.
56.  Yes  No Cots are spaced two (2) feet apart on all sides.
57.  Yes  No Children lie in such a way that direct face-to-face positions are avoided.
- a. The majority of cots that the facility uses are: (*regular canvas, vinyl, plastic, water-proofed canvas*)
- \_\_\_\_\_
- b. The majority are sanitized by the following method: \_\_\_\_\_
- \_\_\_\_\_
- (*Regular canvas coverings are taken off the frame and washed in bleach and warm water in a clothes washer for 25 minutes.*)
58.  Yes  No A different child uses a different cot each day.
59.  Yes  No The same child uses the same cot each day.
- a. How frequently are cots sanitized? \_\_\_\_\_
- Each child's blanket is stored:
- b.  Yes  No On individually marked cot
- c.  Yes  No In individually marked cubicle
- d.  Yes  No In individually marked sack

**SECTION 13 470 IAC 3-4.1-7(d) - SMOKING**

60.  Yes  No Smoking is prohibited in the kitchen, in the presence of children and in areas which will be occupied by children.

**SECTION 14 470 IAC 3-4.1-9-2(c) - TWO (2) YEAR OLDS AND ABOVE WHO ARE NOT TOILET TRAINED**

61.  Yes  No We accept two (2) year old and older children who are in diapers or pull-ups.

The diaper changing table consists of:

a.  Yes  No Soft washable (*plastic covered*) pad

b.  Yes  No A sanitizable table

c.  Yes  No Clean waterproof, disposable paper which covers the entire pad and is discarded after each use.

62.  Yes  No The diaper changing pad is sanitized when it becomes soiled and at the end of the day.

*If no changing table / cot is used, omit items 61 and 62; answer items 63 through 67.*

63.  Yes  No Time of bowel movements is entered on a daily chart.

64.  Yes  No The consulting physician has approved a skin cleansing procedure.

**ATTACH A COPY OF THE SKIN CLEANSING PROCEDURE THAT CONTAINS THE HEALTH CARE CONSULTANT'S ORIGINAL SIGNATURE AND DATE.**

65.  Yes  No Caregivers wash their hands before and after diapering children.

66.  Yes  No Soiled diapers / pull-ups shall be kept in a plastic bag in a tightly covered, sanitary container that is inaccessible to children.

67.  Yes  No A supply of diapers / pull-ups shall be available at all times, stored off the floor, and inaccessible to children.

**HAVE YOU ATTACHED ONE (1) COPY OF THE FOLLOWING TO EACH PROGRAM?**

The form used for the child's health examination.

The current recommended first aid directives for the care of ill or injured children that have been signed and dated by the health care consultant. These procedures must itemize the care for seizures, choking, hemorrhage, poisoning and artificial respiration (and shock if licensed for children under two (2) years of age).

The form used for the employee health examination.

Health care consultant's signed and dated skin cleansing procedures for diapered two (2) year olds.

Signature of: (*check one*)  Owner  President of Board of Directors  Director

Date signed (*month, day, year*)





# HEALTH CARE PROGRAM FOR CHILD CARE CENTERS PROCEDURE FOR SKIN CARE - DIAPERING

State Form 49971 (R3 / 2-15)

FSSA - MS02  
402 WEST WASHINGTON STREET, RM W361  
INDIANAPOLIS, IN 46204

**Objective:** To cleanse baby's skin after urination and / or bowel movement.  
To insure comfort to baby.  
To prevent diaper rash.

**Equipment:** Waterproof paper (*wax paper*) \* \_\_\_\_\_  
Soap for cleaning after bowel movement  
Paper towel **for drying only**  
Diaper  
Tightly covered sanitary waste containers, lined with plastic (*one for soiled diapers and one for washcloths*).  
Disposable gloves  
Sanitizing solution (*1% bleach solution or its equivalent*).

**Procedure:**

1. Wash hands with soap and warm water and dry with disposable paper towel.
2. Gather equipment and put on diapering area.
3. Spread wax paper on changing table. **Cover entire length and width of pad.**
4. Pick up baby and place on diapering table.
5. Put on gloves (*if blood is present, medical disposable gloves must be worn.*)
6. Release diaper.
7. Using ankle hold to insure safety, remove soiled diaper.
8. Place soiled diaper on **wax paper** or into plastic bag.
9. Gently wash baby's bottom with \* \_\_\_\_\_ downward cleansing, and dry with towel. Avoid hard rubbing. Baby's skin is very sensitive.
  - To cleanse girls, spread labia apart gently, wash and dry between skin folds (*cleaning **downward only** - cleaning cloth must not touch vaginal area if it has touched rectal area*).
  - To cleanse boys, merely wash and dry. In uncircumcised boy, **never** attempt to pull back the foreskin.
  - Use soap and rinse well if child had bowel movement.
10. Remove gloves.
11. Put diaper on child.
12. Wash child's hands.
13. Take child to safe area.
14. If blood is present on diaper table, put medical gloves on.
15. Discard soiled diaper, washcloth and towel, and wax paper into tightly covered sanitary waste container lined with plastic bag.
16. Sanitize diaper changing pad and table.
17. Remove gloves and discard in covered container.
18. **Wash hands with soap and warm water and dry with disposable paper towel.**
19. Record on child's record and note any unusual observations such as rash, loose bowel movement, bleeding, etc.

\* State what you will use for skin cleansing (*i.e., disposable wipe, terry washcloth, etc.*) and to cover changing table pad.

Signature of health care consultant

Date signed (*month, day, year*)





# HEALTH CARE PROGRAM FOR CHILD CARE CENTERS CHILD CARE CENTER HEALTH RECORD

State Form 49969 (R4 / 2-15)

FSSA - MS02  
402 WEST WASHINGTON STREET, RM W361  
INDIANAPOLIS, IN 46204

Name of child ( <i>last, first</i> )	Date of birth ( <i>month, day, year</i> )	Date of admission ( <i>month, day, year</i> )
Address ( <i>number and street, city, state, and ZIP code</i> )		
Child lives with ( <i>relationship</i> )	Name	Telephone number (      )

MEDICAL HISTORY			
Communicable Disease	Month / Year	Condition	Explain if present
		Allergies:	-----
			-----
		Handicapping conditions:	-----
<b>Screenings</b>	<b>Result / Date (<i>month, day, year</i>)</b>		
TB Risk / Symptom		Other:	-----
Developmental Screen			-----
Lead			-----

PHYSICAL EXAMINATION	
Date of exam ( <i>month, day, year</i> )	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:

Note any unusual findings:

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Does this child have any health condition that would be hazardous either to the child or to other children in a group setting as a result of participation in normal activities (*including sports*)?

Yes  No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:

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Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:

Yes  No

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# HEALTH CARE PROGRAM FOR CHILD CARE CENTERS RECORD OF ADULT PHYSICAL HEALTH EXAMINATION GROUP HOMES / INSTITUTIONS

State Form 49970 (R5 / 2-15)

**FAMILY AND SOCIAL SERVICES  
ADMINISTRATION**  
402 W. Washington St., Room W361  
Indianapolis, IN 46204

Name	Date of birth ( <i>month, day, year</i> )
Address ( <i>number and street, city, state, and ZIP code</i> )	

MEDICAL HISTORY					
I. List past hospitalizations / operations / accidents:					
II. Communicable diseases you have had:					
<input type="checkbox"/> Measles	Month / year	<input type="checkbox"/> Scarlet Fever	Month / year	<input type="checkbox"/> Rubella (German Measles)	Month / year
<input type="checkbox"/> Chicken Pox	Month / year	<input type="checkbox"/> Mumps	Month / year	<input type="checkbox"/> Whooping Cough	Month / year
<input type="checkbox"/> Other:	Month / year	<input type="checkbox"/> Tdap Booster	Month / year		
III. Conditions ( <i>Please explain if present</i> ):					
Allergies:					
Chronic health conditions:					
Use of any drugs / medication:					
Why?					

PHYSICAL EXAMINATION		
I. Mantoux TB skin test or ISDH approved screen *	Date ( <i>month, day, year</i> )	Result ( <i>in mm</i> )
Chest X-ray, if above screen is positive?	Date ( <i>month, day, year</i> )	Result
Other laboratory test as ordered by physician:		
II. Does this person have any health condition that would be hazardous to the person or to the children in a group setting as a result of participation in normal activities ( <i>including sports</i> )?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, what modifications of normal activities are necessary?		
III. Have you prescribed any medications and / or special routines ( <i>such as diet</i> ) which should be included in planning this person's activities?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Explain:		

Date of exam ( <i>month, day, year</i> )	Signature of physician / nurse practitioner	Printed name of physician / nurse practitioner	Telephone number (   )
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\* Annual ISDH approved screening for tuberculosis is required.

# HEALTH CARE PROGRAM FOR CHILD CARE CENTERS SUGGESTED FIRST AID DIRECTIVES

Part of State Form 45877 (R8 / 2-15)

## FAMILY AND SOCIAL SERVICES ADMINISTRATION

402 W. Washington St., Room W361  
Indianapolis, IN 46204

### CHOKING

(Conscious, ages one (1) and above) - Stand or kneel to the side of the child, have them bend over your arm and give five (5) forceful back-blows between the shoulder blades. Each back-blow should be a separate attempt to get the object out. If the five (5) back-blows do not get the object out, give five (5) abdominal thrusts. Stand or kneel behind the child, with your arms around their waist and make a fist, placing it just above the naval. With moderate pressure use your other hand to press the fist into the child's abdomen with five (5) quick, upward thrusts. Repeat five (5) back blows followed by five (5) abdominal thrusts until the obstruction is cleared, the child begins to cough, or becomes unconscious.

(Unconscious) - **Contact 911 and/or emergency services immediately and begin CPR.**

(Conscious Infants) - Have someone call 911 or, if you are alone, call 911 as soon as possible. Support infant's head and neck. Turn infant face down on your forearm. Lower your forearm onto your thigh. Give five (5) back blows forcefully between infant's shoulder blades with heel of hand. Turn infant onto back. Place middle and index fingers on breastbone between nipple line and end of breastbone. Quickly give at least five (5) chest thrusts by compressing the breastbone one-half to one inch with each thrust. Repeat backblows and chest thrusts until object is coughed up, infant starts to cry, cough, and breathe, or medical personnel arrives and takes over.

(Unconscious Infants) - **Contact 911 and/or emergency services immediately and begin CPR.**

### POISONING

Call Poison Control Center (1-800-222-1222) immediately! Have the poison container handy for reference when talking to the center. Do not induce vomiting or give anything by mouth. Check the child's airway, breathing and circulation.

### HEMORRHAGING

Use a protective barrier between you and the child (gloves). Then, with a clean pad, apply firm continuous pressure to the bleeding site. Do not move or change pads, but you may place additional pads on top of the original one. If bleeding persists, call a doctor or an ambulance. Open wounds may require a tetanus shot.

### SEIZURE

Clear the area around the child of hard or sharp objects. Loosen tight clothing around the neck. Do not restrain the child. Do not force fingers or objects into the child's mouth. After the seizure is over and if the child is not experiencing breathing difficulties, lay him on his side until he regains consciousness or until he can be seen by emergency medical personnel. After the seizure, allow the child to rest. Notify parents immediately. If child is experiencing breathing difficulty, or if seizure is lasting longer than 5 minutes, call an ambulance at once.

### ARTIFICIAL RESPIRATION (*Rescue Breathing*)

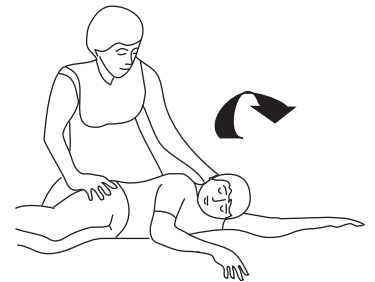
Position child on the back; if not breathing, open airway by gently tilting the head back and lifting chin. Look, listen, and feel for breathing. If still not breathing, keep head tilted back and pinch nose shut. Give two regular breaths, and then one regular breath every 4 seconds thereafter. Continue for one minute; then look, listen, and feel for the return of breathing. Continue rescue breathing until medical help arrives or breathing resumes.

\* If using one-way pulmonary resuscitation device, be sure your mouth and child's mouth are sealed around the device.

(Modification for infants only) - Proceed as above, but place your mouth over nose and mouth of the infant. Give light puffs every 3 seconds.

### SHOCK

If skin is cold and clammy, as well as face pale or child has nausea or vomiting, or shallow breathing, call for emergency help. Keep the child lying down. Elevate the feet if there are no leg injuries or pain.



Signature of health care provider

Date signed (month, day year)

# FIRST AID SUPPLY LIST

Part of State Form 45877 (R8 / 2-15)

FSSA - MS02  
402 WEST WASHINGTON STREET, RM W361  
INDIANAPOLIS, IN 46204

INSTRUCTIONS: Post with stored medication and supplies.

Mild soap  
Adhesive bandages  
Gauze pads and tape  
Medical gloves  
1% bleach  
One-way pulmonary resuscitation device (*artificial respiration mask*)

*(Keep in locked cabinet)*

Alcohol  
Hydrogen Peroxide  
Thermometer  
Scissors  
Flashlight  
Medications, ointments only as follows: (*include name of medicine or skin product, dosage, frequency of use and reason to use for each item listed.*) \*

\* If no medication or ointments are included, form does not need to be signed.

Signature of physician / nurse practitioner

Date (*month, day, year*)



# RECORD OF MEDICATION ORDER

State Form 49968 (R3 / 2-15)

FSSA - MS02  
402 WEST WASHINGTON STREET, RM W361  
INDIANAPOLIS, IN 46204

All medications, medicinal products, physician's sample medications, and medicinal skin care products given or used at a child care center must include the exact name of medication, dosage to be given, time to be given and reason for use. (If used for fever, the degree of temperature must be stated.) A prescriber order is valid for one (1) year.

1. Name of child	Exact name of medication	
Dosage to be given	Time to be given ( <i>frequency</i> )	
Reason for use: -----		
Signature of physician / nurse practitioner		Date ( <i>month, day, year</i> )
2. Name of child	Exact name of medication	
Dosage to be given	Time to be given ( <i>frequency</i> )	
Reason for use: -----		
Signature of physician / nurse practitioner		Date ( <i>month, day, year</i> )
3. Name of child	Exact name of medication	
Dosage to be given	Time to be given ( <i>frequency</i> )	
Reason for use: -----		
Signature of physician / nurse practitioner		Date ( <i>month, day, year</i> )
4. Name of child	Exact name of medication	
Dosage to be given	Time to be given ( <i>frequency</i> )	
Reason for use: -----		
Signature of physician / nurse practitioner		Date ( <i>month, day, year</i> )
5. Name of child	Exact name of medication	
Dosage to be given	Time to be given ( <i>frequency</i> )	
Reason for use: -----		
Signature of physician / nurse practitioner		Date ( <i>month, day, year</i> )