Chapter 29

Child Care

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Child care impacts the health and development of children and the economic stability of families. For too many young children and their families, affordable high-quality child care is not accessible. Pediatricians have a role in helping children receive safe, enriching care in high-quality early childhood education (ECE) settings that allows parents to be able to work.

As an environment in which children learn, grow, and play, child care is a component of the social determinants of health. The majority of young children regularly spend time in at least one nonparental child care arrangement. Routine exposure to high-quality child care provides an opportunity for early education in language, early literacy, math, and social skills, as well as for teaching children health-promoting behaviors and for identifying early signs of delays or special needs. Inadequate child care supply and poor availability block these opportunities for many children, disproportionately those from low-resourced families. Instead, many young children are exposed to a patchwork of child care arrangements that are unstable, unaffordable, and often poorly resourced, adding stress that harms child and family well-being.

Child care provision is affected by many factors, derived from family demand, child care supply, and child/family policy. With increasing movement of mothers into the workplace across the globe, the prime reason most families use child care is to support employment of both parents. After childbirth, unpaid maternity leave is the typical situation among U.S. mothers. The U.S. federal leave program allows for 12 weeks of unpaid job-protected leave during pregnancy or after childbirth, but only covers approximately 50% of the workforce because companies with <50 employees, with part-time employees, and those working in informal labor markets are exempt. Several states and cities have passed paid family leave laws.

In part because of the financial burden of an unpaid maternity leave, many mothers return to work, and their children may begin child care in the first few weeks after birth. In a 2000 Family and Medical Leave Act survey, only 10% of respondents reported taking more than 60 days for maternity leave. Approximately 44% of mothers in 2005–2007 were working by the time their first child was 3-4 months of age, and approximately 63% of mothers were working by the time their first child was 12 months. Some mothers face work requirements if they are receiving public benefits because of the reforms to welfare passed by the U.S. Congress in 1996. Many mothers feel strong financial motivation or even pressure to work, especially in single-parent households, or have strong incentive to work for short- and long-term financial security. Employment is not the only factor driving child care use; young children of *unemployed* mothers spend on average 21 hours per week in child care. Many parents want their children to have child care experiences for the potential benefits that early learning environments can give to their children. Given these realities, child care quality is of great concern, yet the quality of child care and early education environments varies widely, and the supply of high-quality child care is largely deemed inadequate.

The COVID-19 pandemic revealed the fragility of America's child care system. Relative to adults, young children have been far less likely to suffer severe medical complications from coronavirus infection, and rates of transmission in child care facilities that followed mitigation protocols have been low. However, the downstream effects of the pandemic on young children have been acute. Burdensome child care cost and access barriers became exaggerated. Parents of young children report significant concerns about their children's safety and education during the pandemic and describe significant disruptions and impacts on families' well-being. Estimates indicate that 1 in every 500 U.S. children have experienced COVID-19 orphanhood or the loss of a caregiving grandparent, further highlighting a crisis in early childhood caregiving.

QUALITY, PROVISION, REGULATION, AND ACCESS

Child Care Quality

High-quality child care is characterized by warm, responsive, and stimulating interactions between children and child care providers. These caregivers express positive feelings toward the children; are emotionally involved, engaged, and aware of the child's needs and sensitive and responsive to their initiations; speak directly with children in a manner that is elaborative and stimulating while being age-appropriate; and ask questions and encourage children's ideas and verbalizations. Structural quality features of the setting, including ratio of children to adults, group size, and caregiver education and training, act indirectly on child outcomes by facilitating high-quality interactions. It would be highly unlikely, if not impossible, for even the most sensitive and stimulating provider to engage in high-quality interactions with each child, if, for example, the provider was the sole caregiver of 10 toddlers.

Poor-quality child care settings and unsafe environments that do not meet children's basic physical and emotional needs can result in developmental delays tied to lack of healthy relationships with adults or developmentally inappropriate activities, toxic stress, neglect, or injury or death from fire, building hazards, disease, and inadequate staff oversight. State regulations put a "floor" on structural quality and basic staff indicators to mitigate risks and safeguard health and safety. Although structural indicators are more easily monitored in licensing, some but not all research suggests only modest relationships of structural indicators with child outcomes. When it comes to process quality, a body of studies demonstrates small-to-modest associations with short-term child development and some evidence of long-term impacts.

The early childhood field is focusing increasingly on effective practices, evidence-based curricula, and programs that are reported to have moderate-to-large effects on child outcomes. Some specific teacher practices are related to gains in academic and social-emotional skills among preschool students. Evidence-informed and evaluated ECE curricula with aligned professional development can have substantial impacts on child outcomes across several developmental domains. Primary caregiving, the practice in infant and toddler classrooms of assigning one teacher the primary responsibility for the care of a small group of children and developing relationships with their families, is consistent with research showing that infants who experience stable, consistent, sensitive and responsive care develop more secure attachment relationships and more positive developmental outcomes. Family engagement, in which early educators partner with families to share their unique knowledge of each child to build positive and goal-oriented relationships, relates to gains in preschool children's social and early academic skills and reduced problem behaviors.

Integration of Health and Safety Within Quality Practices

The American Academy of Pediatrics (AAP), the American Public Health Association, and the National Resource Center for Health and Safety in Child Care and Early Education provide health and safety guidelines in *Caring for Our Children (CFOC): National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 4th ed.* (https://nrckids.org/CFOC; 2019). These national standards represent the best evidence on quality practices and address health and safety as an integrated component of early care and education. The intent is for the guidelines to serve as a resource for states and other entities to improve health and safety standards in licensing and quality rating improvement systems. An additional objective is for the various monitoring agencies and mechanisms to work together to collaboratively safeguard children and minimize or eliminate the duplication and burden of complicated and sometimes conflicting procedures and requirements.

The current guidelines include sections in 10 areas (Table 29.1). The National Resource Center also provides updated online resources: (1) up-to-date CFOC Standards Online Database (https://nrckids.org/CFOC and (2) a crosswalk of COVID-19 questions with CFOC

Table 29.1 *Caring for Our Children* Performance Standards: Chapters and Topics

1. **Staffing:** Child-staff ratio, group size, minimum age; background checks (criminal history, sex offender registry, and child abuse and neglect registry checks), qualifications, professional development, training
2. **Program Activities for Healthy Development:** Developmental activities (general and by age), supervision and discipline, parent/guardian relationships, health education
3. **Health Promotion and Protection:** Health promotion in child care (health checks and supervision, physical activity, limiting screen time, safe sleep, oral health); hygiene (diapering, hand hygiene, exposure to bodily fluids); cleaning, sanitizing, and disinfecting; tobacco and drug use; animals; emergency procedures; child abuse and neglect; sun safety and insect repellent; strangulation hazards; management of illness
4. **Nutrition and Food Service:** General and by age, meal service, seating, and supervision, nutrition learning experiences for children and for parents/guardians, food safety, and more
5. **Facilities, Supplies, Equipment, and Environmental Health:** Space per child, exits, ventilation, lighting, noise, furnishings, equipment, and more
6. **Play Areas/Playgrounds and Transportation:** Playground equipment, water play areas, toys
7. **Infectious Diseases:** Immunizations, respiratory tract infections, enteric (diarrheal) infections and hepatitis A virus, skin and mucous membrane infections, blood-borne infections, herpes viruses, interaction with state or local health departments, judicious use of antibiotics
8. **Children with Special Healthcare Needs and Disabilities:** Inclusion, service plans, coordination and documentation, periodic reevaluation, assessment of facilities for children with special needs, additional standards
9. **Administration:** Governance, policies, human resources, records
10. **Licensing and Community Action:** Regulatory policy, licensing agency, facility licensing, health department responsibilities and role, caregiver/teacher support, public policy issues and resource development

From the American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. Caring for Our Children: National Health and Safety Performance Standards; *Guidelines for Early Care and Education Programs*. 4th ed., Itasca, IL: American Academy of Pediatrics; 2019. (https://nrckids.org/CFOC/TOC).

standards (https://nrckids.org/files/CFOC.Crosswalk.pdf) to help child care health consultants and providers learn how the CFOC standards address provision of safe and healthy early care and education environments during the COVID-19 pandemic.

Child Care Settings and Use

Public early education programs (such as Head Start and targeted state-funded prekindergarten programs) have historically been designed as policy mechanisms to close the school readiness gap among children with fewer resources, whereas child care has been seen as necessary when parents (usually mothers) work while their children are young. Despite these historical "silos," all early care and education settings serve both purposes: they are early learning environments for children and necessary supports for working parents.

Quality of care matters for all child care settings, but there are key differences in the structure and provision of care that influence organizational and business operations, regulatory mandates, and accessibility and affordability for families.

Child care settings vary widely and fall into four broad categories from the least to the most formal:

1. Relative or friend cares for a child in the relative's or friend's home or in the child's home
2. Nonrelative care who comes to the child's home, such as nannies, babysitters, or au pairs
3. Home-based child care in which an individual runs a child care business in their own home and cares for a few or several children, often including children of mixed ages, siblings, or the provider's own children
4. Center-based care, provided in nonresidential facilities for children grouped by age, including preschools, prekindergarten programs, Head Start centers, and child care centers.

Child care centers and early education programs are administered by a wide array of businesses and organizations, including for-profit providers or companies, religious organizations, public and private schools including early childhood special education programs, nonprofits and other community organizations, cooperatives, employer-based child care, and public agencies. Increasingly, publicly funded prekindergarten programs contract with existing community-based centers and home-based providers for program delivery. With a few exceptions (such as faith-affiliated child care), center-based child care programs must satisfy state licensing laws for safety practices. For other child care options, governmental oversight for health and safety is rarer; many home-based child care programs are licensed, whereas many others are unknown to regulatory agencies, and family, friend, and nanny care are almost never regulated. Child care licensing and regulation is described in the next section.

Approximately 59% of children 5 years and younger and not yet in kindergarten were in at least 1 weekly nonparental child care arrangement, as reported by their parents in the U.S. Census Bureau's 2019 National Household Education Surveys Program. Forty-two percent of children less than 1 year of age, 55% of 1-2 year olds, and 74% of 3-5 year olds were in nonparental care. Nearly 60% of those in at least one child care arrangement were in a center-based arrangement, 38% were in relative care, and 20% were in nonrelative care in a private home; children may have been in more than one type of arrangement. Center-based arrangements were most common among preschoolers, whereas relative care arrangements were most common among infants.

Child Care Closures

The COVID-19 pandemic accelerated a worsening trend of child care closures. In 2012, there were approximately 129,000 center-based programs serving 6.98 million children from birth through age 5. Between 2014 and 2017, the number of licensed child care programs of all types in the United States decreased to approximately 109,000 centers. The number of listed home-based providers (which includes licensed or otherwise regulated providers) decreased by about 25% between 2012 and 2019.

In response to COVID-19, by April 2020 new state public health requirements resulted in closing 70% of U.S. child care centers; more than 35% of child care workers became unemployed. Reasons for this include COVID-19 outbreaks and preventative health protocols such as social distancing with limits in group sizes and child:staff ratios. As the pandemic continued, reasons for new or even permanent closures included staffing shortages as well as business models that cannot support a program's financial survival at low enrollment rates. However, child masking within the first year of the pandemic was associated with a 13-14% reduction in child care closure rates.

Licensing, Regulation, Monitoring, and Accreditation

State and territory licensing agencies enumerate which providers are subject to licensing to legally operate and monitor those providers' compliance with foundational, mandated regulations to protect children's safety, health, and well-being. Many states and territories also offer systems of child care monitoring that are usually voluntary in nature, such as quality rating and improvement systems (QRIS), and various professional organizations offer voluntary accreditation systems to assess whether providers meet higher-quality standards, often (but not always) requiring licensure as a prerequisite to participation.

Licensing

Licensing and regulatory requirements establish the minimum requirements necessary to protect the health and safety of children in

child care. Typically, these include basic health and safety standards such as sanitary practices, child and provider vaccinations, access to a healthcare professional, and facilities and equipment hazards and safety, as well as basic structural and caregiver characteristics such as background checks, the ratio of children to staff, group sizes, and minimum caregiver education and training requirements. Most child care centers and preschools and many family child care providers are subject to state licensing and regulation. All states regulate child care centers, as does the District of Columbia, and most states regulate family child care providers.

Pediatricians are encouraged to learn about their own state's child care licensing rules. Large differences between states mean large differences in allowable levels of quality. The most common child:staff ratios are 4:1 for infants, 6:1 for toddlers, and 10:1 for preschoolers. However, some states permit ratios that are 5:1 or 6:1 for infants 9 months of age or younger.

State and territory child care licensing regulations are maintained in a searchable National Database of Child Care Licensing Regulations (https://childcareta.acf.hhs.gov/licensing) by the National Center on Early Childhood Quality Assurance (NCECQA). The site provides a tool for searching state and territory licensing regulations and agency contact information. Licensing requirements are frequently updated.

Unlicensed settings and even licensed providers in states with low licensing and regulatory standards may be providing care at quality levels below professional recommendations. Moreover, various types of programs may be exempt from licensure, such as faith-affiliated child care programs, and exemptions are specific to each state; as many as one third of child care centers are legally exempt in some states. Centers are often exempted if care is offered by other organizations such as school districts that provide external oversight. The smallest homes (three or four children in care) are often license-exempt, encompassing relative, friend, and neighbor caregivers as well as babysitters, nannies, and au pairs. Some of these providers and the families who use them may not even think of themselves as providing "child care." The Child Care Development Block Grant (CCDBG) reauthorization in 2014 required states and territories to expand their monitoring of legally exempt providers to protect the health and safety of children receiving subsidized child care. Most states require exempt centers and family child care homes to meet some licensure requirements such as background checks and to receive an annual inspection to receive child care subsidy payments.

Other Quality Monitoring Systems

Several voluntary public and private initiatives require that child care settings meet their own sets of guidelines and regulations in areas considered critical to effective practice and child outcomes to receive either state or federal funding. These diverse initiatives include those that focus on nutrition (the Child and Adult Care Food Program [CACFP]), inclusion (the Individuals with Disabilities Education Act [IDEA]), and financial assistance to low-income working parents (child care subsidies through the CCDBG). Most states have quality initiatives called QRIS. Publicly funded early education programs, including the federal Head Start and Early Head Start program as well as state and local public prekindergarten have their own program performance standards.

Participating providers benefit in ways that may include technical assistance supports, professional development, and additional funding often tied to the numbers of children served under the program. About 75% of early care and education centers report receiving funds from multiple sources. Providers may also value earning a public-facing "seal of approval" to help families learn about higher-quality programs.

These programs all monitor eligibility and compliance with program standards. For example, Head Start and most of the state prekindergarten programs that restrict enrollment to low-income families require verification of family eligibility (although some states' and cities' prekindergarten programs are universally available to all preschool-age children regardless of family income). Other eligibility standards include verification of parental employment for child care subsidies or verification of nutritious food for low-income families for receipt of CACFP funds. Other monitoring may cover staffing, meals and snacks, curricula and teaching, and other areas of service delivery. QRIS systems work within the infrastructure of the early care and education system to assess, incentivize, and support higher levels of quality. Examples of incentives and supports include tiered subsidy reimbursement systems in which participating providers who achieve levels of quality beyond basic licensing requirements are entitled to higher subsidy payments, public funding to facilitate accreditation, professional development systems and coaching, and program assessments and technical assistance.

Accreditation

A smaller portion of providers become accredited by National Association for the Education of Young Children (NAEYC), National Association for Family Child Care (NAFCC), or other organizations by voluntarily meeting high-quality, developmentally appropriate, professionally recommended standards. The accreditation process goes beyond health and safety practices and structural and caregiver characteristics to examine the quality of child–caregiver interactions. Evidence indicates that child care programs that complete voluntary accreditation through NAEYC provide an environment that better facilitates children's overall development, but few providers are accredited. This is partly the result of a lack of knowledge, resources, and incentives for providers to improve quality, but it may also be partly because of expenses providers incur in becoming accredited.

Child Care Access

As one social determinant of health, access to affordable high-quality child care that supports child development and meets family needs is critical.

Access to child care goes beyond simple "supply" (numbers of available slots) and "demand" (numbers of young children needing extrafamilial care). Barriers to access include aspects of affordability, hours of operation, location, transportation, and culturally or linguistically appropriate care. Barriers to access to high-quality child care are pervasive among families in which caregivers work irregular, fluctuating, or nontraditional work schedules, families with infants and toddlers, families for whom English is not the primary language spoken at home, and families with children with disabilities or special needs.

Two thirds of children 5 years of age and younger have both parents in the workforce or in school or training programs. Nearly 30% of low-income mothers of children under 6 years of age work nonstandard hours, but child care supply during nonstandard or irregular hours is extremely limited. Over 30% of parents with children in weekly care report that the arrangement does not cover the hours needed for work very well. Many more report that they are not in the workforce or school, or not working the hours or shifts that they need or want, due to lack of affordable accessible child care.

SCREENING AND SUPPORT FOR CHILD DEVELOPMENT AND HEALTH

Child Care and Child Behavior

Before the COVID-19 pandemic, about 192,000 U.S. young children were being expelled or suspended from child care programs annually for concerns rising from developmentally typical crying and temper tantrums to physical aggression to violations of various "zero tolerance policies," such as bringing a water gun to child care. In fact, young children are expelled from child care and preschool programs at a rate more than 3 times that for kindergarten through 12th graders. Young children experiencing any number of adverse childhood events are at significantly increased odds of preschool expulsion, such as exposure to domestic or community violence, family mental illness and substance abuse, poverty, parental divorce, and parental incarceration. These disciplinary exclusions are disproportionately applied to young males and to children of color; implicit biases account for at least some of these disproportionalities. These early disciplinary exclusions predict later negative school attitudes, academic failure and grade retention, and later expulsions and suspensions, as well as a 10-fold increase in high-school dropout rates and an 8-fold increase in later incarceration.

State efforts to reduce early childhood exclusionary discipline include early childhood mental health consultation (ECMHC) models to support child care providers, who are often not well trained in managing child behavior, as well as build capacity to raise child care quality for all children. ECMHC links a mental health professional with an early education and care provider in an ongoing problem-solving and capacity-building relationship. ECMHC has been shown to be effective in statewide randomized controlled trials, and now exist in several states and cities. Because this is a rapidly evolving area of support, clinicians wishing to provide guidance to parents of young children at risk of early disciplinary exclusion should consider inquiring about the existence of an ECMHC system within their state or locality by contacting their state early childhood department and/or state/local child care resource and referral agency. Local regulations may limit or prohibit the exclusion of children in response to behaviors that may be a symptomatic expression of a diagnosed disability or special education need, providing a potential method for safeguarding a child's ability to receive early care and education, as described in the next section.

Children with Special Needs

Children with cognitive, physical, or emotional disabilities who require special care and instruction often require particular attention when it comes to their participation in most child care settings. Guiding principles of services for children with disabilities advocate supporting children in natural environments, including child care. Furthermore, the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 prohibit discrimination against children and adults with disabilities by requiring equal access to offered programs and services.

Child care can be, and often is, utilized for delivery of support services to children with special needs and/or for linking families to services such as early intervention. Furthermore, clinicians can draw on child care providers for important evaluative data regarding a child's well-being, as these providers have extensive daily contact with the child and may have broad, professional understanding of normative child development. Child care providers often conduct screenings for developmental milestones and delays using standardized instruments. A child care provider may be the first to identify a child's potential language delay. Child care providers are also necessary and valuable partners in the development and administration of early intervention service plans. However, many child care providers and settings are unprepared to identify or administer services for children with special needs.

Children with special needs may be eligible for special educational services under IDEA. The purpose of this law is to provide "free appropriate public education," regardless of disability or chronic illness, to all eligible children, birth to 21 years of age, in a natural and/or least-restrictive environment. Eligible children include those with mental, physical, or emotional disabilities who, because of their disability or chronic illness, require special instruction to learn. As a part of these services, a formal plan of intervention is to be developed by the service providers, families, and the children's healthcare providers. Federal funds are available to implement a collaborative early intervention system of services for eligible infants and toddlers between the ages of birth and 3 years and their families. These services include screening, assessment, service coordination, and collaborative development of an **individualized family service plan (IFSP).** The IFSP describes early intervention services for the child's health, therapeutic, and educational needs and supports needed by the family. An understanding of the child's routines and real-life opportunities and activities, such as eating, playing, interacting with others, and working on developmental skills, is crucial to enhancing a child's ability to achieve the functional goals of the IFSP. Therefore it is critical that child care providers be involved in IFSP development or revision, with parental consent. Child care providers should also become familiar with the child's IFSP and understand the providers' role and the resources available to support the family and child care provider. Additionally, IDEA provides support for eligible children 3 years of age and older to receive services through the local school district. This includes development of a written **individualized education program (IEP)**, with implementation being the responsibility of the local education agency in either a public or private preschool setting. As with IFSPs, child care providers should become familiar with the preschooler's special needs as identified in the IEP and may become involved, with parental consent, in IEP development and review meetings. In cases where children may have or be at risk of developmental delays, a diagnosis is important for obtaining and coordinating services and further evaluation. To this end, clinicians can partner with child care providers to screen and monitor children's behavior and development. Even if a young child is not being provided special educational services, special accommodations may be requested for any child whose access to child care is being adversely impacted by a diagnosable developmental or behavioral disability through Section 504 of the Rehabilitation Act of 1973.

Sick Children and Control of Infectious Disease

When children are ill, they may be excluded from out-of-home child care and under state licensure child care programs are required to exclude children with certain conditions. Children in child care are of an age that places them at increased risk for acquiring infectious diseases. Participation in group settings elevates exposure, leading to increased infections, especially during the first year of child care exposure and especially with infants. Children enrolled in such settings have a higher incidence of illness (upper respiratory tract infections, otitis media, diarrhea, hepatitis A infections, skin conditions, and asthma) than those cared for at home, especially in the preschool years; these illnesses have no long-term adverse consequences. Child care providers that follow child care licensure guidelines for handwashing, diapering, and food handling, and manage child illness appropriately, can reduce communicable illnesses.

CFOC (2019) and its up-to-date online supplement and the AAP (Table 29.2) offer guidelines and recommendations regarding the conditions under which sick children should and should not be excluded from group programs. State laws typically mirror these guidelines but may be stricter in some states. Although exclusion from child care due to mild illness is often unnecessary, their summary of guidelines states that a child should be excluded temporarily from care if the signs or symptoms of the illness does any of the following:

- Prevents the child from participating in daycare activities
- Results in a level of care that is greater than the staff can provide
- Poses a contagion risk of serious diseases to other children and staff

For COVID-19 exposure or symptoms or recovery go to https://www.cdc.gov/coronavirus/2019-nCoV/index.html

Health checks should be performed on each child every day. If symptoms develop during child care but do not require exclusion, written or verbal communication after the daycare is appropriate. Emergencies must be addressed with 911 calls and immediate notification of the family. If nonemergent but requiring exclusion, the parents should be notified to take the child home. Parents should have a backup plan when exclusions occur. *Return to child care is usually permissible without a primary healthcare visit.*

CFOC also provides guidelines for control of infectious disease outbreaks and for exclusion of any child or staff member who is suspected of contributing to transmission of the illness, who is not adequately immunized when there is an outbreak of a vaccine-preventable disease, or when the circulating pathogen poses an increased risk to the individual.

During the first 3 months of the COVID-19 pandemic in the United States, exposure to child care was not associated with an elevated risk of COVID-19 transmission to adult child care providers within the context of the considerable efforts that were employed to reduce transmission. Although enhanced hand hygiene and surface disinfecting were the most common transmission mitigation methods, many child care programs also engaged in daily symptom screening and temperature checks, social distancing efforts, and cohorting (i.e., keeping groups of children separate to help control the speed of transmission). Despite Centers for Disease Control and Prevention (CDC) guidance, masking of adults and children were rarely employed; federal guidance and requirements in several states, child care provider COVID-19 vaccination rates in June 2021 were only 78.2%. COVID-19 modifications and

Table 29.2 Signs and Symptoms for Consideration of Exclusion or Inclusion in Child Care

SIGN OR SYMPTOM	COMMON CAUSES	COMPLAINTS OR WHAT MIGHT BE SEEN	NOTIFY HEALTH CONSULTANT	NOTIFY PARENT	TEMPORARILY EXCLUDE?	IF EXCLUDED, READMIT WHEN
Cold symptoms	*Viruses* (early stage of many viruses) • Adenovirus • Coronavirus • Enterovirus • Influenza virus • Parainfluenza virus • Respiratory syncytial virus (RSV) • Rhinovirus Bacteria • Mycoplasma • Pertussis	• Coughing • Runny or stuffy nose • Scratchy throat • Sneezing • Fever • Watery eyes	Not necessary unless epidemics occur (i.e., RSV or vaccine-preventable disease like measles or varicella [chickenpox])	Yes	No, unless • Fever accompanied by behavior change. • Child looks or acts very ill. • Child has difficulty breathing. • Child has blood-red or purple rash not associated with injury. • Child meets routine exclusion criteria.	Exclusion criteria are resolved.
Cough (cough is a body response to something that is irritating tissues in the airway anywhere from the nose to the lungs)	• Common cold • Lower respiratory infection (e.g., pneumonia, bronchiolitis) • Croup • Asthma • Sinus infection • Bronchitis • Pertussis • Noninfectious causes like allergies	• Dry or wet cough • Runny nose (clear, white, or yellow-green) • Sore throat • Throat irritation • Hoarse voice, barking cough • Coughing fits	Not necessary unless the cough is due to a vaccine-preventable disease, such as pertussis	Yes	No, unless • Severe cough. • Rapid or difficult breathing. • Wheezing if not already evaluated and treated. • Cyanosis (i.e., blue color of skin or mucous membranes). • Pertussis is diagnosed and not yet treated. • Fever with behavior change. • Child meets routine exclusion criteria.	Exclusion criteria are resolved.
Diaper rash	• Irritation by rubbing of diaper material against skin wet with urine or stool • Infection with yeast or bacteria	• Redness • Scaling • Red bumps • Sores • Cracking of skin in diaper region	Not necessary	Yes	No, unless • Oozing sores that leak body fluids outside the diaper. • Child meets routine exclusion criteria.	Exclusion criteria are resolved.
Diarrhea	• Usually viral, less commonly bacterial or parasitic • Noninfectious causes such as dietary (drinking too much juice), medications, inflammatory bowel disease, or cystic fibrosis	• Frequent loose or watery stools compared with child's normal pattern. (Note that exclusively breastfed infants normally have frequent unformed and somewhat watery stools or may have several days with no stools.) • Abdominal cramps • Fever • Generally not feeling well • Vomiting occasionally present	Yes, if one or more cases of bloody diarrhea or two or more children in same group with diarrhea within a week	Yes	Yes, if • Directed by the local health department as part of outbreak management. • Stool is not contained in the diaper for diapered children. • Diarrhea is causing "accidents" for toilet-trained children. • Stool frequency exceeds 2 stools above normal during the time the child is in the program because this may cause too much work for teachers/caregivers and make it difficult to maintain good sanitation. • Blood/mucus in stool. • Black stools. • No urine output in 8 hours. • Jaundice (i.e., yellow skin or eyes). • Fever with behavior change. • Looks or acts very ill. • Child meets routine exclusion criteria.	• Cleared to return by healthcare provider for all cases of bloody diarrhea and diarrhea caused by Shiga toxin-producing *Escherichia coli*, *Shigella*, or *Salmonella* serotype Typhi until negative stool culture requirement has been met. • Diapered children have their stool contained by the diaper (even if the stools remain loose) and toilet-trained children do not have toileting accidents. • Stool frequency is no more than 2 stools above normal during the time the child is in the program, or what has become normal for that child when the child seems otherwise well. • Exclusion criteria are resolved.

Continued

Table 29.2 Signs and Symptoms for Consideration of Exclusion or Inclusion in Child Care—cont'd

SIGN OR SYMPTOM	COMMON CAUSES	COMPLAINTS OR WHAT MIGHT BE SEEN	NOTIFY HEALTH CONSULTANT	NOTIFY PARENT	TEMPORARILY EXCLUDE?	IF EXCLUDED, READMIT WHEN
Difficult or noisy breathing	• Common cold • Croup • Epiglottitis • Bronchiolitis • Asthma • Pneumonia • Object stuck in airway • Exposed to a known trigger of asthma symptoms (e.g., animal dander, pollen)	• Common cold: stuffy/runny nose, sore throat, cough, or mild fever • Croup: barking cough, hoarseness, fever, possible chest discomfort (symptoms worse at night), or very noisy breathing, especially when breathing in • Epiglottitis: gasping noisily for breath with mouth wide open, chin pulled down, high fever, or bluish (cyanotic) nails and skin; drooling, unwilling to lie down • Bronchiolitis and asthma: child is working hard to breathe; rapid breathing; space between ribs looks like it is sucked in with each breath (retractions); wheezing; whistling sound with breathing; cold/cough; irritable and unwell. Takes longer to breathe out than to breathe in. • Pneumonia: deep cough, fever, rapid breathing, or space between ribs looks like it is sucked in with each breath (retractions) • Object stuck in airway: symptoms similar to croup (listed previously) • Exposed to a known trigger of asthma symptoms: a known trigger and breathing that sounds or looks different from what is normal for that child	Not necessary except for epiglottitis	Yes	Yes, if • Fever with behavior change. • Child looks or acts very ill. • Child has difficulty breathing. • Rapid or difficult breathing. • Wheezing if not already evaluated and treated. • Cyanosis (i.e., blue color of skin or mucous membranes). • Cough interferes with activities. • Breath sounds can be heard when the child is at rest. • Child has blood-red or purple rash not associated with injury. • Child meets routine exclusion criteria.	Exclusion criteria are resolved.
Earache	• Bacteria • Often occurs in context of common cold virus	• Fever • Pain or irritability • Difficulty hearing • "Blocked ears" • Drainage • Swelling around ear	Not necessary	Yes	No, unless child meets routine exclusion criteria.	Exclusion criteria are resolved.

Table 29.2 Signs and Symptoms for Consideration of Exclusion or Inclusion in Child Care—cont'd

SIGN OR SYMPTOM	COMMON CAUSES	COMPLAINTS OR WHAT MIGHT BE SEEN	NOTIFY HEALTH CONSULTANT	NOTIFY PARENT	TEMPORARILY EXCLUDE?	IF EXCLUDED, READMIT WHEN
Eye irritation, pinkeye	• Bacterial infection of the membrane covering one or both eyes and eyelids (bacterial conjunctivitis) • Viral infection of the membrane covering one or both eyes and eyelids (viral conjunctivitis) • Allergic irritation of the membrane covering one or both eyes and eyelids (allergic conjunctivitis) • Chemical irritation of the membrane covering the eye and eyelid (irritant conjunctivitis) (e.g., swimming in heavily chlorinated water, air pollution, smoke exposure)	• Bacterial infection: pink color of the "whites" of eyes and thick yellow/green discharge. Eyelid may be irritated, swollen, or crusted. • Viral infection: pinkish/red color of the whites of the eye; irritated, swollen eyelids; watery discharge with or without some crusting around the eyelids; may have associated cold symptoms. • Allergic and chemical irritation: red, tearing, itchy, puffy eyelids; runny nose, sneezing; watery/stringy discharge with or without some crusting around the eyelids.	Yes, if two or more children have red eyes with watery discharge	Yes	*For bacterial conjunctivitis* No. Exclusion is no longer required for this condition. Healthcare providers may vary on whether to treat this condition with antibiotic medication. The role of antibiotics in treatment and preventing spread is unclear. Most children with pinkeye get better after 5 or 6 days without antibiotics. *For other eye problems* No, unless child meets other exclusion criteria. *Note:* One type of viral conjunctivitis spreads rapidly and requires exclusion. If two or more children in the group have watery red eyes without any known chemical irritant exposure, exclusion may be required and health authorities should be notified to determine whether the situation involves the uncommon epidemic conjunctivitis caused by a specific type of adenovirus. Herpes simplex conjunctivitis (red eyes with blistering/vesicles on eyelid) occurs rarely and would also require exclusion if there is eye watering.	• *For bacterial conjunctivitis,* once parent has discussed with healthcare provider. Antibiotics may or may not be prescribed. • Exclusion criteria are resolved.
Fever	• Any viral, bacterial, or parasitic infection • Vigorous exercise • Reaction to medication or vaccine • Other noninfectious illnesses (e.g., rheumatoid arthritis, malignancy)	Flushing, tired, irritable, decreased activity *Notes:* • Fever alone is not harmful. When a child has an infection, raising the body temperature is part of the body's normal defense against germs. • Rapid elevation of body temperature sometimes triggers a febrile seizure in young children; this usually is outgrown by age 6 yr. The first time a febrile seizure happens, the child requires medical evaluation. These seizures are frightening but are usually brief (less than 15 minutes) and do not cause the child any long-term harm. Parents should inform their child's healthcare provider every time the child has a seizure, even if the child is known to have febrile seizures. Warning: *Do not* give aspirin. It has been linked to an increased risk of Reye syndrome (a rare and serious disease affecting the brain and liver).	Not necessary	Yes	No, unless • Behavior change or other signs of illness in addition to fever or child meets other routine exclusion criteria. • Unable to participate. • Care would compromise staff's ability to care for other children. *Note:* A temperature considered meaningfully elevated above normal, although not necessarily an indication of a significant health problem, for infants and children older than 2 mo is above 101°F (38.3°C) from any site (axillary, oral, or rectal). *Get medical attention* when infants younger than 4 mo have unexplained fever. In any infant younger than 2 mo, a temperature above 100.4°F (38.0°C) is considered meaningfully elevated and requires that the child get medical attention immediately, within an hour if possible. The fever is not harmful; however, the illness causing it may be serious in this age group.	Exclusion criteria are resolved.

Continued

Table 29.2 Signs and Symptoms for Consideration of Exclusion or Inclusion in Child Care—cont'd

SIGN OR SYMPTOM	COMMON CAUSES	COMPLAINTS OR WHAT MIGHT BE SEEN	NOTIFY HEALTH CONSULTANT	NOTIFY PARENT	TEMPORARILY EXCLUDE?	IF EXCLUDED, READMIT WHEN
Headache	• Any bacterial/viral infection • Other noninfectious causes	• Tired and irritable • Can occur with or without other symptoms	Not necessary	Yes	No, unless child meets routine exclusion criteria. *Note:* Notify healthcare provider in case of sudden, severe headache with vomiting or stiff neck that might signal meningitis. It would be concerning if the back of the neck is painful or the child cannot look at his or her belly button (putting chin to chest)—different from soreness in the side of the neck.	Exclusion criteria are resolved.
Itching	• Ringworm • Chickenpox • Pinworm • Head lice • Scabies • Allergic or irritant reaction (e.g., poison ivy) • Dry skin or eczema • Impetigo	• Ringworm: itchy ring-shaped patches on skin or bald patches on scalp. • Chickenpox: blister-like spots surrounded by red halos on scalp, face, and body; fever; irritable. • Pinworm: anal itching. • Head lice: small insects or white egg sheaths that look like grains of sand (nits) in hair. • Scabies: severely itchy red bumps on warm areas of body, especially between fingers or toes. • Allergic or irritant reaction: raised, circular, mobile rash; reddening of the skin; blisters occur with local reactions (poison ivy, contact reaction). • Dry skin or eczema: dry areas on body. More often worse on cheeks, in front of elbows, and behind knees. In infants, may be dry areas on face and anywhere on body but not usually in the diaper area. If swollen, red, or oozing, think about infection. • Impetigo: areas of crusted yellow, oozing sores. Often around mouth or nasal openings or areas of broken skin (insect bites, scrapes).	Yes, for infestations such as lice and scabies; if more than one child in group has impetigo or ringworm; for chickenpox	Yes	*For chickenpox:* Yes, until lesions are fully crusted *For ringworm, impetigo, scabies, and head lice:* Yes, at the end of the day Children should be referred to a healthcare provider at the end of the day for treatment. *For pinworm, allergic or irritant reactions like hives, and eczema:* No, unless appears infected as a weeping or crusty sore *Note:* Although exclusion for these conditions is not necessary, families should seek advice from the child's health professional for how to care for these health problems. *For any other itching:* No, unless the child meets routine exclusion criteria.	• Exclusion criteria are resolved. • On medication or treated as recommended by a healthcare provider if treatment is indicated for the condition. For conditions that require application of antibiotics to lesions or taking antibiotics by mouth, the period of treatment to reduce risk of spread to others is usually 24 hours. For most children with insect infestations or parasites, readmission as soon as the treatment has been given is acceptable.
Mouth sores	• Oral thrush (yeast infection) • Herpes or coxsackie-virus infection • Canker sores	• Oral thrush: white patches on tongue, gums, and along inner cheeks • Herpes or coxsackievirus infection: pain on swallowing; fever; painful, white/red spots in mouth; swollen neck glands; fever blister, cold sore; reddened, swollen, painful lips • Canker sores: painful ulcers inside cheeks or on gums	Not necessary	Yes	No, unless • Drooling steadily related to mouth sores. • Fever with behavior change. • Child meets routine exclusion criteria.	Exclusion criteria are resolved.

Table 29.2 Signs and Symptoms for Consideration of Exclusion or Inclusion in Child Care—cont'd

SIGN OR SYMPTOM	COMMON CAUSES	COMPLAINTS OR WHAT MIGHT BE SEEN	NOTIFY HEALTH CONSULTANT	NOTIFY PARENT	TEMPORARILY EXCLUDE?	IF EXCLUDED, READMIT WHEN
Rash	Many causes • Viral: roseola infantum, fifth disease, chickenpox, herpesvirus, molluscum contagiosum, warts, cold sores, shingles (herpes zoster), and others • Skin infections and infestations: ringworm (fungus), scabies (parasite), impetigo, abscesses, and cellulitis (bacteria) • Scarlet fever (strep infection) • Severe bacterial infections: meningococcus, pneumococcus, *Staphylococcus* (methicillin-susceptible *S. aureus*; methicillin-resistant *S. aureus*), *Streptococcus* • Noninfectious causes: allergy (hives), eczema, contact (irritant) dermatitis, medication related, poison ivy	• Skin may show similar findings with many different causes. Determining cause of rash requires a competent healthcare provider evaluation that takes into account information other than just how rash looks. However, if the child appears well other than the rash, a healthcare provider visit is not necessary. • Viral: usually signs of general illness such as runny nose, cough, and fever (except not for warts or molluscum). Some viral rashes have a distinctive appearance. • Minor skin infections and infestations: see Itching. • More serious skin infections: redness, pain, fever, pus. • Severe bacterial infections: rare. These children usually have fever with a rapidly spreading blood-red rash and may be very ill. • Allergy may be associated with a raised, itchy, pink rash with bumps that can be as small as a pinpoint or large welts known as hives. See also Itching for what might be seen for allergy or contact (irritant) dermatitis or eczema.	For outbreaks, such as multiple children with impetigo within a group	Yes	No, unless • Rash with behavior change or fever. • Has oozing/open wound. • Has bruising not associated with injury. • Has joint pain and rash. • Rapidly spreading blood-red rash. • Tender, red area of skin, especially if it is increasing in size or tenderness. • Child meets routine exclusion criteria. • Diagnosed with a vaccine-preventable condition, such as chickenpox.	• On antibiotic medication for required period (if indicated). • Infestations (lice and scabies) and ringworm can be treated at the end of the day with immediate return the following day. • Exclusion criteria are resolved.
Sore throat (pharyngitis)	• Viral: common cold viruses that cause upper respiratory infections • Strep throat	• Viral: verbal children will complain of sore throat; younger children may be irritable with decreased appetite and increased drooling (refusal to swallow). Often see symptoms associated with upper respiratory illness, such as runny nose, cough, and congestion. • Strep throat: signs of the body's fight against infection include red tissue with white patches on sides of throat, at back of tongue (tonsil area), and at back wall of throat. Unlike viral pharyngitis, strep throat infections are *not* accompanied with cough or runny nose in children older than 3 yr. • Tonsils may be large, even touching each other. Swollen lymph nodes (sometimes called "swollen glands") occur as body fights off the infection.	Not necessary	Yes	No, unless • Inability to swallow. • Excessive drooling with breathing difficulty. • Fever with behavior change. • Child meets routine exclusion criteria. *Note:* Most children with red back of throat or tonsils, pus on tonsils, or swollen lymph nodes have viral infections. If strep is present, 12 hours of antibiotics is required before return to care. However, tests for strep infection are not often necessary for children younger than 3 yr because these children do not develop rheumatic heart disease, which is the primary reason for treatment of strep throat.	• Able to swallow. • On medication at least 12 hours (if strep). • Exclusion criteria are resolved.

Continued

Table 29.2 Signs and Symptoms for Consideration of Exclusion or Inclusion in Child Care—cont'd

SIGN OR SYMPTOM	COMMON CAUSES	COMPLAINTS OR WHAT MIGHT BE SEEN	NOTIFY HEALTH CONSULTANT	NOTIFY PARENT	TEMPORARILY EXCLUDE?	IF EXCLUDED, READMIT WHEN
Stomachache	• Viral gastroenteritis or strep throat • Problems with internal organs of the abdomen such as intestine, colon, liver, bladder • Nonspecific, behavioral, and dietary causes • If combined with hives, may be associated with a severe allergic reaction	• Viral gastroenteritis or strep throat: Vomiting and diarrhea or cramping are signs of a viral infection of the stomach or intestine. Strep throat may cause stomachache with sore throat, headache, and possible fever. In children older than 3 yr, if cough or runny nose is present, strep is very unlikely. • Problems with internal organs of the abdomen: persistent severe pain in abdomen. • Nonspecific stomachache: vague complaints without vomiting/diarrhea or much change in activity.	If multiple cases in same group within 1 week	Yes	No, unless • Severe pain causing child to double over or scream. • Abdominal pain after injury. • Bloody/black stools. • No urine output for 8 hours. • Diarrhea (see Diarrhea). • Vomiting (see Vomiting). • Yellow skin/eyes. • Fever with behavior change. • Looks or acts very ill. • Child meets routine exclusion criteria.	• Pain resolves. • Able to participate. • Exclusion criteria are resolved.
Swollen glands (properly called swollen lymph nodes)	• Normal body defense response to viral or bacterial infection in the area where lymph nodes are located (i.e., in the neck for any upper respiratory infection) • Bacterial infection of lymph nodes that is more than the normal response to infection near where the lymph nodes are located	• Normal lymph node response: swelling at front, sides, and back of the neck and ear; in the armpit or groin; or anywhere else near an area of an infection. Usually, these nodes are less than 1 inch across. • Bacterial infection of lymph nodes: swollen, warm lymph nodes with overlying pink skin, tender to the touch, usually located near an area of the body that has been infected. Usually these nodes are larger than 1 inch across.	Not necessary	Yes	No, unless • Difficulty breathing or swallowing. • Red, tender, warm glands. • Fever with behavior change. • Child meets routine exclusion criteria.	• Child is on antibiotics (if indicated). • Exclusion criteria are resolved.
Vomiting	• Viral infection of the stomach or intestine (gastroenteritis) • Coughing strongly • Other viral illness with fever • Noninfectious causes: food allergy (vomiting, sometimes with hives), trauma, dietary and medication related, headache	Diarrhea, vomiting, or cramping for viral gastroenteritis	For outbreak	Yes	Yes, if • Vomited more than 2 times in 24 hours • Vomiting and fever • Vomiting with hives • Vomit that appears green/bloody • No urine output in 8 hours • Recent history of head injury • Looks or acts very ill • Child meets routine exclusion criteria.	• Vomiting ends. • Able to participate. • Exclusion criteria are resolved.

From Aronson SS, Shope TR, (eds). *Managing Infectious Diseases in Child Care and Schools: a quick reference guide*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics, 2017.

considerations are itemized in the Crosswalk (https://nrckids.org/files/CFOC.Crosswalk.pdf) and include, for example, discussion of daily symptom checks for children as well as daily screening procedures and exclusion criteria for staff.

Most families need to arrange to keep sick children at home necessitating staying home from work or having backup plans with an alternative caregiver. Alternative care arrangements outside the home for sick children are relatively rare but may include either (1) care in the child's own center, if it offers special provisions designed for the care of ill children (sometimes called the **infirmary model** or **sick daycare**), or (2) care in a center that serves only children with illness or temporary conditions. Although it is important that such arrangements emphasize preventing further spread of disease, one study found no occurrence of additional transmission of communicable disease in children attending a sick center.

Protection and Promotion of Child Health

Child care has a role in protecting and promoting child health and well-being. Child care providers are often the first to notice signs of child abuse and neglect and are a major source of child welfare referrals. Findings of increased health-related issues in the first year of child care are likely a testament to early detection benefits provided by child care providers.

Sudden Infant Death Syndrome

A disproportionate number of sudden infant death syndrome (SIDS) deaths occur in child care centers or family-based child care homes. Infants who are back-sleepers at home but are put to sleep on their front in child care settings have a higher risk of SIDS. Providers and parents should be made aware of the importance of placing infants on their backs to sleep.

Asthma and Respiratory Illness

Children enrolled in prekindergarten may have a greater risk of asthma diagnosis during prekindergarten but a lower risk in the years following prekindergarten, when compared with children who were not exposed to prekindergarten. Enrollment in prekindergarten may increase the early detection of asthma symptoms.

A 10-year follow-up of a birth cohort has found no association between child care attendance and respiratory infections, asthma, allergic rhinitis, or skin-prick test reactivity. Another study found that in the first year of elementary school, children who had attended child care had fewer absences from school, half as many episodes of asthma, and less acute respiratory illness than their peers who had never attended child care. These results are perhaps related to protection against respiratory illness through early exposure or a shift in the age-related peak of illness, although selection of illness-prone children into homecare may play a role. Other factors include children in child care potentially being less exposed to passive smoking than children at home.

Vision and Hearing Problems

Children enrolled in a citywide universal prekindergarten program had higher probability of diagnosis of vision problems, receipt of treatment for hearing or vision problems, and receiving an immunization. These effects were not offset by lower rates in the kindergarten year, suggesting that identification and treatment of these conditions was accelerated by enrollment in universal prekindergarten. As hearing and vision problems could potentially delay learning and cause behavioral problems, early detection and treatment is beneficial for future health and school readiness.

Obesity and Promotion of Healthy Behaviors

There is insufficient research on longitudinal associations between child care, diet, and physical activity behaviors. Some limited research suggests a negative or mixed association between child care exposure and healthy behaviors, but the strength of these associations, and whether any causal implications exist, are difficult to tease apart. Other research suggests that child care center-based interventions are generally found to be effective in improving physical activity and may be effective at improving dietary behaviors.

The CDC identifies child care settings as one of the best places to reach young children with obesity prevention efforts. Through their Spectrum of Opportunities framework (https://www.cdc.gov/obesity/strategies/childcareece.html), they outline how a state's early care and education system can embed recommended standards and support for obesity prevention, including nutrition, infant feeding, physical activity, and screen time.

ROLE OF PEDIATRIC PROVIDERS

Consultation, Referrals, and Screening to Improve Access

Many parents are first-time purchasers of child care with little experience and very immediate needs; they may select care in a market that does little to provide them with useful information about child care arrangements. To inform their child care decisions, parents may turn to their child's healthcare provider as the only professional with expertise in child development with whom they have regular and convenient contact. Primary care clinicians should screen for child care just as they do for other social determinants of health, asking about child care arrangements and offering information about resources to help find and pay for child care to reinforce the importance of child care and increase the chances that children are enrolled in high-quality settings.

It is difficult for many parents to find high-quality child care that they can accept and afford. Many parents also worry how their child will fare in child care (e.g., they may worry that their child will feel distressed by the group settings, suffer from separation from the parents, or even be subjected to neglect or abuse). Practical concerns of transportation, scheduling to cover their work or school hours, and reliability are also common. The reliability of the arrangement is often rated as a "very important" selection factor by a higher proportion of parents than any other factor, followed by availability and staff qualifications. Among those who reported difficulty finding child care, cost was most often the primary reason, followed by lack of open slots, quality, then location or other reasons. Worries about finding quality child care are especially likely among parents with greater barriers to child care access and fewer personally accessible family and community resources. With the coronavirus pandemic, parents may be worried about the transmission of COVID-19 and about sporadic disruptions in service caused by quarantines or temporary closures, and unfounded fears about the safety of vaccines or facial masks.

Primary care practices can share information with parents about publicly available sources of information to help them find or pay for child care (Table 29.3). For example, they can

- Refer low-income parents to Head Start, which serves 3-4 year old children, or Early Head Start programs, which serves low-income expecting families and their children until their child's third birthday
- Refer low-income working parents to apply for child care subsidies and financial assistance in their state or county
- Refer parents to their local child care resource and referral agency for help finding and selecting child care; these can be located via the national association, Child Care Aware of America (www.childcareaware.org/families)

Some parents may think of child care only as babysitting focusing mainly on whether the child is safe and warm and may not fully appreciate the potential consequences of unenriched care for their child's cognitive, linguistic, and social development. These parents may be less likely to select a high-quality child care arrangement. Healthcare providers can help parents understand the importance for their child's development of selecting high-quality care by describing how it looks and providing referrals and tips on how to find and select high-quality child care. Families facing socioeconomic challenges accessing high-quality care should be referred to available resources listed previously and in Table 29.3.

When a healthcare provider talks with a parent about a child care arrangement, it also is important to consider the individual child's health concerns, dispositions, and physiologic responses to the environment. Like all environments, child care is experienced differently

Table 29.3 Child Care Information Resources

ORGANIZATION	SPONSOR	WEBSITE AND CONTACT INFORMATION
All Our Kin		https://allourkin.org/
Caring for Our Children: National Resource Center for Health and Safety in Child Care and Early Education (NRC)	American Academy of Pediatrics, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care and Early Education	*Caring for Our Children, National Health and Safety Performance Standards* https://nrckids.org/CFOC
Child Care Aware of America		http://www.childcareaware.org
Healthy Child Care America	American Academy of Pediatrics	http://www.healthychildcare.org
HealthySteps	Zero to Three	https://www.healthysteps.org/
National Association for the Education of Young Children (NAEYC)		http://www.naeyc.org
National Association for Family Child Care		https://nafcc.org/
National Black Child Development Institute		https://www.nbcdi.org/
National Database of Child Care Licensing Regulations	National Center on Early Childhood Quality Assurance (NCECQA) funded by the U.S. Department of Health and Human Services, Administration for Children and Families.	https://childcareta.acf.hhs.gov/licensing
National Indian Child Care Association		https://www.nicca.us/
Office of Child Care (OCC)	U.S. Department of Health and Human Services, Administration for Children & Families	http://www.acf.hhs.gov/programs/occ
Office of Child Care Technical Assistance Network (CCTAN)	U.S. Department of Health and Human Services, Administration for Children & Families, Office of Child Care	https://childcareta.acf.hhs.gov/
UnidosUS		https://www.unidosus.org/
Zero to Three		https://www.zerotothree.org/

by different children. When an environment lacks adequate support for a child's unique needs, healthy development can be compromised. Some children may be more vulnerable to low-quality child care (or particularly responsive to high-quality child care), such as children with difficult or fearful temperaments, especially if their home environments are characterized by more risk factors, such as poverty or high conflict with a parent. Clinicians can help parents determine how to adjust child care arrangements to best meet their child's specific needs (e.g., allergies, eating and sleeping habits, temperament, and stress-regulation capacities).

Children Who Are Expelled from Child Care

A provider may tell a parent that they will not continue to serve a child because of the child's behaviors. Such expulsions are prohibited in some regulated child care settings, such as Head Start and many state-funded prekindergarten programs. In addition to complete termination of a child's child care arrangement (expulsion), children are sometimes told that they cannot attend for a certain number of days (suspension) or have their hours of care reduced, sent home from care early, or excluded in other ways. Regardless of the form of the exclusion or its stated reason, the result is often extremely stressful for the child and family, and often the child care provider too. Indeed, parents may lose their jobs due to the resulting lack of reliable child care or resort to dangerous alternatives, such as leaving the child unattended or in an unsafe arrangement. Healthcare providers should play an important role during child care expulsions by supporting families' efforts to find alternative care, perhaps through a referral to their local child care resource and referral agency, assessing for any potentially contributory underlying developmental or behavioral concerns, and asking parents about the safety of any alternative care arrangements. (See Standard 2.2.0.8 [Preventing Expulsions, Suspensions, and Other Limitations in Services] of Caring for Our Children, as well as the most recent policy statement on this issue by the AAP.)

Supporting Parents Regarding Children's Health

Parents frequently may ask primary care clinicians about sick children, exposure to and prevention of risks in child care, and support for children with special needs in child care. When children are ill, parents should be advised to follow guidelines for inclusion and temporary exclusion (see CFOF, CDC, and state guidelines) (see Table 29.2). Parents may disagree with child care staff about whether a child meets or does not meet the exclusion criteria, as a substantial amount of work absenteeism is due to a child illness, showing the impact of lost child care on parental employment. However, professional guidelines in CFOC state that if the reason for exclusion relates to the child's ability to participate or the caregiver's ability to provide care for the other children, the caregiver should not be required to accept responsibility for the care of the child.

Primary care clinicians should emphasize that parents of infants ensure that child care providers put infants on their backs to sleep to prevent SIDS and follow vaccination schedules, including COVID-19 vaccination as it is available to children of younger ages. Most states require compliance with scheduled vaccinations for children to participate in licensed group child care settings. As of October 2021, only three states (Connecticut, Illinois, New Jersey, and Washington) plus the District of Columbia required child care providers to be vaccinated against COVID-19 and/or participate in regular testing.

Helping Families of Children with Special Needs

Healthcare providers should work with parents and communicate with other service providers and early intervention staff to identify problems, remove access barriers, and coordinate service delivery for children with special needs. They should also encourage involvement of parents and child care providers in developing special education plans such as IEPs and IFSPs. Federal law emphasizes the central role of the family in the development of these plans, and the team writing this plan must consist of the parent or legal guardian and other professionals

that may be involved in the provision of these services, including child care providers. Healthcare providers have an important role to play on these IFSP teams and may attend meetings at the request of the family. Many children with developmental or other special needs that would qualify them for early childhood special education services will present with health concerns, making the healthcare professionals an essential part of adequate early education planning. Additionally, healthcare professionals may support a child's civil rights to access public services such as preschool when their access or ability to participate fully in the program are at risk of limitation due to a diagnosable disability, health, or mental health condition. Often this may require writing a letter stating the nature of the medical condition and the types of accommodations that may improve the child's ability to participate more fully in the range of activities offered by the program. By supporting a child's civil rights under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, clinicians can and should play an integral role for safeguarding the rights of their patients.

Consulting and Partnering with Child Care Providers

Most state regulations mandate that licensed programs have a formal relationship with a healthcare provider. They can provide consultation to child care providers about measures to protect and maintain the health and safety of children and staff. This may include consultation regarding promoting practices to prevent SIDS; preventing and reducing the spread of communicable disease; reducing allergen, toxin, and parasite exposure; ensuring vaccinations for children and staff; removing environmental hazards; and preventing injuries. In some cases pediatricians have provided ongoing health and mental health consultation to child care programs, such through highly successful programs like HealthySteps (https://www.healthysteps.org/) and "Docs for Tots" (https://docsfortots.org/).

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Chapter 30

Loss, Separation, and Bereavement

Megan E. McCabe and Janet R. Serwint

All children will experience involuntary separations, whether from illness, death, or other causes, from loved ones at some time in their lives. Relatively brief separations of children from their parents usually produce minor transient effects, but more enduring and frequent separation may cause sequelae. The potential impact of each event must be considered in light of the age, stage of development, and experiences of the child; the particular relationship with the absent person; and the nature of the situation.

SEPARATION AND LOSS

Separations may be from temporary causes, such as vacations, parental job requirements, natural disasters or civil unrest, or parental or sibling illness requiring hospitalization. More long-term separations occur as a result of divorce, placement in foster care, or immigration, whereas permanent separation may occur because of death. The initial reaction of young children to separation of any duration may involve crying, such as a tantrum type, protesting type, and a quieter, sadder type. Children's behavior may appear subdued, withdrawn, fussy, or moody, or they may demonstrate resistance to authority. Specific problems may include poor appetite, behavior issues such as acting against caregiver requests, reluctance to go to bed, sleep problems, or regressive behavior, such as requesting a bottle or bed-wetting. School-age children may experience impaired cognitive functioning and poor performance in school. Some children may repeatedly ask for the absent parent and question when the absent parent will return. The child may go to the window or door or out into the neighborhood to look for the absent parent; a few may even leave home or their place of temporary placement to search for their parents. Other children may not refer to the parental absence at all.

A child's response to reunion may surprise or alarm an unprepared parent. A parent who joyfully returns to the family may be met by wary or cautious children. After a brief interchange of affection, children may seem indifferent to the parent's return. This response may indicate anger at being left or wariness that the event will happen again, or the young child may feel, as a result of **magical thinking** (see Chapter 25), as if the child caused the parent's departure. For example, if the parent who frequently says "Stop it, or you'll give me a headache" is hospitalized, the child may feel at fault and guilty. Because of these feelings, children may seem more closely attached to the present parent than to the absent one, or even to the grandparent or babysitter who cared for them during their parent's absence. Some children, particularly younger ones, may become more clinging and dependent than they were before the separation, while continuing any regressive behavior that occurred during the separation. Such behavior may engage the returned parent more closely and help to reestablish the bond that the child felt was broken. Such reactions are usually transient, and within 1-2 weeks, children will have recovered their usual behavior and equilibrium. Recurrent separations may tend to make children wary and guarded about reestablishing the relationship with the repeatedly absent parent, and these traits may affect other personal relationships. Parents should be advised not to try to modify a child's behavior by threatening to leave.

DIVORCE

More sustained experiences of loss, such as divorce or placement in foster care, can give rise to the same kinds of reactions noted earlier, but they are more intense and possibly more lasting. Currently in the United States, approximately 40% of first marriages end in divorce. Divorce has been found to be associated with negative parent functioning, such as parental depression and feelings of incompetence; negative child behavior, such as noncompliance and whining; and negative parent–child interaction, such as inconsistent discipline, decreased communication, and decreased affection. Greater childhood distress is associated with greater parental distress. Continued parental conflict and loss of contact with the noncustodial parent is common.

Two of the most important factors that contribute to morbidity of the children in a divorce include *parental psychopathology* and *disrupted parenting* before the separation. The year after the divorce is the period when problems are most apparent; these problems tend to dissipate over the next 2 years. Depression may be present up to 5 years later, and educational or occupational decline may occur even 10 years later. It is difficult to sort out all confounding factors. Children may suffer when exposed to parental conflict that continues after divorce and that in some cases may escalate. The degree of *interparental conflict* may be the most important factor associated with child morbidity. A continued relationship with the noncustodial parent when there is minimal interparental conflict is associated with more positive outcomes.

School-age children may become depressed, may seem indifferent, or may be extremely angry. Other children appear to deny or avoid the issue, behaviorally or verbally. Most children cling to the hope that the actual placement or separation is not real and only temporary. The child may experience guilt by feeling that the loss, separation, or placement represents rejection and perhaps punishment for misbehavior. Children may protect a parent and assume guilt, believing that their own "badness" caused the parent to depart. Children who feel that their misbehavior caused their parents to separate may have the fantasy that their own trivial or recurrent behavioral patterns caused their parents to become angry at each other. A child might perceive that outwardly