

# Health



To protect the health of children in care the following regulations from the Day Nurseries Act must be followed.

- A caregiver or any other person who normally resides at the residence must have a health assessment and immunization as recommended by the local medical officer of health.
- The caregiver and any adult resident in the home must have a TB skin test done on entry. If the results are negative, no further follow up is required. In the case of a positive TB skin test, proof of a negative chest X-ray is required. All are required to have a tetanus/diphtheria booster every ten years.
- Children must be immunized as required prior to entry. Each child must have a medical history completed by their parents. Immunizations need to be up to date for all other children in the home.(refer to Immunization Schedule)
- Proper attention and care of the sick child, including awareness of contagious diseases are essential.
- Caregivers must observe the children daily for physical and emotional health.
- If you suspect or learn a child has a disease which is communicable and reportable, your caseworker and Public Health should be notified. To notify Public Health please call 519-883-2007.
- Caregivers must ensure that all persons residing in the caregiver's residence or who visit the caregiver's residence are free of communicable diseases as defined in the Health Protection and Promotion Act, R.S.O., 1990, C.H.7, as amended.

**For general questions regarding children's health please call:  
Healthy Children Info Line at 519-883-2245.**

## Why is Disease Control so Important for Children and Caregivers?

### Susceptibility of Young Children to Infection

Infants and toddlers are more susceptible to infections than older children and adults. Younger children have immune systems which are not fully developed. Certain physical features of young children also make them more prone to some infections. For example ear infections are most common in children 10 to 18 months of age due to the size and shape of their immature ear canal.

The occurrence of meningitis due to different bacterial organisms is highest during the first three years of life, with the highest number of cases occurring in the first three to twelve months of life due to the child's immature immune system.

### Spread of Infection in Child Care Settings

Germs are readily spread among children and adult care givers in child care settings for a variety of reasons. Coughing and sneezing at close range is common, along with the sharing of toys. Everything goes into a toddler's mouth. Some researchers have noted that toddlers were found to put a hand or object in their mouth every three minutes. Other studies have found that contamination of toys with faecal bacteria is frequent due to the differing abilities of young children to correctly wash their hands. Viruses that cause respiratory and diarrhoeal illnesses may remain infective on nonporous surfaces such as toys for hours to days at a time.

### Spread of Infection From the Child Care Settings to the Family and Community

The child care setting provides a route for the import and export of various infections to and from the homes of the children and caregivers. An infection acquired in the child care setting may cause disease that is mild or unapparent in the child but may cause severe disease in adults (e.g. Hepatitis A is a mild or unapparent infection in children but is often a prolonged and severe illness in adults.) Other mild infections in children may have severe consequences for care givers or parents who are pregnant (e.g. Rubella - German Measles)

## How are Diseases Spread?

Transmission of germs in child care settings depends partly on the characteristics of the particular germ and the characteristics of the setting, particularly hygienic aspects of child handling, environmental practices and the ages of children attending.

Germs are passed between children and/or care givers in a variety of ways including:

- through the **air** (e.g. coughing or sneezing)
- through **direct contact** with body substances from an infected child or child care caregiver
- through **contact with objects** that are contaminated with germs (e.g. soiled tissues, diapers, toys etc.)
- through **ingestion of food or drink** that has been contaminated with germs due to spoilage or improper food handling practices

Infections will vary in how easy they are to "catch". A disease like chickenpox can easily sweep through a child care setting because it is mainly spread through the air. A disease such as impetigo may spread to a much smaller number of children since it is passed through direct contact with the infected child.

## Daily Observation of Children/Communication with Parents

Daily observations of children for changes in behaviour or appearance and specific signs of illness are important. Communication with parents is also essential. Care givers can alert parents to the importance of keeping care givers informed about any illness a child may have.

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## Proper Attention and Care of the Sick Child in Home Child Care

Children who are sick generally rest better at home. The stimulating atmosphere of a caregiver's home can be tiring for them.

You may decide to care for a child who is **moderately ill**. This may include a child with a slight fever, headache, mild cold, a child recuperating from surgery, etc. **Seriously ill** children should not be cared for with other children.

If a child in your care is absent with a communicable disease, please inform the other parents of children in your home and the Caseworker.

When a child in your home is sick, please contact the parent. The parent may need to take the child home. Isolate the sick child from the other children. If the child is not returning to school that day, inform the school of the child's absence.

When a child is absent from your home for more than 3 days, contact the Caseworker. Contact the Caseworker when you or your own children are ill. Alternate care arrangements for the children in your home may need to be made.

- Children should be exposed to fresh air and sunlight daily, whether playing or resting outside. A program of outdoor activities is essential to promoting good health.

## Temperature Taking

The purpose of taking a child's temperature is to determine if the child has a fever and is ill but don't rely on temperature readings alone. Observing a child's actions and behaviour will give more information on how the child is feeling than the height of the reading on the thermometer.

Babies can have a high temperature reading with a minor insignificant illness or with some serious illnesses they may have no fever or even a subnormal reading.

Body temperature varies according to how active the child is and the time of day. Temperatures tend to be lower in the morning because of the lack of activity. Usually by late afternoon, after a day of activity, the temperature will be highest.

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A child who feels warm and appears flushed does not necessarily have a fever. Check to see what activities the child has been involved with (i.e. running around prior to your observation).

The warmth of the physical surroundings could also affect how the child appears.

Any child who indicates they feel ill needs attention even when the illness turns out to be caused by the stress of being left at the child care setting and not physical or infection related.

**The average normal body temperature by the axillary's method (under the armpit) is 36.4°C or 97.5°F.**

A fever is defined as an axilla temperature of 38°C or 100.4°F or higher.

Parents should be contacted if the child has a fever.

**Note:** A temperature reading taken by the axilla method (under the armpit) will be 0.6°C or 1°F lower than child's actual body temperature.

## Procedure For Administration of Drugs or Medication To A Child In Home Child Care

As a Home Child Care Caregiver you can make a choice as to whether or not you will give medicine to the children in your care. If you do choose to help the parent by giving the child his medication you **must** follow the steps that are listed below:

1. Administer only medication prescribed for the child in your care.  
**Prescription Medication** must be clearly labelled with the child's name, name of the drug or medication, the dosage, the date of purchase and instructions for storage and administration. **Caregivers should not administer prescription drugs that have expired or were originally prescribed for another child.**
2. When the parent asks you to give medicine to her child, she must give you the medicine (not leave it in the child's bag).
3. **Non-Prescription Medication** (Tylenol, Tempra, cough preparations, antibiotics, creams, suntan lotion ....) must be in the original container or package and must be clearly labelled with the child's name, the name of the medication, the dosage and instructions for storage.
4. **Note** - A school-aged child may be permitted to carry their own asthma medication or emergency allergy medication as long as it is clearly labelled as in #1.
5. The child's medicine must be stored in the appropriate place (refrigerator or shelf) and be inaccessible to children.
6. The child's parent is to fill out the Medication Form (see Record Keeping section) with the correct instructions for you. When the medicine is completed, the form is to be sent to the Home Child Care office.
7. The caregiver must be solely responsible for the administration and the care of all medications.

## Headlice Treatment Guidelines

Be aware that contracting headlice has nothing to do with the cleanliness of your child or standards of hygiene in the home.

### How Do Children Get Headlice?

This condition spreads easily from person to person through head to head contact. Lice rarely survive off of a human head for longer than 48 hours. The louse may travel from person to person on combs, brushes, hats, pillows, stuffed toys etc.

### What Do Headlice Look Like?

Adult headlice are tiny brown insects about 2mm (1/16 inch) in length. They do not jump or fly, but cling to human hair. It is usually much easier to see the eggs or "nits" as they are called which the adult louse lay on the hair.

The eggs are tiny pearl-coloured, oval-shaped specks resembling dandruff. They are glued securely to the hair, about 2 - 10 mm (1/16 - 1/2 inch) from the scalp. Dandruff will "flick" off the hair quite easily, whereas these "nits" cannot be removed from the hair shaft, except with some effort. The eggs are usually found in the fine hair behind the ears, above the forehead, and at the back of the neck. Headlice tend to make the head quite itchy, and any scratching should be checked.

### What Do I Do?

Co-operation is essential. **Alert** the parents and the families of the child's playmates, when you find a child infested. This will help to prevent your child from becoming reinfested.

Although this insect does not carry or produce disease, it is important that this condition be brought under immediate control by taking the following steps:

Buy a special lice treatment at your drugstore, **follow directions on label exactly** and carefully.

**Note** As with all chemical products, lice treatment can cause side effects if not used properly.

**Do not** use silicone based products (shampoo, gel or mousse) on hair while being treated with special lice treatment because the silicone based product reduces the effectiveness of the lice treatment product. Read label and use a baby shampoo that does not include silicone.

- **Do not** use on children under 3 years of age without first consulting with your doctor.  
**Note:** Kwellada not to be used on children under 6.
- **Do not** use the lice treatment if you are pregnant (or suspect you may be) or breastfeeding without first consulting your doctor.
- **Do not** use on broken irritated skin or on skin with a rash.
- **Do not** use if you are allergic to any of the products ingredients especially chrysanthemums or ragweed. Read first.
- **Avoid contact with eyes.**
- Use only on person(s) who definitely have eggs or lice in their hair.
- Headlice is not normally found on pets.

**If you see evidence of live lice in 7 - 10 days, the treatment must be performed again. Do not repeat the treatment before the 7 days have elapsed.**

Also:

- Soak and wash all combs and brushes with some of the product.
- Wash all bed linen, towels, clothing, hats, etc. that the affected person is using (use hot soapy water and a hot rinse).
- Articles that cannot be washed should be dry cleaned or sealed in plastic bag for 2 weeks or put in a hot dryer for 20 minutes, as appropriate.
- Vacuuming of objects such as carpets, mattresses, upholstered furniture etc. is strongly recommended.
- Teach children to brush hair vigorously at night. This is a good way of lowering the risk of a new infestation as brushing injures headlice and they die.
- Wear rubber gloves if treating more than one person.
- Treatment should be done in a well ventilated room.

**Note:** It is strongly recommended that all eggs be removed after treatment as no pediculicide has been found to be 100% effective in killing the eggs, but it is not essential to use this product before returning to child care.

## **Can a Person Get Headlice More Than Once?**

Unfortunately, there is no guarantee that a person will not get headlice again. Your knowledge and understanding is the best defence. Now that you know what to do, check your child's head weekly.

## Bloodborne Infections

In recent years there has been increased concern about bloodborne diseases, particularly Hepatitis B and HIV infections. These infections are very rare in infants and preschool children. However, it is important to be aware of the methods to prevent the possibility of transmission of the infection. Children with Hepatitis B, HIV or other bloodborne infections may unknowingly be infected and can appear to be healthy.

### Hepatitis B

Hepatitis B is a virus that causes infection of the liver. The virus is found in body fluids of people with Hepatitis B, including blood, semen, vaginal secretions and saliva.

A small percentage of people who contract Hepatitis B infections become chronic carriers. This means that they may feel healthy but still have the Hepatitis B virus in their system and are able to pass the virus on to other people. Some people carry this virus for many years and never know they have it. Infants or young children contracting this disease are unlikely to have symptoms, but are at higher risk than adults of becoming chronic carriers.

There is a vaccine available that protects against Hepatitis B. This vaccine is not a routine part of early childhood immunization but can be obtained from a physician. The vaccine is generally purchased at a cost to the person requesting the vaccine. (For more information, please contact your family physician.)

### Transmission

Hepatitis B is spread by direct contact with blood or body fluids containing the virus.

The main ways the virus is spread are:

- through sexual contact with someone who is infected
- through direct contact with infected blood i.e. sharing needles for drug use
- from an infected pregnant woman to her unborn child

### Risk to Caregivers

Reports of infection as result of exposure in child care settings have been rare. The risk of spread of Hepatitis B is very low. Hepatitis B virus is not spread through contacts such as hugging, sneezing, coughing, or by sharing food, water, dishes or knives or forks. Because all blood donors are tested for Hepatitis B, in Canada, transfusion of blood or blood products rarely causes infection with Hepatitis B virus.

## Human Immunodeficiency Virus (HIV)

HIV infection and AIDS are caused by the Human Immunodeficiency Virus (HIV). The virus may ultimately destroy the immune system and leave the person vulnerable to life threatening infections and some types of cancer. Children would most likely be infected from a blood transfusion with contaminated blood, or infected at birth. (This is now very uncommon, as all blood is tested for the presence of HIV).

The diagnosis of HIV infection is made by testing blood for the presence of antibodies produced to combat the disease. In most people (99%), antibodies of the Human Immunodeficiency Virus (HIV) appear within 14 weeks after infection.

The time from when a person becomes infected until AIDS develops may be many years. Individuals who have the infection will often not have any symptoms and may appear healthy.

## Transmission

HIV disease is not very infectious or contagious. The virus does not spread as a result of everyday contact in the home or child care setting.

The virus is spread in three ways:

- through sexual contact with someone who is infected
- through direct contact with blood, including blood transfusions and other blood products (although this is highly unlikely because all blood is now tested in Ontario) or sharing needles for drug use
- from the infected pregnant woman to her child before or during birth, or through breastfeeding

## Risk to Caregivers

Transmission from child to child, child to adult, or adult to child (excluding mother to newborn infant) has not been known to occur in child care centres or homes. (Well Beings, 1992)

Child caregivers often ask about biting and the risk of transmission. A limited U.S. study of biting incidents shows no transmission in cases of both unbroken and broken skin.

## Prevention

### Universal Precautions for Contact with Blood or Body Fluids

Universal precautions are routine procedures for handling blood or body fluids. These precautions are necessary since some children may be unknowingly infected with a bloodborne infection such as Hepatitis B or HIV. It is difficult to tell if someone is carrying these viruses, therefore it is **necessary to treat all blood or body fluids as potentially infectious.**

In child care settings the risk for Human Immunodeficiency Virus (HIV) or Hepatitis B (HBV) infection is very low. However, in certain situations you may come into contact with blood or other potentially infectious body fluids. This can occur through a needlestick injury or when these fluids come into contact with broken skin or the mucous membranes of the eyes, nose, and mouth.

The following guidelines are for normally healthy children in child care settings. Children with special medical needs may require additional precautions. For further information contact the family physician or Community Health Department.

These guidelines were adapted for use in child care settings. Universal precautions apply to protection from body fluids such as blood, semen and vaginal fluids. In child care settings the body fluid most commonly encountered where universal precautions need to be applied is **blood.**

**Universal Blood and Body Fluid Precautions** are measures intended to protect you from such exposure. Contact with blood, semen and vaginal fluids and any other body fluids containing visible blood should be avoided. The risk of HIV or HBV infection from other body substances (such as tears or feces) is extremely low or non-existent.

### Five Steps of Universal Precautions

1. Education
2. Hand Washing
3. Wearing Gloves
4. Cleaning Contaminated Surfaces
5. Disposal of Contaminated Articles

#### 1. Education

Know how to implement Universal Precautions in your child care setting:

- identify situations in which you may be at risk
- educate yourself and others
- follow the principles of Universal Precautions

## 2. Hand Washing

Hand washing is your best defence against any infection, including HBV and HIV. Wash your hands thoroughly before and after exposure to blood or body fluids containing blood and following the removal of gloves.

## 3. Wearing Gloves

Protective barriers reduce your risk of exposure to potentially infectious material on broken skin or mucous membranes. Always wear a protective barrier when there will be contact with blood, or fluids with visible blood.

Wear latex or vinyl gloves for all contact with blood and body fluids with visible blood and for wiping up contaminated surfaces. Do not reuse or wash. Wash hands thoroughly following the removal of gloves.

**First Aid:** All children with weeping sores should have the areas covered with a dressing. If care givers must handle the dressing or provide care for a child bleeding from an injury/nosebleed, etc. they should wear disposable gloves and wash their hands after removing and disposing of the gloves.

- First Aid Tips:**
- Playgrounds are a major site of injuries in child care centres.
  - Caregivers may want to carry some gloves and first aid items in pouches around the waist or keep handy in areas where children play in and outdoors.

## 4. Cleaning Contaminated Surfaces

Immediately wipe up spills of potentially infected material with disposable towels. Wash area with hot water and a household cleaner, then rinse. Apply a freshly made solution of household bleach (1 part household bleach to 9 parts water) to the area. Let stand for 10 minutes, then rinse well.

## 5. Disposal of Contaminated Articles

**Contaminated Waste:** Dispose of articles other than clothing soiled with blood or body fluids in plastic bags tied at the top. If the first bag is visibly soiled or leaking, double bag the article before discarding in the trash.

**Laundry:** Handle blood-stained laundry as little as possible. Place in bags that prevent leakage. Rinse the laundry in cold water using gloves and then machine wash in hot water using regular laundry detergent. Soiled clothing should be sent home with parents.

**Sharps:** Any object that could break, cut or puncture the skin can be considered a "sharp". Examples are needles, blades, knives, or broken glass. Any "sharp" may carry infectious materials and should be handled with caution.

## Communicable Disease Reporting Guidelines

### How to Report a Communicable Disease

If you learn or suspect that a child has a disease which is communicable and reportable, Region of Waterloo Public Health should be notified immediately by calling:

**Communicable Disease Reporting Line  
519-883-2007**

**leave a message after 4:30 p.m. at  
519-883-2007 ext 5275**

**or**

**Environmental Health and  
Lifestyle Resources Division  
519-883-2008**

**Note:** Home Child Caregivers are also advised to contact their caseworker in the case of a communicable disease in the home.

## Seizures

### Protocol:

1. Call 911 for an ambulance. If possible have another person call for the ambulance, stay with the child and make him comfortable as possible.
2. Call parent/guardian to inform them of the situation and that an ambulance has been called.

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## Procedure:

- A) If you see the beginning of a seizure try to prevent a dangerous fall by moving the child to the floor or a padded surface. Remove any hard or dangerous objects that the child may bump into and injure himself/herself more. If possible, put a cushion, rolled up towel, or something soft under the head.
- B) Do not try to hold the child still or move the child unless he/she is in danger of hurting him self by banging his/her head against an object. It is impossible to stop or shorten a seizure, let it run its course.
- C) Keep **all** objects out of the child's mouth. It is anatomically impossible for him to swallow his tongue. It is common for a person having a seizure to drool or froth at the mouth. Biting the tongue also happens and may make the froth slightly bloody.
- D) Turn the child to his/her side so that he/she does not inhale mucus or blood. A person having a seizure may hold his breath for what seems like a very long time, so long that they can turn bluish in colour, it is unusual that the child does not start breathing on their own again.
- E) Loosen all tight clothing. Stay with the child and observe how the seizure affects the body parts. Look at a watch if possible to get an idea of how long the seizure lasted. Sometimes a person will vomit just before a seizure, or wet or soil himself during the seizure. When the seizure is over, reassure the child and make him comfortable.
- F) The jerking movement part of the seizure should not last more than 10 minutes. It sometimes takes longer for the child to become fully conscious and aware. During the recovery time, this child may act confused, spaced out, irritable, drowsy or sleepy. Allow him to sleep if he wants to. You can gently rouse the child now and again to check consciousness as you await the ambulance.
- G) Document incident on serious occurrence form and follow serious occurrence protocol.

## Exceptional Circumstances:

It is important to clarify with the parent and physician the nature of the seizure disorder the child experienced. Short term absence seizures may not require medical attention especially in cases where children are having multiple seizures. A procedure form should be completed with the parent and kept on file in the Home Child Care office. A sample of the (Procedure For Occurrence of Seizures) form is included in the record keeping section of this manual.

## Allergies & Anaphylactic Shock

At enrolment parents will be asked to complete an **Application and Consent, Immunization Information Form** and a **Child Profile** to outline any health conditions and concerns for an individual child. In the event that a parent identifies an intolerance, sensitivity, allergy or severe anaphylactic reaction to a substance, that requires an Epinephrine Auto-Injector, they will be asked to complete an **Anaphylaxis Emergency Plan**. The **Anaphylaxis Emergency Plan** is used to provide detailed information on specific allergens and typical reactions from the child. In the cases where children have severe reactions resulting in anaphylactic shock a plan of action will be developed and communicated with the Home Child Care caregiver.

### Intolerances/Sensitivities & Prevention

In cases where the parent/guardian identifies mild allergies or intolerances every effort will be made to reduce exposure to allergens. Special diets and food requirements will be accommodated in consultation with the parent and the Home Child Care caregiver. As general precautions the Home Child Care caregivers are discouraged from wearing strong scents and perfumes; environmentally friendly and non toxic products are used whenever possible for cleaning and disinfecting and vinyl gloves instead of latex are used. In cases where children have asthmatic conditions that require use of an inhaler or other medication parents complete an **Administration of Prescribed and Non Prescribed Medication** form and the medication is stored in an inaccessible container in the Home Child Care caregiver's home.

### Severe Allergies & Anaphylaxis

**Intent:** Anaphylaxis is a serious allergic reaction and can be life-threatening. The allergy may be related to food, insect stings, medicine, latex, exercise etc. The Allergies and Anaphylaxis policy is intended to help support the needs of a child with a severe allergy and provide information on anaphylaxis and awareness to parents, private-home day care caregivers, private-home day care visitors, students, volunteers, and persons who regularly reside at the private-home location. This provision aligns with Sabrina's Law, 2005 legislation which came into effect on January 1, 2006, requiring all district school boards and school authorities in Ontario to develop an anaphylactic policy.

In cases of severe allergic reaction to a substance every effort will be made to eliminate it from the Child Care caregiver's home. The use of warning signs for visitors, action plans identifying the allergen, and removal of specific products from use in the home are all strategies that would be implemented. All Home Child Care caregivers are informed of the situation and guidance provided by the parent/physician on the best formats for elimination.

## Plan of Action/Communication

An **Anaphylaxis Emergency Plan** is created for any child enrolled in Home Child Care who is identified as having a severe allergic reaction that requires an Epinephrine Auto-Injector. A copy of the **Anaphylaxis Emergency Plan** is posted in the caregiver's home and in the child's file. All Home Child Care caregivers are required to read the **Anaphylaxis Emergency Plan** including temporary Home Child Care caregivers who may be providing care from time to time.

The parent reviews and approves the **Anaphylaxis Emergency Plan** which is initialed by the Region of Waterloo Case Worker, the Home Child Care caregiver and the parent. The **Anaphylaxis Emergency Plan** should be reviewed annually. The **Anaphylaxis Emergency Plan** following administration of an Epinephrine Auto-Injector must include a 911 call for an ambulance/emergency medical response.

## Storage of Epinephrine Auto-Injector (EpiPen/Twinject)

Epinephrine Auto-Injectors will be stored in an inaccessible location in the Home Child Care caregiver's home to ensure quick access when and if needed. Epinephrine Auto-Injectors along with instructions for administration will be stored in a pouch which is affixed to the medication. An Epinephrine Auto-Injectors should be kept in the Home Child Care caregiver's home anytime the child is in attendance.

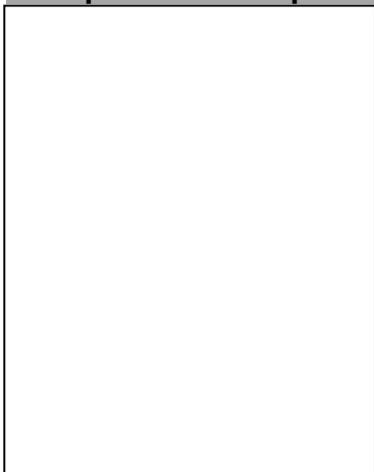
## Administration of Epinephrine Auto-Injectors (EpiPen/Twinject)

Training and administration instructions for use of the Epinephrine Auto-Injectors will be provided through the parent or physician. Epinephrine Auto-Injectors must be checked regularly for expiry dates.

A copy of the **Anaphylaxis Emergency Plan** is attached in Section 10 Record Keeping.

Anaphylaxis Emergency Plan: \_\_\_\_\_ (name)

**This person has a potentially life-threatening allergy (anaphylaxis) to:**



Photo

(Check the appropriate boxes.)

- Peanut  Other: \_\_\_\_\_
- Tree nuts  Insect stings
- Egg  Latex
- Milk  Medication: \_\_\_\_\_

**Food:** The key to preventing an anaphylactic emergency is absolute avoidance of the allergen. People with food allergies should not share food or eat unmarked / bulk foods or products with a “**may contain**” warning.

**Epinephrine Auto-Injector:** Expiry Date \_\_\_\_\_ / \_\_\_\_\_

- Dosage:**  EpiPen® Jr 0.15 mg  EpiPen® 0.30 mg  
 Twinject™ 0.15 mg  Twinject™ 0.30 mg

**Location of Auto-Injector(s):**

- Asthmatic:** Person is at greater risk. If person is having a reaction and has difficulty breathing, give epinephrine auto-injector **before** asthma medication.

**A person having an anaphylactic reaction might have any of these signs and symptoms:**

- **Skin:** hives, swelling, itching, warmth, redness, rash
- **Respiratory (breathing):** wheezing, shortness of breath, throat tightness, cough, hoarse voice, chest pain/tightness, nasal congestion or hay fever-like symptoms (runny itchy nose and watery eyes, sneezing), trouble swallowing
- **Gastrointestinal (stomach):** nausea, pain/cramps, vomiting, diarrhea
- **Cardiovascular (heart):** pale/blue colour, weak pulse, passing out, dizzy/lightheaded, shock
- **Other:** anxiety, feeling of “impending doom”, headache

**Early recognition of symptoms and immediate treatment could save a person’s life.**

**Act quickly. The first signs of a reaction can be mild, but symptoms can get worse very quickly.**

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1. **Give epinephrine auto-injector** (e.g. EpiPen<sup>®</sup> or Twinject<sup>™</sup>) at the first sign of a reaction occurring in conjunction with a known or suspected contact with allergen. Give a second dose in 10 to 15 minutes **or sooner**. **IF** the reaction continues or worsens. (See instructions below.)
2. **Call 911**. Tell them someone is having a life-threatening allergic reaction. Ask them to send an ambulance immediate
3. **Child is to be transported by ambulance to the nearest hospital**, even if symptoms are mild or have stopped. Stay in the hospital for an appropriate period of observation, generally 4 hours, but at the discretion of the ER physician. The reaction could come back.
4. **Call contact parent/guardian or person** on emergency contact form to inform them of the situation and where the child is being transported to.
5. **Contact Home Child Care immediately**, if after 4:30 pm contact Social Services Emergency # 519-883-2230.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Caseworker

\_\_\_\_\_  
Date

\_\_\_\_\_  
Caregiver

\_\_\_\_\_  
Date

I have read and understand the protocol for response to severe allergies and anaphylactic shock.

PR24B #393001 (Revised Sept 2013)

**See “Administration of Prescribed and Non Prescribed Medication” #162453 in Section 10 Records Keeping**

## Smoke-Free Ontario Act

As of May 31, 2006 the Ministry introduced the Smoke Free Ontario Act. The intent of the act is to protect the 80% of Ontarians who do not smoke, especially children. Research now shows that there is no safe level of exposure to second-hand tobacco smoke. We know that second-hand smoke causes cancer, asthma, and many other health problems. We also now know that dangerous chemicals are still present even when you can no longer smell smoke in a room, and long after a cigarette is put out. Over time, these toxins are emitted back into the air through “off gassing”. Children in these environments inhale and consume the off-gassed toxins.

As per Legislative Reference - Smoke-Free Ontario Act 9(1)(2)(3) smoking and/or holding lighted tobacco is prohibited in Private-Home Day Cares whether children are present or not. The Caregiver is to ensure:

- Parents are aware that smoking is prohibited
- No smoking signs are posted in the entrance/exit of the homes
- Ashtrays are removed
- Family members and visitors do not smoke on the premises
- No person is observed smoking or handling a cigarette in the private-home day care location including the backyard if children play in the backyard, whether or not children are present, and in the garage, front yard and driveway when children are present.

**Intent:** As per the Ministry’s Private Home Day Care Policy and Procedure “The intent of this Act is to help protect the health of all Ontarians by prohibiting smoking in all enclosed workplaces and enclosed public places. Under the Act, smoking is prohibited at all times in licensed day nurseries and private-home day care locations whether or not children are present in the home. The requirement that private-home day care locations be smoke free whether children are present or not is a new requirement, which came into force on May 31, 2006.”

“Enforcement of the Smoke-Free Ontario Act is the responsibility of tobacco control inspectors from local public health units. Local public health units will carry out inspections and investigate complaints in licensed day nurseries and private-home day care in order to enforce the Act. Subsection 13(3) of the Act states that the prohibition against smoking in day nurseries and private-home day care homes does not prohibit smoking or holding lighted tobacco for traditional Aboriginal cultural or spiritual purposes.” (Ministry’s Private Home Day Care Policy and Procedure)