

Chapter 8: Managing Chronic Medical Conditions and Special Health Care Needs

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Managing Chronic Medical Conditions and Special Health Care Needs

Introduction

Caregivers and teachers play an important role in the life of children with chronic medical conditions and special health care needs.

Definition: Children and youth with special health care needs (CYSHCN) are defined by the Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), and the Maternal and Child Health Bureau (MCHB) as: *"Those who have or are at increased risk for a chronic physical, development, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally"*. This definition is broad and inclusive, and it emphasizes the characteristics held in common by children with a wide range of diagnoses.

Caring for children with special health care needs provides an opportunity to teach all children in the program about treating everyone with respect, helping others, and including those with differences. It is important for the caregivers and health care providers to communicate well with each other and work together to mobilize resources and strategies that will benefit the children and families in their care.

Americans with Disabilities Act

The Americans with Disabilities Act (ADA) is a federal law, enacted in 1990, that prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications, and governmental activities. The ADA provides child care professionals with an exciting opportunity to serve children with special needs or disabilities. The law guarantees that children with disabilities cannot be excluded from "public accommodations" simply because of a disability. "Public accommodations" refers to private businesses and includes preschools, child care centers, out-of-school time programs and family child care homes.

The ADA requires that child care providers not discriminate against persons with disabilities on the basis of disability, that is, that they provide children and parents with disabilities with an equal opportunity to participate in the child care programs' services. Specifically:

- Child care programs cannot exclude children with disabilities unless their presence would pose a *direct threat* to the health or safety of others or require a *fundamental alteration* of the program.
- Child care programs have to make *reasonable modifications* to their policies and practices to integrate children, parents, and guardians with disabilities into their programs unless doing so would constitute a *fundamental alteration*.
- Child care programs must provide appropriate auxiliary aids and services needed for *effective communication* with children or adults with disabilities, when doing so would not constitute an *undue burden*.
- Child care programs must generally make their facilities accessible to persons with disabilities. Existing facilities are subject to the *readily achievable* standard for barrier removal, while newly constructed facilities and any altered portions of existing facilities must be *fully accessible*.

The ADA does not require child care programs to administer every medication, but does say that a child with special needs may not be excluded if reasonable accommodations to that child's special needs can be made.

The ADA Home Page, which is updated frequently, contains the Department of Justice's regulations and technical assistance materials, as well as press releases on ADA cases and other issues. Several settlement agreements with child care centers are also available on the Home Page. www.usdoj.gov/ctr/ada/adahom1.htm .

There are 10 regional Disability and Business Technical Assistance Centers, or DBTAC's, that are funded by the Department of Education to provide technical assistance under the ADA. One toll-free number connects to the center in your region. **800-949-4232** (voice & TDD)

Benefits of Inclusion

Inclusion is the practice of welcoming and including *all* children, regardless of ability. Inclusive child care should provide all children with the opportunities to interact with each other in an environment that offers activities adapted to meet the needs of all children. Inclusion is more than creating a physical space where all students are brought together. Programs should have well-educated staff, adaptive equipment, and space to include all of the children in their care.

Inclusion will look different for each child. All children have strengths and challenges; children with special needs may not require much more than a typically developing child. Terms used by programs and agencies to describe children with disabilities, delays, and chronic health conditions include children:

- with visual impairment or blindness
- with hearing impairment or deafness
- with physical disabilities
- with behavioral or emotional disabilities
- with cognitive delays or disabilities
- with speech-language delays or disorders
- who are developmentally disabled, developmentally delayed, or at risk for developmental delays

Families of children with special needs are searching for a place where their child will be treated as an individual with unique need, likes, dislikes, and abilities. Finding the right people and programs will enable children to learn and grow in a safe, comfortable environment. Working as a team can increase the strength of the caregiver-family bond. All children have strengths and challenges.

Here are some **tips for inclusive child care programs**:

- Consider enrolling the child on a trial basis to see if your program is able to meet the child's needs.
- Structure and consistency are keys to decreasing undesired behaviors, so be prepared to be patient and flexible. What works with one child, may not work with another; what worked last week may not work this week.

- Providers should not attempt to diagnose a child or judge them based on a diagnosis given. Child care providers will need time to learn each child's individual characteristics. Parents can help providers by sharing information about a child's likes, dislikes, need for structure and routine, etc.
- Many research studies have shown that inclusion benefits all children. Typically developing children are more open and accepting, and children with disabilities achieve greater results.
- In-home child care allows the parent to choose a caregiver who comes into their home to care for the child. All prospective in-home providers must meet all policy requirements including background checks prior to being approved by DHS to receive subsidy payments.

Allergies

What are allergies?

Allergy is the term used to describe the body's over-reaction to something it views as foreign or different. An allergic reaction is a response in various parts of the body to a substance that has been inhaled, eaten, injected (from stings or medicine), or that came into contact with the skin. The body reacts by releasing histamine and other substances that cause allergy symptoms. Allergy symptoms can be as minor as sneezing and itching. For some children, however, allergy symptoms can become very serious or even life-threatening.

What are the signs or symptoms?

Allergies produce many different symptoms, including:

- Stuffy nose
- Runny nose
- Itchy, watery eyes
- Hives
- Eczema
- Wheezing
- Itching of roof of mouth
- Swelling of throat or mouth
- Swelling of the skin
- Stomach cramps

How long does it take after the child is exposed to an allergenic substance before a reaction occurs?

Anywhere from seconds to weeks: it varies with the child, the substance, and many other factors.

When is an allergy contagious?

Never.

What causes allergies?

There are many things that can cause allergic reactions:

- Lotions, oils, perfumes, soaps
- Cigarette smoke
- Wool, polyesters, and other fabrics
- Foods (chocolate, nuts, cow's milk, wheat, soy, shellfish, strawberries, eggs, and others)
- Pollen from grass, flowering plants, trees, and shrubs
- Prescription and over-the counter medications
- Animal dander
- Dust mites
- Saliva and venom from insect stings

What should be done?

Find out about a child's allergies at the time of enrollment. If a child has asthma, this information should be on file, along with the recommended treatment, and the name and phone number of the health care provider.

Try to be sure the child avoids the offending substance if possible. Do not give medication of any kind to an allergic or asthmatic child, unless it is recommended by the child's health care provider and you have written permission from the child's parent.

Managing Food Allergies in Child Care

All food allergies occur when the immune system mistakes a protein in a food as a dangerous invader and produces chemicals to protect the body. This triggers an allergic reaction.

Symptoms of an allergic reaction vary, but can include:

- difficulty breathing
- swelling of the tongue and throat
- itching inside the mouth
- vomiting
- abdominal cramps and diarrhea
- hives
- eczema

In severe cases, a whole body allergic reaction can occur, also known as anaphylaxis.

Anaphylaxis is an extremely serious reaction and can result in loss of consciousness and even death, but it can be treated with a drug called epinephrine.

The primary way to prevent the possibility of an allergic reaction is strict avoidance of the allergy causing food. Allergic reactions can be triggered by eating the food, contact with the food, or, in some cases, by just being near the food.

Young children have the highest incidence of food allergies of any age group. The most common food allergens in young children are:

- Cows' milk
- Eggs
- Soybeans
- Wheat
- Peanuts
- Tree nuts (almonds, cashews, pecans, walnuts)
- Fish
- Shellfish

When a child has an allergic reaction, he or she tends to describe it in very different terms than adults use. Children may say things like, "My tongue/mouth itches," "It (my tongue) feels like there is hair on it", or "My tongue (or mouth) is tingling (or burning)."

Child care providers should discuss allergic reaction symptoms and how the child talks about the reaction with the child's parent. Child care providers need to be alert for the verbal cues and body language the child uses in the event of an allergic reaction.

A child could have a first allergic reaction while in your care, so staff training should be conducted by a child care health consultant or other health care provider. The training should include information on how to:

- Recognize the symptoms of an allergic reaction.
- Treat an allergic reaction.

- Prevent exposure to the food causing the allergic reaction for the child with a known food allergy.
- Develop policies and procedures and communicate the policies to parents so they are understood.
- Maintain required documentation about the child's food allergies, and the appropriate steps taken to keep the allergy causing foods away from the child.

A treatment plan should be developed by the child care provider and the parent with information from the child's health care provider that includes:

- What foods may trigger an allergic reaction.
- Steps for avoiding the food.
- Treatment in the event of an allergic reaction.
- When to contact emergency services.

The specifics of a child's food allergies, along with up to date documentation, should be maintained in the child's records. Any forms and correspondence between the child care provider, the child's family, and the child's health care provider should be included along with any other relevant information.

Child care programs should have a written policy for food allergies that specifically defines the responsibilities of the child's family and the child care program in managing the food allergy. The family's responsibilities include providing documentation of the food allergy from the child's health care provider, providing instructions that need to be taken for avoiding the allergic food, and supplying the medical provider's order for medication administration.

Management of a food allergy requires careful menu planning. Everyone involved in preparing and serving food should be vigilant about accommodating food allergies. Train staff to carefully read food labels and recognize allergens in the ingredient lists. Organize kitchen space to keep food for a food allergic child separate from other foods. Prepare foods for the child with food allergies first in order to prevent cross-contamination. Closely supervise children during meals and snacks to discourage food sharing between a child without a food allergy and one with a food allergy.

Field Trips and Special Events

Young children enjoy field trips, celebrations, and parties. Planning is the key for children with food allergies. You may provide a safe food alternative or you may ask the family to bring one on those special days.

Resources:

Centers for Disease Control and Prevention, *Voluntary Guidelines for Managing Food Allergies in Schools and Early Care and Education Programs*. Washington, DC: U.S. Department of Health and Human Services; 2013.

Nutrition Action: Managing Food Allergies in Childcare
http://www.healthychild.net/NutritionAction.php?article_id=507

Anemia

What is it?

Anemia is a condition in which blood has a lower than normal number of red blood cells. Anemia can also occur if red blood cells don't contain enough hemoglobin. Hemoglobin is an iron-rich protein that gives blood its red color. This protein helps red blood cells carry oxygen from the lungs to the rest of the body.

If you have anemia, your body doesn't get enough oxygen-rich blood. As a result, you may feel tired or weak. Other symptoms include:

- Pale skin
- A fast or irregular heartbeat
- Shortness of breath
- Dizziness
- Cold hands and feet
- Headache

Anemia can be caused by many things, but the three main bodily mechanisms that produce it are:

1. **Excessive destruction of red blood cells:** sickle cell disease, toxins from liver or kidney disease
2. **Blood loss:** gastrointestinal conditions, menstruation and childbirth
3. **Inadequate production of red blood cells:** kidney disease, diabetes, rheumatoid arthritis

Lead poisoning can lead to anemia.

- Anemia makes it easier for lead to get into the blood.
- Lead poisoning and anemia are both detected by a blood test.
- Lead poisoning and iron deficiency anemia are both preventable.
- Practice good nutrition and proper handwashing to help prevent lead poisoning and iron deficiency anemia.

Iron-deficiency anemia, and other nutritional anemias can be prevented and mild cases can be reversed by eating diets high in iron. Vitamin C helps the body use iron, so ***combine foods high in iron and vitamin C*** in meals and snacks.

Some foods high in iron

Beef
Pork
Liver
Tofu
Cooked beans
Dried fruit
Iron-fortified cereals
Enriched tortillas and breads
Leafy greens

Some foods high in vitamin C

Broccoli
Cabbage
Cauliflower
Tomatoes
Potatoes
Bell peppers
Oranges
Melon
Strawberries

Asthma

Asthma is the most common chronic disease among children who use child care. It occurs in 7 to 10 percent of all preschool and school-aged children. With appropriate care at the health care provider's office, home and child care, most children with asthma do extremely well in child care settings and can participate in all activities.

Asthma is a condition in which the air passages of the lungs become temporarily narrowed and swollen and produce a thick clear mucous, causing the child to have difficulty breathing. The symptoms can disappear temporarily with treatment and/or removal from whatever is causing the asthma. Asthma cannot be cured and it has been recently learned that repeated attacks can cause permanent damage to the lungs. Asthma *can* be controlled with appropriate care.

Signs and symptoms of asthma

Each child may have different asthma symptoms. The parents and health care provider should tell you what to watch for.

- Coughing (children often have a cough as an early or only symptom of asthma)
- Complaint of tightness in the chest
- Wheezing
- Rapid breathing or difficulty breathing
- Decrease in peak flow meter reading
- Unusual tiredness
- Difficulty playing, eating, or talking

Indications of severe asthma episode:

- Flaring nostrils or mouth open
- Bluish color to the lips or nails (late sign: call 911)
- Sucking in chest or neck muscles (retractions)

Asthma triggers

Asthma episodes are usually started by “triggers,” events that begin an asthma attack. Each child will have different triggers. Not every child has identified triggers.

- Allergies to substances such as pollen, mold, cockroaches, animal dander, or dust mites
- Allergies to a particular food
- Infections such as colds or other viruses
- Cold air or sudden temperature or weather changes
- Exercise or overexertion
- Very strong emotions such as laughing, crying and stress

Discuss a child's asthma history with the parent at enrollment. Have parent document information regarding medications, a description of the child's triggers, symptoms, and a plan of what to do during an attack. This information should be entered on the child's Asthma Action Plan (see a sample in the Appendix).

Procedure When Child Has an Asthma Episode

- Remove the child from the trigger, if known.
- Remove the child from strenuous play activities (running, jumping, etc.)
- Have the child sit upright and try to keep the child calm and relaxed.
- Encourage the child to drink fluids (but nothing ice cold).
- Administer medications as indicated by the parent and health care provider.
- Notify all staff of signs that may signal an impending attack.
- If you are unsure, it is better to call the parents to take the child to the health care provider, than wait until the child is in severe distress. Every child is different and will need an individualized treatment plan.

It is a good idea to provide staff training on asthma, including signs and symptoms of asthma, administration of medications, and the asthma emergency plan.

Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder (ADHD) is a condition that causes a person to be overactive and impulsive or have a hard time paying attention, or both. These behaviors may begin in early childhood or not detected until a child is older.

Diagnosis

ADHD affects approximately 3 to 5 percent of all school-age children and is three times more common in boys than girls. Many children continue to have behaviors of ADHD as adults. ADHD affects all socioeconomic, cultural, and racial backgrounds. More than 20 percent of children with ADHD also have learning disabilities. However, having a diagnosis of ADHD or a learning disability is not related to intelligence.

Diagnosis of ADHD is made by a physician, psychiatrist, psychologist, or licensed social worker, with close collaboration and input from the parents, teachers, and child care providers. Children with ADHD demonstrate behaviors that generally fall into **three categories**: inattention, hyperactivity, and impulsivity.

Examples of inattention (trouble paying attention) include a child who:

- Makes careless mistakes.
- Has difficulty paying attention in tasks or play activities.
- Does not seem to listen to what is being said.
- Does not follow through or finish activities or tasks.
- Avoids or strongly dislikes routine tasks or activities.
- Is easily distracted and forgetful.

Examples of hyperactivity (being very active) include a child who:

- Fidgets with hands and feet, or squirms in seat.
- Has difficulty playing quietly.
- Is “on the go” or acts as if “driven by a motor”.
- Talks excessively.
- Has difficulty waiting in line or for a turn.

Examples of impulsivity (acting before thinking) include a child who:

- Blurts out answers to questions before they have been completed.
- Has difficulty waiting in lines or waiting for a turn.
- Interrupts or intrudes on others.

All of these behaviors are common for children at different ages and stages of development. Many 2-year-olds are “on the go” and many 3 and 4 year olds fidget when seated. For a child to be diagnosed with ADHD, some of these behaviors must have appeared before the child was 7 years of age, have lasted for at least six months, and be happening enough to cause concern at home and school, and possibly the child care setting.

Causes

Scientists have not been able to determine the exact cause of ADHD, though research suggests it may be caused by a chemical imbalance or a lack of certain chemicals in the brain responsible for attention and activity. There is evidence that if one or both parents have ADHD, their children are more likely to show symptoms as well. Exposure to toxins (including drugs and alcohol during pregnancy), brain injury, and childhood illnesses may also contribute. ADHD is not caused by too much TV or poor parenting.

Treatment

All interventions for children with ADHD should help build the child's sense of self-esteem. A team approach using educational, psychological, behavioral, and medical techniques is recommended and requires an effort by parents, teachers, child care and health care providers to find the right combination of responses.

Children with ADHD are typically "hands-on" learners and often respond to:

- Lower adult-child ratios
- Predictable environments
- Individualized programming
- Structure, routine, and consistency
- Motivating and interesting curricula
- Shorter activity periods
- Use of positive reinforcement
- Supplementing verbal instructions with visual aids

Counseling is an important part of the treatment plan and it may help to have the family involved in the counseling.

Physical activities can help the child with ADHD to improve coordination and self-esteem and provide an outlet for extra energy.

Tips for Child Care Providers:

- Learn what you can about ADHD.
- Ask the child's parents for suggestions and tips that they have found useful at home.
- Try to be consistent with the ways the child's parents guide and manage behavior.
- Let the child take regular breaks and have access to a quiet place to regroup.
- Have clear rules and consistent schedules for the child.
- Don't forget to look for and praise appropriate behavior.

This information is from the California Childcare Health Program, www.ucsfchildcarehealth.org.

Autism Spectrum Disorders (ASDs)

What are Autism Spectrum Disorders?

Autism spectrum disorders (ASDs) are a group of developmental disabilities caused by a problem with the brain. Children with ASDs have trouble in three core areas of their development:

- Language difficulties – especially no apparent desire to communicate
- Social interactions
- Restricted interests or behaviors that are repeated over and over again

How common are they?

- According to the Centers for Disease Control and Prevention (CDC), 2-6 out of 1000 children has an ASD diagnosis.
- These disorders affect children of all ethnicities.
- Boys are four times more likely to be diagnosed than girls.
- The CDC estimates that in the United States up to 500,000 individuals between the ages of 0 and 21 have an ASD.
- The number of children diagnosed with autism has increased since 1990.

What causes Autism Spectrum Disorder?

No one knows exactly what causes ASD. However, it is clear that autism is a biological brain disorder.

- Scientists believe genes play an important role in the development of autism.
- Environmental factors may also play a role.
- Studies show that **immunizations DO NOT cause ASD.**

Early Warning Signs of ASD in infants and toddlers:

- Has limited eye contact and diminished responsiveness to others.
- Does not babble, point, or make meaningful gestures by one year of age.
- Has loss of language and /or social skills during the second year.
- Does not play “pretend” games.
- Does not respond to his or her name at one year.
- Does not smile.
- Becomes attached to unusual objects.
- Seems to be hearing impaired at times.
- Exhibits unusual repetitive behaviors like hand flapping, humming, or rocking.
- Does not use eye contact and finger pointing for the social purpose of sharing experiences with others.

Warning Signs of ASD in pre-school aged children:

- Has difficulty with change.
- Is unable to imitate the behaviors of others.
- Has difficulty expressing emotion and responding to the emotion of others.
- Repeats or echoes words or phrases.
- Has difficulty initiating and maintaining a conversation with another child.

- Laughs, cries, or shows distress for no apparent reason.
- Has uncontrollable tantrums.
- May not want to cuddle or be cuddled.
- Has uneven gross and fine motor skills.
- Plays oddly with toys or objects.
- Has unusual reaction to sensory stimuli (sounds, smells, tastes, touches, pain).
- Has no real fear of danger.

If you notice any of these warning signs in a child in your care, **talk with the parents** about your concerns and suggest that a health care provider who is familiar with evaluating developmental delay evaluate the child.

Early diagnosis of ASDs can lead to early intervention services. The time to intervene is when that child is a toddler, when her young brain is still more “plastic” and can be taught new skills. The child who is unable to have social relationships or communicate his needs and feelings is at risk for becoming an adult with severe disabilities.

Treatment

There is no cure for autism or ASDs. The best hope is for children to receive early and intensive intervention that focuses on teaching the child communication and social skills that allow him to connect to the world. Developmental and behavioral interventions form the core of treatment for children with ASD. Some children have special dietary requirements and some are on medication. It is important to have the parents fill out a Special Care Plan (see the Appendix) and learn about how you can provide the best care for the child.

The treatment team for children with ASDs can include:

- Developmental pediatrician
- Pediatric neurologist
- Child psychiatrist and /or child psychologist
- Occupational therapist
- Speech therapist

How can you assist and support the child with ASD in a child care setting?

- Communicate with the family regularly and follow the Special Care Plan.
- Keep messages simple and direct.
- Use objects and actions along with words when communicating.
- Focus on improving the child’s communication skills and emphasize spoken language by having the child ask for something by name when possible.
- Establish a predictable environment including teachers’ language, behaviors, daily routines and classroom furnishing and materials.
- Do not rush the child; children with ASD need more time and patience from you to complete their tasks.
- Whispering may be a useful communication tool that can be used for both talking with and calming down a child with ASD.
- Do not require eye contact when talking with the child.

Diabetes

Diabetes is a serious illness in which the body is unable to properly change sugar from food into energy. A simple sugar called glucose is the main source of energy for our body. Insulin, a hormone produced by the pancreas – a large gland behind the stomach – helps the body use the glucose for energy.

Diabetes happens when the body does not produce enough insulin (Type 1 or insulin-dependent), or use it properly (Type 2 or non-insulin dependent). As a result glucose begins to build up in the blood, creating high sugar levels in the body.

Type 1 Diabetes occurs when the pancreas does not produce insulin.

- It requires multiple doses of insulin every day through shots or an insulin pump.
- It accounts for 5 to 10 % of all cases of diabetes and is the most prevalent type of diabetes among children and adolescents.
- Type 1 diabetes cannot be prevented.

The three big symptoms of Type 1 Diabetes are:

1. Constant thirst
2. Frequent urination
3. Rapid weight loss

Anyone experiencing these symptoms should see their health care provider.

Type 2 Diabetes

- Occurs when the pancreas does not produce enough insulin or body cells do not use insulin properly (*Insulin Resistance*).
- Is managed with diet and exercise, oral medication, and sometimes insulin.
- Increase in diagnosis of type 2 diabetes among children and adolescents in the U.S.

Symptoms of Type 2 Diabetes:

- Increased thirst and urination
- Blurry vision
- Feeling tired or ill
- Dark skin around the neck or armpits
- Frequent infections (usually yeast infections)
- Slow healing cuts and bruises
- Numbness and tingling of the hands and feet

These symptoms usually occur gradually and may go unnoticed.

Two kinds of problems occur when the body does not make insulin:

1. **Hyperglycemia**, or high blood sugar, occurs with both types of diabetes. It occurs when the body gets too little insulin, too much food, too little exercise, or with illnesses. Stress from a cold, sore throat, or other illness may increase the level of blood glucose.

Symptoms include:

- Frequent urination
 - Excessive thirst
 - Extreme hunger
 - Unusual weight loss
 - Irritability
 - Poor sleep
 - Nausea and vomiting
 - Weakness
 - Blurred vision
2. **Hypoglycemia**, or low blood sugar, is more common in people with Type 1 diabetes. It is the most common immediate health problem and is also called “insulin reaction” or “insulin shock”. It occurs when the body gets too much insulin, too little food, a delayed meal or more than the usual amount of exercise. Symptoms may include:

- Hunger
- Pale skin
- Weakness
- Dizziness
- Headache
- Shakiness
- Changes in mood or behavior
- Sweating
- Rapid pulse

Every child with diabetes will be different.

- Diabetes requires a constant juggling of insulin/medication with physical activity and food.
- It is important to recognize the signs of “high” and “low” blood sugar levels.
- Children with diabetes can do the same every day activities as students without diabetes.
- A child with a diabetes emergency will need help from child care staff.

Diabetes Management in Child Care:

- Designate personnel trained in diabetes.
- Have access to the tools that monitor and maintain blood glucose levels.
- Assist the child with performing diabetes care tasks as needed.
- Plan for disposal of sharps and materials that come in contact with blood.
- Be prepared to recognize and treat hypo and hyperglycemia.
- Be prepared to administer insulin or glucagon as needed.
- Develop a plan for disasters and emergencies.

- Follow individualized meal plans.
- Develop plans for field trips, class parties, and extracurricular activities.
- Have an individual care plan in place for each child with a chronic condition or special health care need.

Diabetes Medical Management Plan (DMMP)

The DMMP must be in place for the child's diabetes care to be implemented in the child care program. It should be:

- Individualized.
- Developed by the child's health care team, parents, and child (if applicable), and signed by the physician.
- Implemented collaboratively by the program diabetes team including:
 - Program director
 - Teacher or caregiver
 - Parent or guardian
 - Student (if developmentally appropriate)
 - Other designated personnel

DMMP Required Information Includes:

- Emergency contact information
- Level of self-care
- Blood glucose monitoring
- Insulin/medication administration
- Glucagon administration
- Meal and snack schedule
- Physical activity and sports
- Recognition and treatment of hypo and hyperglycemia

Other Recommended areas to include:

- Date of diagnosis
- Current health status
- Specific medical orders
- Nutrition requirements – including provisions for meals and snacks
- List of diabetes equipment and supplies needed for child care
- Location for and timing of blood sugar monitoring and treatment
- Maintenance of confidentiality and child's right to privacy

Refer to the Appendix to find:

- Diabetes Medical Management Plan
- Diabetes Management Log
- Hypoglycemia emergency care plan
- Hyperglycemia emergency care plan
- Special Health Care Plan

Students with Diabetes

Developmental Issues, Diabetes Care Tasks and Educational Considerations

The childcare provider can play an important role in guiding children to participate in their care to the extent appropriate for their age and developmental level. The degree of independence the child is able to participate in their care should be agreed upon by the medical provider, parent/guardian, child (if appropriate), and childcare team.

In general, childcare and after school care staff can anticipate:

1. The infant, toddler, and pre-school age child is unable to perform diabetes care tasks independently. Assistance and close supervision by the staff in diabetes care is necessary.
2. The elementary school student is able to cooperate in all diabetes care tasks, and perform independently with varying degrees of competence at school. Staff supervision in diabetes care is recommended.
3. The middle school student should be able to perform most diabetes care tasks independently under circumstances when not experiencing hypoglycemia. Periodic staff supervision is recommended.
4. The high school student most probably will perform all diabetes care tasks independently, when not experiencing hypoglycemia. Staff surveillance is recommended.

Age (years)	Developmental Issues	Diabetes Care Tasks	Educational Considerations
Below age 3 years	<p>Developing trusting relationship or bond with caregivers</p> <p>Developing the desire for greater autonomy</p>	<p>Preventing and treating hypoglycemia</p> <p>Avoid extreme fluctuations in blood glucose levels due to irregular food intake</p> <p>Toddlers may refuse to cooperate with his/her diabetes care</p>	<p>The diabetes regime is adjusted quickly to the child's dynamic growth and development</p> <p>Staff must learn the skills to provide diabetes management and perform associated diabetes tasks while meeting the developmental needs of the child</p> <p>Staff – establish a schedule</p> <p>Manage the picky eater</p> <p>Limit setting and coping with toddler's lack of cooperation</p>

<p>4 to 5 years</p>	<p>Knows likes and dislikes</p> <p>Identifies with “good” and “bad”</p> <p>Fear of intrusive procedures</p> <p>Magical thinking</p>	<p>Child can: Pinch own skin</p> <p>Collect urine for ketones</p> <p>Turn on glucose meter</p> <p>Help with recording data</p> <p>May begin to identify symptoms of hypoglycemia and alert adults</p>	<p>Can use guided play, play therapy, artwork to express concerns and to learn</p>
<p>6 to 7 years</p>	<p>Physically coordinated</p> <p>Concrete reasoning</p> <p>Able to share and cooperate</p>	<p>Can begin to identify carbohydrates in foods</p> <p>Can help with injections</p> <p>Can help with blood testing – able to prick own finger</p> <p>Able to activate bolus on pump with supervision</p> <p>Able to connect and disconnect insulin pump with assistance</p>	<p>May need reminders and supervision</p>
<p>8 to 10 years</p>	<p>Increased need for independence</p> <p>Does not want to be different</p> <p>Developing “scientific mind”</p> <p>Intrigued by tests</p> <p>Feelings of sadness, anxiety, isolation, and friendlessness</p>	<p>Able to participate in meal planning</p> <p>Correctly able to identify foods that fit into meal plan</p> <p>Increased independence with injections, blood and urine testing</p> <p>Able to keep records</p>	<p>Understands only immediate consequences of diabetes control, not long term</p> <p>Finds support groups, camps, individual counseling useful</p> <p>Learns best when information is presented in a fun and interesting way</p>

11 to 13 years	<p>Puberty: hormonal and physical changes may occur more for females</p> <p>Dependent versus independent struggles between parent and child, care giver and child</p> <p>Aware of body image; concerned with not being different</p> <p>More involved with peers than family</p>	<p>Can help plan meals and snacks along with starting carbohydrate counting</p> <p>Able to recognize and treat hypoglycemia</p> <p>Able to measure and inject own insulin</p> <p>Able to recognize patterns in blood glucose levels</p> <p>May need help assessing urine tests</p> <p>Able to connect and disconnect insulin pump</p> <p>Hormones of puberty can affect glucose control during this time.</p>	<p>Peer pressure begins to influence decisions</p> <p>May want to hide their disease from their peers</p>
14+	<p>Hormonal and physical changes continue</p> <p>Increased physical and social activities</p> <p>Experimentation and risk-taking behaviors</p> <p>At risk for eating disorders</p> <p>Strong peer pressure</p> <p>Values independence and self-image</p> <p>Finds assuming responsibility for self-management the most difficult task</p>	<p>Able to identify appropriate portion sizes</p> <p>Able to alter food intake in relation to blood glucose level</p> <p>Able to anticipate and prevent hypoglycemia</p> <p>Able to calculate insulin dose based on blood glucose level</p> <p>Can independently administer insulin</p> <p>Able to understand role of exercise in calculating insulin needs</p>	<p>Still needs some supervision and review regarding insulin dosing</p> <p>Knows consequences of poor diabetes control</p> <p>Learns best when educational content is pertinent to adolescent issues</p> <p>Able to learn problem solving with adults and negotiate treatment</p> <p>Likes discussion and support groups among peers</p>

Eczema

What is it?

Eczema is a chronic skin problem that causes dry, red, itchy skin. It is also called *atopic dermatitis*.

Who gets eczema?

Eczema is the most common skin problem treated by pediatric dermatologists. About 65% of patients develop symptoms before age one, and about 90% before age five. Many babies outgrow eczema by age four, and some children outgrow eczema by the time they are young adults. Eczema often runs in families with a history of eczema or other allergic conditions, but it is not contagious.

Common signs and symptoms:

- Dry, red, itchy skin and rashes. The rashes can be oozing or very dry.
- **In babies**, a rash often appears on the face and scalp.
- **In younger children**, a rash often appears in the folds of the elbows and knees.
- **In teens and young adults**, a rash often appears on the hands and feet.

There are times when the symptoms are worse (flare-ups) followed by times when the skin gets better or clears up completely (remissions).

How to prevent flare-ups:

- Keep the child's skin moisturized.
 - Use fragrance-free moisturizers.
 - Cream or ointment is more moisturizing than lotion.
- Avoid irritants.
 - Children should wear soft fabrics such as 100% cotton clothing.
 - Use mild, unscented soap for bathing and handwashing.
 - The child's parent should be careful to use mild laundry detergent with no dyes or perfumes and no fabric softener sheet in the dryer.
- Remind child not to scratch. Scratching can make the rash worse and lead to infection.
- Parent should consult with child's health care provider about things that might trigger a flare-up.

Treatment

The child's health care provider will recommend medication to help the child feel better and to keep the symptoms of eczema under control. Eczema medication can be given two ways:

- Topical – applied to the skin (available as creams or ointments)
- Oral – taken by mouth (available in pill or liquid form)

Remember to develop a Special Health Care Plan with the parents and the child's health care provider so you can provide the best care possible.

www.HealthyChildren.org (2015), *Eczema: How to Help Your Child Avoid the Itch*.

Hearing Loss

A hearing loss, hard of hearing, hearing impairment, or deafness is a partial or total inability to hear. In children it may affect the development of language. Good hearing is necessary for a child to learn to talk. Newborn infants can hear a full range of sounds from the moment they are born (and even before)! Infants demonstrate that they hear as they quickly learn to recognize and respond to familiar voices. Hearing children turn to new sounds and their language development continually progresses.

Hearing impairment occurs when there is a problem with or damage to one or more parts of the ear. *Types of hearing loss:*

- **Conductive** results from a problem with the outer or middle ear, including the ear canal, eardrum, or ossicles. A blockage or other structural problem interferes with how sound get conducted through the ear, making sound levels seem lower. In many cases, conductive hearing loss can be corrected with medications or surgery.
- **Sensorineural** results from damage to the inner ear (cochlea) or the auditory nerve. The most common type is caused by the outer hair cells not functioning correctly. The person has trouble hearing clearly, understanding speech, and interpreting various sounds. This type of hearing loss is permanent. It may be treated with hearing aids. In most severe cases, both outer and inner hair cells aren't working correctly. This is also a type of permanent hearing loss and can be treated with a cochlear implant.
- In some other cases, the outer hair cells work correctly, but the inner hair cells or the nerve are damaged. This type of hearing loss is called **auditory neuropathy spectrum disorder**. The transmission of sound from the inner ear to the brain is then disorganized. Children with auditory neuropathy spectrum disorder can develop strong language and communication skills with the help of medical devices, therapy, and visual communication techniques.
- **Mixed** occurs when someone has both conductive and sensorineural hearing problems.
- **Central** happens when the cochlea is working properly, but other parts of the brain are not. This is a less frequent type of hearing loss and is more difficult to treat.
- **Auditory processing disorders (APD)** – not exactly a type of hearing loss because someone with APD can usually hear well in a quiet environment. Most people with APD have difficulty hearing in a noisy environment. In most cases APD can be treated with proper therapy.

Common Causes of Hearing Loss:

- Otitis media – the medical term for an ear infection that affects the middle ear which can cause a buildup of fluid behind the eardrum. Even after the infection gets better, fluid might stay in the middle ear for weeks.
- Blockages in the ear, such as a foreign object, impacted ear wax, or dirt.
- Damage to parts of the ear – for example a hole in the eardrum from a cotton swab inserted too far or a sudden change in air pressure.
- Genetic disorders – some genetic disorders may interfere with the proper development of the inner ear and the auditory nerve.
- Injuries to the ear or head, such as a skull fracture.

- Complications during pregnancy or birth.
- Infections or illnesses.
- Medications – certain medications, such as antibiotics and chemotherapy drugs can cause hearing loss.
- Loud noise – a sudden loud noise or exposure to high noise levels over time can cause permanent damage to the tiny hair cells in the cochlea.

Congenital hearing loss is present at birth. **Acquired** hearing loss happens later in life and it can be sudden or progressive. About 1 in 300 children are born with hearing loss, making hearing loss one of the most common birth defects in the United States.

Hearing Screening and Evaluation

In Oklahoma all babies are screened for hearing loss before they leave the hospital.

Oklahoma State Law §63-1-543. Screening for detection of congenital or acquired hearing loss.

A. This act shall be known and may be cited as the “**Newborn Infant Hearing Screening Act**”.

B. Every infant born in this state shall be screened for the detection of congenital or acquired hearing loss prior to discharge from the facility where the infant was born. A physician, audiologist or other qualified person shall administer such screening procedure in accordance with accepted medical practices and in the manner prescribed by the State Board of Health.

If a baby does not pass the hearing screening at birth, more testing needs to be done. The results are sent to the infant’s health care provider and to the parents. Information about where hearing can be checked is also sent to the family.

If you suspect an infant or child in your care has a hearing loss, ask the parents to have the child evaluated by a trained professional. Parents can contact their child’s health care provider or local health department.

Indicators of Potential Hearing Loss

- Frequent mouth breathing
- Failure to turn toward the direction of a sound
- Delay in acquiring language
- Development of poor speech patterns
- Using gestures rather than words
- Unusual voice quality – one that is extremely high, low, hoarse, or monotone
- Difficulty understanding and following directions
- Mispronouncing many words
- Failing to respond to normal sounds and voices
- Responding to questions inappropriately

Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome (HIV/AIDS)

What is it?

HIV/AIDS is an infection caused by a virus called human immunodeficiency virus (HIV) that over time damages the body's immune system and other organs, and can lead to severe life-threatening illness.

What are the symptoms?

When a person is first infected with HIV he or she may have no symptoms or may become ill with a fever, night sweats, sore throat, general tiredness, swollen lymph glands, and a skin rash lasting for a few days to a few weeks. These early symptoms go away by themselves. However, the virus stays in the body and causes increasing loss of immune function. This results in the body becoming unable to fight off infections. The late stage of this infection is called acquired immunodeficiency syndrome (AIDS). A person who is infected becomes potentially infectious to others for life.

Early symptoms of HIV infection in children include:

- Failure to grow and gain weight
- Chronic diarrhea without a specific cause
- Enlarged liver and spleen
- Swollen lymph glands
- Chronic thrush (yeast infections)
- Skin infections
- Pneumonia
- Bacterial, viral, fungal, and parasitic infections that healthy children do not usually get

Many children are infected with HIV for years before developing any symptoms.

Who gets it and how?

HIV is not easily transmitted. For HIV to spread, the virus, present in blood and other body fluids, must enter the uninfected person's blood stream through a break in the skin or through mucous membranes. In a child care setting this can only happen through blood-to-blood exchange. It cannot be transmitted through urine, stool, vomit, saliva, mucous, or sweat.

HIV is most commonly spread:

- By sharing contaminated needles
- Through sexual intercourse
- By infected pregnant women to the fetus

Less commonly, HIV may be spread:

- By infected mothers who breastfeed their infants
- To health care workers, primarily after being stuck with a needle containing HIV infected blood
- By exposure of open skin or mucous membranes to HIV contaminated body fluids

Recommendations for child care providers who care for children with HIV/AIDS:

- Protect all children and staff by strictly following special procedures for cleaning and handling blood and body fluids containing blood (standard precautions).
- Provide education to all staff members on standard precautions, including information on blood-borne pathogens and diseases and methods to control exposure, as well as accurate information about HIV/AIDS.
- Protect people with HIV from infection by communicable diseases by excluding them when there is an outbreak (upon the advice of their health care provider).
- Notify parents of all children if there is a case of chicken pox, tuberculosis, fifth disease, diarrheal disease, or measles in another child attending the program.
- Immediately refer children with HIV to their health care providers to receive appropriate preventive measures and advice about readmission to child care if they are exposed to measles or chicken pox.
- Protect the right to privacy by maintaining confidential records and by giving medical information only to persons who need to know, and with the consent of the parent.
- Help children with HIV/AIDS lead as normal a life as possible.

To reduce the risk of spreading HIV (or any other blood-borne infection), all child care providers should routinely follow these precautions:

- Make sure everyone uses good hand washing procedures.
- Make sure all adults use good diapering practices.
- Wear gloves when changing a diaper soiled with bloody stools.
- Wash skin on which breast milk has spilled with soap and water immediately.
- Do not allow children to share toothbrushes.
- Wear gloves when cleaning up blood and bodily fluid spills.
- Immediately clean and disinfect surfaces on which blood or bodily fluids have spilled.
- Cover open wounds on children and adults.
- Develop policies and procedures to follow in the event of an exposure to blood.

Who should be notified?

- Notify your local health department if someone in your program has this disease. They will provide you with further information.
- Parents and children attending group programs **do not have the “right” to know** the HIV status of other children in the program.
- Caregivers and teachers need to know when a child has an immunodeficiency, so that precautions can be taken to protect the child from infections. However, this does not require knowledge of HIV status.

Juvenile Rheumatoid Arthritis

What is it?

Juvenile rheumatoid arthritis, also known as juvenile idiopathic arthritis occurs when the body's immune system attacks its own cells and tissues. It's unknown why this happens, but both heredity and environment seem to play a role.

Common signs and symptoms:

- Joints that are warm to the touch
- Swelling and tenderness to the joints
- Fever
- Rash
- Favoring one limb over another or limping
- Pain (often worse following sleep or inactivity)
- Stiffness, especially upon waking
- Inability to bend or straighten joints completely
- Decreased physical activity
- Fatigue
- Sleep problems
- Swollen lymph nodes
- Reduced appetite and weight loss

Diagnosis

An early diagnosis and aggressive treatment are vital to preventing or slowing joint damage and preserving mobility. If you have concerns about a child be sure to discuss this with the parent and suggest they visit with the child's health care provider.

Treatment

- There is no cure, but with prompt diagnosis and early treatment, remission is possible.
- The goal of treatment is to relieve inflammation, control pain, and improve quality of life.
- The treatment plan may include medication, exercise, eye care, dental care and proper nutrition.

Self-care

Getting plenty of physical activity, eating well and learning how to cope with the challenges of the disease will be beneficial for children with arthritis.

- ***Remember to develop a Special Health Care Plan with the parents and the child's health care provider so you can provide the best care possible.***

Seizure Disorders

A seizure disorder is a neurological condition usually diagnosed after a person has had at least two seizures that were not caused by some known medical condition. Brain cells communicate by using electricity. A seizure is a sudden surge of too much electrical activity in the brain.

Seizures can be caused by low blood sugar, accidental poisoning, drug overdose, an infection, a head injury, or abnormality of the brain. Some children under five years old have *febrile seizures*, which can develop when they have a fever – usually above 100.4 degrees. Seizures that happen more than once or over and over might indicate a seizure disorder. The cause of a seizure disorder is usually not known.

Children with seizure disorders usually have normal intelligence, however;

- Some children may have difficulties thinking and remembering.
- Some children may have behavioral and emotional problems that include:
 - Difficulties with concentration
 - Problems with temper control
 - Hyperactivity
 - Impulsiveness

What does a seizure look like?

Some seizures are difficult to notice, while others are very dramatic. Seizures can be:

- *Generalized*, which affect all of the brain and cause the child to lose consciousness, and his or her body to stiffen and the limbs to shake.
- *Partial*, which affect just parts of the brain. It can take many different forms and may partly affect consciousness.

How to help during seizures

- Stay calm!
- Keep the child from getting hurt during the seizure; help ease her to the floor.
- Remove hazards such as hard or sharp objects that can cause injury if the child falls or knocks against them.
- Loosen clothing around the child's head and neck and remove glasses.
- Gently turn the child on his side so any fluid in the mouth can drain safely.
- Talk softly to reassure the child.
- Explain to the other children what is happening – the child is having a seizure, it will be over soon, and she is not in pain.
- Keep track of when the seizure started and how long it lasted.
- Stay with the child as he comes out of the seizure to reassure him.

What *NOT* to do during a seizure

- **DO NOT** put anything in the child's mouth.
- **DO NOT** try and restrain the child's movements.
- **DO NOT** try to bring the child out of the seizure by using cold water or shaking – it won't work and could be harmful.

- **DO NOT** give the child anything to eat or drink before fully awake.

When to call 911 for emergency help

- If the child has never had a seizure before.
- If the seizure lasts longer than five minutes in a child with a known seizure disorder.
- If the child has more than one seizure without fully regaining consciousness.

When a seizure ends, the brain begins to recover and the child returns to awareness. Be calm and reassuring because the child may be confused and frightened, and may not remember the seizure. Let the child rest or sleep as needed.

Most children with seizures take medication to control their seizures. Some medications may cause changes in the child's behavior or learning, and some can occasionally cause side effects. If you notice a change in behavior or any physical side effects such as rash, stomach pain, frequent nosebleeds, or excessive sleepiness, discuss this with the child's parent. It is also a good idea to document what you observe and when, and keep the notes on file.

How to prepare your program

- Train staff on how to identify and respond to a child having a seizure.
- Develop a *Seizure Care Plan* with the child's parent. See the Appendix for a sample.
- Have parent fill out the *Medication Administration Form*. See the form in the Appendix.
- Provide written documentation, including who is responsible to care for the child, how they have been trained, and how to store and administer any prescribed medication.
- Document every seizure in the child's *Seizure Activity Log*. See the sample log in the Appendix.
- Keep a copy of the child's *Seizure Care Plan*, *Seizure Activity Log*, and *Medication Log* of any medication given, in the child's file.

Sickle Cell Disease

What is it?

- Sickle cell is an inherited condition in which red blood cells change shape. Instead of being round and smooth, they form a “c” shape like a crescent moon.
- The red blood cells can get stuck in blood vessels and block blood flow, which can cause pain or swelling and keep the body from fighting infection.
- The abnormally shaped red blood cells do not live as long as regular cells, so children with sickle cell disease have a low blood count and must make new red blood cells more quickly.
- Children are born with the condition and have it for life. Some children are more severely affected; some have a milder form.

What are some characteristics of children with sickle cell disease?

- Hand-foot syndrome – swollen hands and feet may be the first signs of sickle cell in babies. The swelling is caused by the sickle-shaped red blood cells blocking blood flow out of their hands and feet.
- Pale skin or nail beds.
- Yellow tint to the skin or whites of the eyes.
- Child is small and slender for his or her age.

Children with sickle cell may have increased absences because of complications and may need to be hospitalized for treatment. **Some complications** include:

- **Pain.** Pain can happen in any part of the body but often occurs in the hands, feet and joints. Chest pain can be especially serious.
- **Fever.** Children with sickle cell disease have a hard time fighting infection. Fevers must be evaluated by the child’s health care provider.
- **Pneumonia** can be very serious in children with sickle cell disease.
- **Splenic sequestration** is an emergency. Sickled cells can clog up the spleen and keep it from working properly (straining the blood and removing damaged cells and infection). The sickled cells can cause the spleen to back up. The spleen can get very big if that happens and sometimes break open – which is a life-threatening emergency.
- **Aplastic crisis.** Abnormal blood cells have a shorter life span, so the body needs to make new blood cells very quickly. If something like an infection prevents the body from keeping up with making new blood cells, the child can get a dangerously low blood count very quickly.
- **Strokes.** If sickled cells block the blood flow to the brain, a stroke can occur.

What adaptations may be needed?

1. Medications. Children with sickle cell may take:
 - Penicillin from two months until five years of age (to help prevent infection)
 - Acetaminophen or ibuprofen (for pain control)
 - Extra Folic Acid (because of the red blood cells needed)
 - Special vaccinations (in addition to required)

2. Dietary considerations. Children with sickle cell disease should have at least 8 cups of water or fluid daily.
3. Physical environment
 - Hydration helps prevent sickling, so allowing the child to have a water bottle is a good idea.
 - Children with sickle cell disease may need increased bathroom breaks.
4. Be aware of what is considered an emergency

Inform parents immediately for:

- Fever
- Pain that does not improve with medication and rest
- Cough or mild chest pain
- Abdominal pain or swelling
- Paleness or increased tiredness
- Painful erection

Call emergency medical services – 911 if:

- Difficulty breathing
- Seizure or loss of consciousness
- Headache or dizziness
- Change in vision
- Numbness or inability to move a body part
- Severe pain
- The spleen gets enlarged
- Prolonged erection

Remember to develop a Special Health Care Plan with the parents and the child's health care provider so you can provide the best care possible.

Resources for further information

- The Sickle Cell Information Center, www.scinfo.org/teacher.html
- National Heart, Lung and Blood Institute, www.nhlbi.nih.gov

Visual Impairment

Visual impairment is a term experts use to describe any kind of vision loss, whether it's someone who cannot see at all or someone who has partial vision loss. Some people are completely blind, but many others have what's called **legal blindness**. They haven't lost their sight completely but have lost enough vision that they'd have to stand 20 feet from an object to see it as well as someone with perfect vision could from 200 feet away.

Some babies have **congenital blindness**, which means they are visually impaired at birth. Congenital blindness can be caused by a number of things — it can be inherited, or caused by an infection (like German measles) that's transmitted from the mother to the developing fetus during pregnancy.

The American Foundation for the Blind estimates that 10 million people in the United States are visually impaired. **Visual impairments include:**

- **Myopia** or nearsightedness. A child who is nearsighted can see objects that are near, but has poor distance vision.
- **Amblyopia** or “lazy eye” is a decrease in the child’s vision that can happen even when there is no problem with the structure of the eye. The decrease in vision results when one or both eyes send a blurry image to the brain. The brain then “learns” to only see blurry with that eye, even when glasses are used.
- **Strabismus**, where the eyes look in different directions and do not focus simultaneously on a single point. It is commonly referred to as crossed eyes.
- **Hyperopia** or farsightedness is thought to be a normal occurrence in children under the age of five and is caused by a shortness of the eyeball. This condition often corrects itself as children mature and their eyeballs change shape. Children who are farsighted can see objects clearly at a distance, but have trouble focusing on near objects.
- **Congenital Cataracts**, where the lens of the eye is cloudy.
- **Retinopathy of Prematurity**, which may occur in premature babies when the light-sensitive retina hasn’t developed sufficiently before birth.
- **Retinitis Pigmentosa**, a rare inherited disease that slowly destroys the retina.
- **Coloboma**, where a portion of the structure of the eye is missing.
- **Optic Nerve Hypoplasia**, which is caused by underdeveloped fibers in the optic nerve and which affects depth perception, sensitivity to light, and acuity of vision.
- **Cortical Visual Impairment (CVI)**, which is caused by damage to the part of the brain related to vision, not to the eyes themselves.
- **Glaucoma** is an increase in pressure inside the eye. The increased pressure impairs vision by damaging the optic nerve. It is mostly seen in older adults, but babies may be born with the condition.

There are also numerous other eye conditions that can cause visual impairment.

It’s important to diagnose and address visual impairment in children as soon as possible. Some vision screening may occur at birth, especially if the baby is born prematurely or there’s a family history of vision problems, but baby wellness visits as early as six months should also include basic vision screening to ensure the baby’s eyes are developing and functioning as expected.

Early signs of vision problems in infants and toddlers:

- Jerky or fluttering eye movements.
- Eyes that wander in opposite directions or are crossed (after three months).
- Inability to focus or follow a moving object (after three months).
- Pupil of one eye larger than the other.
- Absence of a blink reflex.
- Drooping of one or both lids.
- Cloudiness on the eyeball.
- Chronic tearing.

Signs of vision problems in older children:

- Eyes that don't move together when following an object or a face.
- Strains to see distant objects; squints or screws up face.
- Crossed eyes, eyes that turn out or in, eyes that flutter from side to side or up and down, or eyes that do not seem to focus.
- Eyes that bulge, dance, or bounce in rapid rhythmic movements.
- Pupils that are unequal in size or that appear white instead of black.
- Repeated shutting or covering of one eye.
- Tilts head to one side.
- Unusual degree of clumsiness, such as frequent bumping into things or knocking things over.
- Frequent squinting, blinking, eye-rubbing, or face crunching, especially when there's no bright light present.
- Sitting too close to the TV or holding toys and books too close to the face.

If any of these symptoms are present, parents will want to have their child's eyes professionally examined. Early detection and treatment are very important to the child's development.

Special Needs Rate and Certification Process

If a family is receiving DHS subsidy, you may be certified to receive a higher reimbursement rate. The child must be participating in one of the following programs:

- SoonerStart (IFSP required)
- Special Education Services (IEP required)
- Supplemental Security Income (Health Professional's statement required if the child doesn't receive SoonerStart or Special Ed services)

In order to qualify:

- The provider must have a current contract with DHS and be qualified to care for the child as determined by the facility's licensing specialist.
- The child must be eligible for subsidized child care and meet the definition of a child with disabilities.
- The scoring of the special needs form must meet minimum criteria to receive the enhanced rate.
- If approved, the enhanced rate is applied the first of the month after eligibility for the special needs rate is established.

The process for applying for a special needs rate has changed effective November 1, 2014:

- Child care providers will be able to initiate the special needs rate process by accessing the revised form *Certification for Special Needs Rate for Licensed Child Care Homes and Centers 08AD006E/ADM-123* on the Provider Web at <https://www.ebt.acs-inc.com/ecc/>.
- Parents or Guardians will no longer have to contact their worker to initiate the process.
- The provider will be able to print the form and fill it out with the parent or guardian before giving it to their licensing specialist.
- Once the licensing specialist has determined eligibility for the provider, the form is scanned and emailed to the AFS Child Care Subsidy unit.
- AFS Child Care Subsidy staff score the form to determine if the child's needs qualifies for the special needs rate.

For more information contact:

Department of Human Services

Adult and Family Services, Child Care Subsidy

Phone: 405-521-3931

Email: ChildCareContracts@okdhs.org

Training

The **child's parent** is the expert on their child and the best source for information.

Child Care Resource and Referral Agencies

Each regional child care resource and referral agency (R&R) holds training for child care providers on different topics. You can locate your regional R&R through the Oklahoma Child Care Resource and Referral Association website at www.oklahomachildcare.org.

The Center for Early Childhood and Professional Development has a list of training opportunities on their website through the Statewide Training Calendar at <https://okregistry.org/>.

The **Warmline for Oklahoma Child Care Providers** offers free telephone consultation to child care providers on numerous topics of concern. Consultants can also refer providers to appropriate services and resources within their communities. The website is <http://warmline.health.ok.gov> or you can call the Warmline at **1-800-574-5437**.

Other Resources:

- **Family Voices** is a national grassroots network of families and friends which advocates for health care services and provides information for families with children with special health care needs. www.familyvoices.org.
- **The Oklahoma Family Network (OFN)** is a statewide, non-profit agency that supports Oklahoma families with critically ill infants or children with special health care needs or disabilities. The website is <http://oklahomafamilynetwork.org>, or call 405-271-5972 or 877-871-5072.
- The flagship program, Oklahoma's statewide Parent-to-Parent Mentorship Program, provides informational, educational and emotional support to Oklahoma families of children with any type of special need. The Family-to-Family Health Care Information Resource Center Program provides healthcare information and education, empowering families of children with special health care needs to care for their children to support good long-term outcomes. <http://oklahomafamilynetwork.org>
- **Sooner Success** provides statewide information and referrals for Oklahomans with special needs. Sooner Success; <http://soonersuccess.ouhsc.edu/> 1-877-441-0434.
- **SoonerStart** is Oklahoma's early intervention program. It is designed to meet the needs of families with infants or toddlers with developmental delays. The website is <http://ok.gov/sde/soonerstart>.