Standard 5: HEALTH

A Guide to the NAEYC Early Childhood Program Standard and Related Accreditation Criteria

National Association for the Education of Young Children

naeyc Accreditation


Self-Study materials and accreditation assessment tools were developed for NAEYC under contract by the Center for Improving Child Care Quality, University of California–Los Angeles. Editorial support for the materials came from many people, including: Jenna Bilmes, Melinda Brookshire, Judy Calder, Carol Cole, Carol Brunson Day, Erin Gordon, and Billie Weiser. The literature review in Section 6 of each Self-Study book was prepared by Brandt Chamberlain and Ellen Smith under the direction of Carollee Howes, in conjunction with the UCLA Center for Improving Child Care Quality.

Most important, NAEYC gratefully acknowledges the early childhood programs and educators who earn NAEYC Accreditation and bring to life the level of quality embodied by the NAEYC Early Childhood Program Standards and Accreditation Criteria, helping the children that they serve develop, learn, and achieve their full potential.

Cover photos © from left: Nancy P. Alexander, Marilyn Nolt, Joel Goldman, Ellen B. Senisi, Elisabeth Nichols, and Ellen B. Senisi.


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Standard 5: HEALTH

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Since its founding in 1926, NAEYC has strived to improve the quality of group programs for young children by defining a vision for high quality and then providing tools and resources to achieve that vision. For more than 20 years, NAEYC Accreditation has been one of the Association’s most powerful mechanisms in this regard. The system sets the standard for excellence—for families and the public as well as the early childhood profession—and, through the Self-Study process, offers support to programs to meet the standard.

Beginning in 2000, NAEYC launched a comprehensive review of its accreditation system, resulting in the design and implementation of a reinvented system. A new set of 10 NAEYC Early Childhood Program Standards and more than 400 Accreditation Criteria were adopted by the Association in 2005. Each of the 10 standards is a broad statement that describes a critical component of early childhood program functioning. How programs meet that standard is defined by specific accreditation criteria. The criteria are organized by topic areas that highlight the key issues within that standard. Some of the criteria are “universal,” meaning that they apply to all children, while others apply to particular age categories: infant, toddler/two, preschool, and kindergarten. Many criteria apply to more than one age category. Programs use only the criteria that apply to the age categories they serve.

Together, the standards and their criteria define what NAEYC believes every early childhood education program should be. The standards are set high to match the vision for NAEYC Accreditation: that NAEYC Accreditation and NAEYC-Accredited programs are leading the way to higher quality in all programs. Setting standards for high quality and having NAEYC-Accredited programs meet those standards will help many more people recognize the value of early childhood education.

As one of the results of reinvention, NAEYC is increasing its support to programs in Self-Study and is encouraging programs to enroll in Self-Study even if they have no intention of pursuing NAEYC Accreditation. Ideally, all programs will think about how they can create a better place for children to grow and learn. As part of this effort, the Self-Study resources have been greatly expanded. Separate books have been created for each standard and are available independent of the Self-Study Kit. Thus, you may be reading this volume from one of several perspectives:

- as a teacher or administrator in an NAEYC-Accredited program seeking re-accreditation under the new standards;
- as a teacher or administrator enrolled in Self-Study for the first time;
- as a teacher or administrator interested in learning more about this standard and possibly thinking about the accreditation process; or
as a student of early childhood education, learning about the importance of the standard on health.

Whatever your perspective, we hope that you find this resource to be a helpful tool in improving the quality of the early childhood programs that you touch and, thus, in enhancing the quality of life for young children.

Each of the program standard books follows a similar format. They are organized around a basic framework of four questions for programs:

- **What do you need to know** to study your practices in this standard? (i.e., What is the standard and why is it important to quality?)
- **What do you need to think about** as you study how your program performs the criteria in this standard? (i.e., What does it mean for your program?)
- **What do you need to do to improve** your ability to meet the criteria for this standard and to gather evidence of your progress? (i.e., What do you need to do for Self-Study?)
- **What do you need to do to demonstrate** that your program meets the 10 standards, if you want to formally pursue NAEYC Accreditation after completing Self-Study? (i.e., What do you need to do for Self-Assessment?)

The book provides information and resources to help you consider each of these questions in relation to the NAEYC Early Childhood Program Standards and Accreditation Criteria. Each book provides resources that are related to a standard and that are based on tools used in the assessment process for NAEYC Accreditation. Note: the tools themselves are provided at TORCH—The Online Resource Center Headquarters for program improvement through NAEYC Accreditation; see www.naeyc.org/selfstudy. As you use the framework to consider changes to your program, you will be encouraged to follow six tasks for Self-Study:

- Create shared understandings of key concepts about accreditation, the standards, the criteria, and implications for the program.
- Gather evidence using the Self-Study tools.
- Determine strengths and weaknesses using the standards and criteria as your measure of quality.
- Develop improvement plans as needed.
- Make improvements and document your progress.
- Evaluate results and determine next steps.

Before becoming Applicants for NAEYC Accreditation, programs will find it helpful to complete these tasks, considering each standard. As a program evaluates its results and determines next steps, it may find that further study and improvements are needed for some standards. Programs are ready to apply for NAEYC Accreditation when they are confident that they can demonstrate that each standard is met.

Programs not intending to seek accreditation at this time are encouraged to use the tasks to address specific areas, perhaps subgroups of criteria within a particular standard, to make improvements.
Overview of Steps to Achieve NAEYC Accreditation

<table>
<thead>
<tr>
<th>Steps</th>
<th>Tasks for Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1: Enrollment/</td>
<td>■ Complete enrollment form and submit enrollment fee</td>
</tr>
<tr>
<td>Self-Study</td>
<td>■ Review the Self-Study Kit and online resources at TORCH (see <a href="http://www.naeyc.org/selfstudy">www.naeyc.org/selfstudy</a>)</td>
</tr>
<tr>
<td></td>
<td>■ Engage in Self-Study, considering these suggestions:</td>
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<tr>
<td></td>
<td>• Create shared understandings of key concepts about accreditation, the standards,</td>
</tr>
<tr>
<td></td>
<td>the criteria, and implications for the program</td>
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<tr>
<td></td>
<td>• Gather information</td>
</tr>
<tr>
<td></td>
<td>• Determine strengths and weaknesses</td>
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<tr>
<td></td>
<td>• Develop improvement plans as needed</td>
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<td>• Make improvements and document progress</td>
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<tr>
<td></td>
<td>• Evaluate results and determine next steps</td>
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<tr>
<td></td>
<td>■ Prepare to meet eligibility requirements</td>
</tr>
<tr>
<td></td>
<td>■ Currently NAEYC Accredited? To maintain accreditation status, verify deadlines for</td>
</tr>
<tr>
<td></td>
<td>Step 2: Application/Self-Assessment and Step 3: Candidacy</td>
</tr>
<tr>
<td>Step 2:</td>
<td>■ Complete application, selecting a due date for submission of Candidacy Materials,</td>
</tr>
<tr>
<td>Application/Self-Assessment</td>
<td>and pay application fee</td>
</tr>
<tr>
<td></td>
<td>■ Meet eligibility requirements</td>
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<td></td>
<td>■ Engage in formal Self-Assessment—Must complete all requirements in the Guide to</td>
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<td>Self-Assessment available online to enrolled programs:</td>
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<tr>
<td></td>
<td>• Plan formal Self-Assessment, involving families, teaching staff members, and</td>
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<td></td>
<td>program administrators</td>
</tr>
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<td></td>
<td>• Document evidence that all standards are met, building on results of Self-Study</td>
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<tr>
<td></td>
<td>• “Fine-tune” program performance, making improvements as needed to make sure that</td>
</tr>
<tr>
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<td>all required criteria and at least 80 percent of criteria within each standard</td>
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<td>are met by the program overall and that every classroom consistently performs at</td>
</tr>
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<td>least 70 percent of all applicable criteria</td>
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<td></td>
<td>■ Prepare to meet all Candidacy Requirements</td>
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<td></td>
<td>■ Complete Candidacy Materials, including documentation of performance on selected</td>
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<td>criteria as requested by the NAEYC Academy</td>
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<tr>
<td>Step 3: Candidacy</td>
<td>■ Submit Candidacy Materials and fee by chosen due date</td>
</tr>
<tr>
<td></td>
<td>■ Meet Candidacy Requirements</td>
</tr>
<tr>
<td></td>
<td>■ Prepare for site visit by NAEYC Assessors</td>
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<td></td>
<td>■ Continue to gather evidence of performance and make improvements</td>
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## Overview of Steps to Achieve NAEYC Accreditation

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<table>
<thead>
<tr>
<th>Steps</th>
<th>Tasks for Programs</th>
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</table>
| Step 4: Meeting the Standards/ Accreditation Decision | - Participate in site visit  
                                          - Complete site visit evaluation and submit it to the NAEYC Academy  
                                          - Deferred programs—May choose to return to Step 2: Application/Self-Assessment or Step 3: Candidacy  
                                          - Denied programs—May choose to return to Step 2: Application/Self-Assessment  
                                          - Accredited programs: Sustain quality over the five-year term—as documented through annual reports, reports of program changes, and results of unannounced visits if randomly selected—and pay applicable fees |

| Maintaining the Standards                  |                                                                                     |


Program Requirements for Each Step of NAEYC Accreditation

<table>
<thead>
<tr>
<th>Steps</th>
<th>Program Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1: Enrollment/ Self-Study</td>
<td>No requirements</td>
</tr>
<tr>
<td>Step 2: Application/ Self-Assessment</td>
<td>Open to any program interested in using the Self-Study Kit and tools for program improvement</td>
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<td></td>
<td>Open to any center- or school-based program serving children birth through kindergarten that also</td>
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<td></td>
<td>Serves a minimum of 10 children</td>
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<td></td>
<td>Is in operation for at least one year before submitting materials for Step 3: Candidacy</td>
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<td></td>
<td>Is regulated by the appropriate licensing or regulatory body (or alternative if ineligible for licensing/regulation)</td>
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<tr>
<td></td>
<td>Is located in the United States or its territories, unless affiliated with U.S. government</td>
</tr>
<tr>
<td>Step 3: Candidacy</td>
<td>Program is willing to meet each of the 10 NAEYC Early Childhood Program Standards</td>
</tr>
<tr>
<td></td>
<td>Leaders demonstrate knowledge of the NAEYC Accreditation process</td>
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<td></td>
<td>Program completes the formal, comprehensive Self-Assessment following requirements in the Guide to Self-Assessment available online to enrolled programs</td>
</tr>
<tr>
<td></td>
<td>The program must do the following:</td>
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<td>Maintain good standing in its licensing or regulatory status within the last year or since its last inspection</td>
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<td>Demonstrate necessary early childhood and management and leadership expertise among members of its teaching and leadership staff</td>
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<td></td>
<td>Provide documentation of a collaborative process used to complete its Candidacy Materials, which has actively engaged the program administrator, the teaching staff, families, and the program’s governing body (when applicable)</td>
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<tr>
<td></td>
<td>Believe that it can meet each of the 10 NAEYC Early Childhood Program Standards and that it can document satisfactory performance on at least 80 percent of the NAEYC Accreditation Criteria for each standard</td>
</tr>
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Program Requirements for Each Step of NAEYC Accreditation
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Steps

Program Requirements

Step 4: Meeting the Standards/Accreditation Decision

Meet all applicable required criteria and continue to meet all Candidacy and eligibility requirements

Meet each of the 10 NAEYC Early Childhood Program Standards by demonstrating proficiency in at least 80 percent of each standard’s associated accreditation criteria assessed during the site visit, with no individual classroom scoring below 70 percent on its assessed criteria

Maintaining the Standards

Maintain level of quality expected of NAEYC-Accredited programs

Self-report any major changes to the program within 90 days

Submit to unannounced visits if randomly selected or verification visits in response to program changes, complaints, or questions about the program’s continued ability to meet the requirements of NAEYC Accreditation

Submit annual reports on each anniversary with applicable fees
NAEYC Early Childhood Program Standards

1. **Relationships:** The program promotes positive relationships among all children and adults to encourage each child’s sense of individual worth and belonging as part of a community and to foster each child’s ability to contribute as a responsible community member.

2. **Curriculum:** The program implements a curriculum that is consistent with its goals for children and promotes learning and development in each of the following areas: social, emotional, physical, language and cognitive.

3. **Teaching:** The program uses developmentally, culturally, and linguistically appropriate and effective teaching approaches that enhance each child’s learning and development in the context of the program’s curriculum goals.

4. **Assessment of Child Progress:** The program is informed by ongoing systematic, formal, and informal assessment approaches to provide information on children’s learning and development. These assessments occur within the context of reciprocal communications with families and with sensitivity to the cultural contexts in which children develop. Assessment results are used to benefit children by informing sound decisions about children, teaching, and program improvement.

5. **Health:** The program promotes the nutrition and health of children and protects children and staff from illness and injury.

6. **Teachers:** The program employs and supports a teaching staff that has the educational qualifications, knowledge, and professional commitment necessary to promote children’s learning and development and to support families’ diverse needs and interests.

7. **Families:** The program establishes and maintains collaborative relationships with each child’s family to foster children’s development in all settings. These relationships are sensitive to family composition, language, and culture.

8. **Community Relationships:** The program establishes relationships with and uses the resources of the children’s communities to support the achievement of program goals.

9. **Physical Environment:** The program has a safe and healthful environment that provides appropriate and well-maintained indoor and outdoor physical environments. The environment includes facilities, equipment, and materials to facilitate child and staff learning and development.

10. **Leadership and Management:** The program effectively implements policies, procedures, and systems that support stable staff and strong personnel, fiscal, and program management so all children, families, and staff have high-quality experiences.
**Why Is Health Important to Quality?**

To benefit from the opportunities for learning and development offered by child care centers, preschools, or kindergartens, children need to be healthy. The tools and information that support efforts to improve the quality of early childhood programs in the areas of health and safety are readily available. Quality programs are informed about and use health and safety resources to develop and implement policies, practices, and procedures that protect the health and safety of young children, staff, and family members.

Never before have so many resources been available to improve the health and safety of early childhood program environments. Beginning in the late 1980s, a dedicated group of individuals representing the American Academy of Pediatrics, the American Public Health Association, and the Maternal Child Health Bureau collaborated with partners in various disciplines involved in early care and education to develop policies and resources to improve the health and safety of children, families, and staff in early childhood programs. *Caring for Our Children: Guidelines for Out-of-Home Child Care Programs* was first written and published in 1992 by the American Academy of Pediatrics, with a second edition released in 2002. This comprehensive set of national health and safety standards was a response to many years of effort by advocates for quality child care.

In 1995, the Healthy Child Care America Campaign was launched through a collaborative effort of the Child Care Bureau and the Maternal and Child Health Bureau. The vision of the campaign was to (a) create and maximize linkages between healthcare providers and the child care community and (b) develop comprehensive and coordinated services to benefit children across the country. Also in 1995, the Maternal and Child Health Bureau funded the establishment of the National Resource Center for Health and Safety in Child Care, whose primary mission is to promote health and safety in out-of-home child care settings throughout the nation. Links to each of the projects are included in Section 6.

**What Is the Standard for Health?**

**Program Standard:** The program promotes the nutrition and health of children and protects children and staff from illness and injury.
Rationale: To benefit from education and maintain quality of life, children need to be as healthy as possible. Health is a state of complete physical, oral, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization 1948). Children depend on adults (who also are as healthy as possible) to make healthy choices for them and to teach them to make healthy choices for themselves. Although some degree of risk taking is desirable for learning, a quality program prevents hazardous practices and environments that are likely to result in adverse consequences for children, staff, families, or communities.

Topic Areas within the Health Standard

The Health Standard comprises three topic areas (5.A through 5.C). The topic areas are summarized here.

5.A.—Promoting and Protecting Children’s Health and Controlling Infectious Disease. This topic area addresses practices for health promotion and protection for children and adult staff in the program, including plans and policies for immunizations, communicable disease, CPR and first-aid training, as well as standards for diapering, hand washing, feeding, and dispensing of medication, and the use of health professionals.

5.B.—Ensuring Children’s Nutritional Well-Being. This topic area addresses children’s nutrition, including food-serving practices, menus, health requirements, refrigeration requirements, and allergies.

5.C.—Maintaining a Healthful Environment. This topic area addresses issues related to maintaining an environment that supports the health of children and staff.

A Guide to the Standards and Criteria Chart

Standard: There are 10 NAEYC Early Childhood Program Standards. Each standard describes an essential element that together with the other nine standards provide a definition of quality for child care, preschools, and kindergarten programs. Standards are numbered 1 to 10.

Topic areas: Within each standard are topic areas that highlight the big ideas to more fully express the meaning and value of the standard. Each topic area includes criteria that further define the meaning of quality in that area. The topic areas are identified by capital letters (A, B, C, etc.). The number of topic areas within a standard vary.

Criteria: Each criterion provides specific details to guide program plans, policies, and practices. The criteria are numbered (01, 02, 03, etc.) within their topic area.

Indicators: Many of the criteria are straightforward statements such as “Teachers use their understanding of children’s ideas to plan new learning experiences.” Other criteria have multiple indicators that define very specific aspects of more complex criteria. Each indicator is identified by a lowercase letter (a, b, c, etc.).

Age category: Each criterion within each program standard is identified by its relevant age category (or categories). Many criteria are identified as “universal” (U), meaning that all classrooms and programs pursuing NAEYC Accreditation must address these criteria. These aspects of quality should be seen in any program or classroom serving children birth through kindergarten, though they may look somewhat different in practice depending on the children’s age.

continued on next page
Other criteria apply to specific age categories:

I = infant = birth to 15 months
T = toddler/two = 12 to 36 months
P = preschool = 30 months to 5 years
K = kindergarten = children enrolled in a public or private kindergarten program

The age categories for each criterion are indicated by an X.

Note that there is some overlap among the age ranges for each category, especially for the infant and toddler/two categories. This overlap is purposeful to allow programs some flexibility in grouping children. When a group consists only of children whose ages are listed in two different age categories, for example, 12 to 15 months, the group may be designated as serving either category (i.e., infant or toddler/two). The designation chosen by the program will determine which age category is used for assessment purposes. If a group includes children whose ages range beyond the overlapping portion of two age categories, then the group is a mixed-age group. For mixed-age groups, universal criteria and criteria relevant to the age categories for that group apply. For example, a group of children 24 to 48 months must meet universal, toddler/two, and preschool criteria.

**Assessment category:** The assessment category column in the criteria informs programs of how the criterion is considered in scoring after the site visit to determine NAEYC Accreditation. Although programs will consider all the criteria during Self-Study and will need to be prepared to be assessed on any criteria, the site visit will include only a sample of the more than 400 criteria.\(^1\) Criteria are grouped by the following categories for the purposes of the site visit:

- **Required**—Required criteria are so fundamental to program quality that they must be fulfilled to achieve NAEYC Accreditation. The following are required criteria related to the Health Standard.

  - **5.A.03**—At least one staff member who has a certificate showing satisfactory completion of pediatric first-aid training, including managing a blocked airway and providing rescue breathing for infants and children, is always present with each group of children. When the program includes swimming and wading and when a child in the group has a special health condition that might require CPR, one staff person who has successfully completed training in CPR is present in the program at all times.

  - **5.A.12 (Indicator a)**—To reduce the risk of sudden infant death syndrome (SIDS): Infants, unless otherwise ordered by a physician, are placed on their backs to sleep on a firm surface manufactured for sale as infant sleeping equipment that meets the standards of the United States Consumer Product Safety Commission.

\(^{1}\) The determination of which criteria are used in specific site visits is based on the results of an extensive series of field tests conducted to establish valid and reliable measures of the NAEYC Early Childhood Program Standards.
A Guide to the Standards and Criteria Chart
(continued from page 14)

(If all the indicators in this criterion, this indicator only is required of all programs serving infants.)

- **Always Assessed (Always)**—These criteria will be assessed during each site visit and are considered as part of the overall score to determine accreditation status.

- **Randomly Assessed (Random)** — These criteria could be assessed during a site visit, and programs should be prepared to be assessed on any of the random criteria.

- **Emerging Practice (Emerging)** — These criteria are ones that are important to program quality but are not yet widely practiced, and time is needed for the early childhood field and individual programs to develop the capacity (through additional training, major facility renovations, or other significant steps) to meet them. Programs may be assessed on emerging practice criteria. When programs are assessed on these criteria and they meet them, then the program will receive credit for doing so. However, a program will not be penalized for failing to meet an emerging practice criterion. NAEYC will assess overall performance of all programs on the emerging practice criteria to determine how those criteria will be considered in the future. Emerging practices criteria related to the Health Standard include the following:
  
  - **5.A.08 (Indicator h)**—Each changing area is separated by a partial wall or is located at least three feet from other areas that children use and is used exclusively for one designated group of children. For kindergartners, the program may use an under-clothing changing area designated for and used only by this age group. (If all the indicators listed in this criterion, this indicator only is an emerging practice.)
  
  - **5.A.10**—Precautions are taken to ensure that communal water play does not spread infectious disease. No child drinks the water. Children with sores on their hands are not permitted to participate in communal water play. Fresh potable water is used, and the water is changed before a new group of children comes to participate in the water play activity. When the activity period is completed with each group of children, the water is drained. Alternatively, fresh potable water flows freely through the water play table and out through a drain in the table.
  
  - **5.A.13**—After each feeding, infant’s teeth and gums are wiped with a disposable tissue (or clean soft cloth used only for one child and laundered daily) to remove liquid that coats the teeth and gums.
  
  - **5.B.02 (Indicator e)**—Food that comes from home for sharing among the children must be either whole fruits or commercially prepared packaged foods in factory-sealed containers. (If all the indicators in this criterion, this indicator only is an emerging practice.)
• 5.B.10 (Indicator a)—Except for human milk, staff serve only formula and infant food that comes to the facility in factory-sealed containers (e.g., ready-to-feed powder or concentrate formulas and baby food jars) prepared according to the manufacturer’s instructions. (Of all the indicators in this criterion, this indicator only is an emerging practice.)

Sources of evidence: Evidence is a critical concept for NAEYC Accreditation. The process is designed to focus on evidence of the program’s ability to meet the standards and criteria consistently over time, not simply on the day of the site visit. Specific tools are provided online at TORCH (see www.naeyc.org/selfstudy) to help you gather documentation of your program’s past, present, and future performance related to each standard.

The sources of evidence are:
O = Observable Criteria
FS = Family Survey
TS = Teaching Staff Survey
PP = Program Portfolio
CP = Classroom Portfolio

Additional tips for understanding the standards and criteria chart:
- Text in bold is provided to highlight particular concepts within the criterion when helpful to aid understanding.
- The term teaching staff is used to refer to all members of the teaching team, including teachers and assistant teachers–teacher aides; for more information about definitions of teaching staff and their qualifications, see Getting Started included in the Self-Study Kit.
- The following example will illustrate the various features of the criteria chart.
EXAMPLE: the number 5.A.03 found in the far left column of the criteria indicates the following:
- 5—The number of the standard; Standard 5 is the Health Standard
- A—Topic Area, in this case, “Promoting and Protecting Children’s Health and Controlling Infectious Disease”
- 03—Criterion, in this case, “At least one staff member who has a certificate showing satisfactory completion of pediatric first-aid training, including managing a blocked airway and providing rescue breathing for infants and children, is always present with each group of children. When the program includes swimming and wading and when a child in the group has a special health condition that might require CPR, one staff person who has successfully completed training in CPR is present in the program at all times.” Indicators for age categories with respect to the criterion are marked by an X in each appropriate box (U, I, T, P, K).
What Are the NAEYC Accreditation Criteria for the Health Standard?

The following chart presents the topic areas and criteria for the Health Standard. It also shows the age categories for which each criterion is relevant, the assessment category for each criterion, and the sources of evidence that are used to assess each criterion.

**NAEYC Accreditation Criteria for Health Standard**

<table>
<thead>
<tr>
<th>Number</th>
<th>Age Category</th>
<th>NAEYC Accreditation Criterion</th>
<th>Assessment Category</th>
<th>Sources of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.A.01</td>
<td>X X X X</td>
<td>Promoting and Protecting Children’s Health and Controlling Infectious Disease</td>
<td>Random</td>
<td>PP</td>
</tr>
</tbody>
</table>

The program maintains current health records for each child:

a. Within six weeks after a child begins the program, and as age-appropriate thereafter, health records document the dates of services to show that the child is current for routine screening tests and immunizations according to the schedule recommended, published in print, and posted on the Web sites of the American Academy of Pediatrics, the Centers for Disease Control of the United States Public Health Service (CDC-USPHS), and the Academy of Family Practice.

b. When a child is overdue for any routine health services, parents, legal guardians, or both provide evidence of an appointment for those services before the child’s entry into the program and as a condition of remaining enrolled in the program, except for any immunization for which parents are using religious exemption.

Child health records include:

c. current information about any health insurance coverage required for treatment in an emergency;

d. results of health examinations, showing up-to-date immunizations and screening tests with an indication of normal or abnormal results and any follow-up required for abnormal results;

e. current emergency contact information for each child, which is kept up to date by a specified method during the year;

f. names of individuals authorized by the family to have access to health information about the child;

g. instructions for any of the child’s special health needs such as allergies or chronic illness (e.g., asthma, hearing or vision impairments, feeding needs, neuromuscular conditions, urinary or other ongoing health problems, seizures, diabetes); and

h. supporting evidence for cases in which a child is under-immunized because of a medical condition (documented by a licensed health professional) or the family’s beliefs. Staff implement a plan to exclude the child promptly if a vaccine-preventable disease to which children are susceptible occurs in the program.

When a program is subject to a governmental rule or regulation that prohibits or exceeds the expectation outlined in a criterion, that rule or regulation takes precedence. When a governmental rule or regulation differs in other ways, or sets a lower threshold of performance, NAEYC Accreditation Criteria take precedence.
NAEYC Accreditation Criteria for Health Standard

<table>
<thead>
<tr>
<th>Number</th>
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<th>NAEYC Accreditation Criterion</th>
<th>Assessment Category</th>
<th>Sources of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.A.02</td>
<td>X X X X X</td>
<td>The program has and implements a written agreement with a health consultant who is either a licensed pediatric health professional or a health professional with specific training in health consultation for early childhood programs. a. The health consultant visits at least two times a year and as needed. Where infants and toddler/twos are in care, the health consultant visits the program at least four times a year and as needed. b. The health consultant observes program practices and reviews and makes recommendations about the program’s practices and written health policies to ensure health promotion and prevention of infection and injury. The consultation addresses physical, social-emotional, nutritional, and oral health, including the care and exclusion of ill children. c. Unless the program participates in the United States Department of Agriculture’s Child and Adult Care Food Program, at least two times a year a registered dietitian or pediatric public health nutritionist evaluates the menus for nutritional content; portion sizes; nationally recommended limits on juice, sugar, sodium, and saturated fats; food service operations; special feeding needs to be met by the program; and procedures used for food brought from home. d. The program documents compliance and implements corrections according to the recommendations of the consultant (or consultants). (This criterion is an Emerging Practice.)</td>
<td>Emerging</td>
<td>PP</td>
</tr>
<tr>
<td>5.A.03</td>
<td>X X X X X</td>
<td>At least one staff member who has a certificate showing satisfactory completion of pediatric first-aid training, including managing a blocked airway and providing rescue breathing for infants and children, is always present with each group of children. When the program includes swimming and wading and when a child in the group has a special health condition that might require CPR, one staff person who has successfully completed training in CPR is present in the program at all times. (This is a required criterion.)</td>
<td>Required</td>
<td>PP; TS</td>
</tr>
<tr>
<td>5.A.04</td>
<td>X X X X X</td>
<td>The program follows these practices in the event of illness: a. If an illness prevents the child from participating comfortably in activities or creates a greater need for care than the staff can provide without compromising the health and safety of other children or if a child’s condition is suspected to be contagious and requires exclusion as identified by public health authorities, then the child is made</td>
<td>Random</td>
<td>PP; TS</td>
</tr>
</tbody>
</table>

AGE CATEGORIES
U = universal
I = infant
T = toddler/two
P = preschool
K = kindergarten

SOURCES OF EVIDENCE
O = Observable Criteria
FS = Family Survey
TS = Teaching Staff Survey
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comfortable in a location where she or he is supervised by a familiar caregiver. If the child is suspected of having a contagious disease, then until she or he can be picked up by the family, the child is located where new individuals will not be exposed.

b. The program immediately notifies the parent, legal guardian, or other person authorized by the parent when a child has any sign or symptom that requires exclusion from the program.

A program that allows ill children or staff to remain in the program implements plans that have been reviewed by a health professional about

c. what level and types of illness require exclusion;  
d. how care is provided for those who are ill but who are not excluded; and  
e. when it is necessary to require consultation and documentation from a health care provider for an ill child or staff member.

- Staff and teachers provide information to families verbally and in writing about any unusual level or type of communicable disease to which their child was exposed, signs and symptoms of the disease, mode of transmission, period of communicability, and control measures that are being implemented at the program and that families should implement at home.

b. The program has documentation that it has cooperative arrangements with local health authorities and has, at least annually, made contact with those authorities to keep current on relevant health information and to arrange for obtaining advice when outbreaks of communicable disease occur.

- Children of all ages have daily opportunities for outdoor play (when weather, air quality, and environmental safety conditions do not pose a health risk).

b. When outdoor opportunities for large-motor activities are not possible because of conditions, the program provides similar activities inside.

c. Indoor equipment for large-motor activities meets national safety standards and is supervised at the same level as outdoor equipment.

To protect against cold, heat, sun injury, and insect-borne disease, the program ensures that:

a. Children wear clothing that is dry and layered for warmth in cold weather.

b. Children have the opportunity to play in the shade. When in the sun, they wear sun-protective
c. **When public health authorities recommend** use of insect repellents due to a high risk of insect-borne disease, only repellents containing DEET are used, and these are applied only on children older than two months. Staff apply insect repellent no more than once a day and only with written parental permission.

For children who are unable to use the toilet consistently, the program makes sure that:

a. Staff use only commercially available disposable diapers or pull-ups unless the child has a medical reason that does not permit their use (the health provider documents the medical reason).

b. For children who require cloth diapers, the diaper has an absorbent inner lining completely contained within an outer covering made of waterproof material that prevents the escape of feces and urine. Both the diaper and the outer covering are changed as a unit.

c. Cloth diapers and clothing that are soiled by urine or feces are immediately placed in a plastic bag (without rinsing or avoidable handling) and sent home that day for laundering.

Staff check children for signs that diapers or pull-ups are wet or contain feces

d. at least every 2 hours when children are awake and

e. when children awaken.

f. Diapers are changed when wet or soiled.

g. Staff change children’s diapers or soiled underwear in the designated changing areas and not elsewhere in the facility.

h. Each changing area is separated by a partial wall or is located at least three feet from other areas that children use and is used exclusively for one designated group of children. For kindergartners, the program may use an underclothing changing area designated for and used only by this age group. *(This indicator only is an Emerging Practice.)*

i. At all times, caregivers have a hand on the child when the child is being changed on an elevated surface.

In the changing area, staff

j. post and

k. follow changing procedures (as outlined in the Cleaning and Sanitation Frequency Table).

l. These procedures are used to evaluate teaching staff who change diapers.
NAEYC Accreditation Criteria for Health Standard

<table>
<thead>
<tr>
<th>Number</th>
<th>Age Category</th>
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<th>Sources of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.A.09</td>
<td>X X X X X</td>
<td>The program follows these practices regarding hand washing:</td>
<td>Random</td>
<td>O; PP</td>
</tr>
</tbody>
</table>

a. Staff members and those children who are developmentally able to learn personal hygiene are taught hand-washing procedures and are periodically monitored.
b. Hand washing is required by all staff, volunteers, and children when hand washing would reduce the risk of transmission of infectious diseases to themselves and to others.
c. Staff assist children with hand washing as needed to successfully complete the task. Children wash either independently or with staff assistance.

Children and adults wash their hands
d. on arrival for the day;
e. after diapering or using the toilet (use of wet wipes is acceptable for infants);
f. after handling body fluids (e.g., blowing or wiping a nose, coughing on a hand, or touching any mucus, blood, or vomit);
g. before meals and snacks, before preparing or serving food, or after handling any raw food that requires cooking (e.g., meat, eggs, poultry);
h. after playing in water that is shared by two or more people;
i. after handling pets and other animals or any materials such as sand, dirt, or surfaces that might be contaminated by contact with animals; and
j. when moving from one group to another (e.g., visiting) that involves contact with infants and toddler/twos.

Adults also wash their hands
k. before and after feeding a child,
l. before and after administering medication,
m. after assisting a child with toileting, and
n. after handling garbage or cleaning.

Proper hand-washing procedures are followed by adults and children and include

o. using liquid soap and running water;

continued on next page
p. rubbing hands vigorously for at least 10 seconds, including back of hands, wrists, between fingers, under and around any jewelry, and under fingernails; rinsing well; drying hands with a paper towel, a single-use towel, or a dryer; and avoiding touching the faucet with just-washed hands (e.g., by using a paper towel to turn off water).

Except when handling blood or body fluids that might contain blood (when wearing gloves is required), wearing gloves is an optional supplement, but not a substitute, for hand washing in any required hand-washing situation listed above.

q. Staff wear gloves when contamination with blood may occur.

r. Staff do not use hand-washing sinks for bathing children or for removing smeared fecal material.

s. In situations where sinks are used for both food preparation and other purposes, staff clean and sanitize the sinks before using them to prepare food.

**Note:** The use of alcohol-based hand rubs in lieu of hand washing is not recommended for early education and child care settings. If these products are used as a temporary measure, a sufficient amount must be used to keep the hands wet for 15 seconds. Since the alcohol-based hand rubs are toxic and flammable, they must be stored and used according to the manufacturer’s instructions.

Precautions are taken to ensure that communal water play does not spread infectious disease. No child drinks the water. Children with sores on their hands are not permitted to participate in communal water play. Fresh potable water is used, and the water is changed before a new group of children comes to participate in the water play activity. When the activity period is completed with each group of children, the water is drained. Alternatively, fresh potable water flows freely through the water play table and out through a drain in the table. (This criterion is an Emerging Practice.)

**Safeguards are used with all medications for children:**

a. Staff administer both prescription and over-the-counter medications to a child only if the child’s record documents that the parent or legal guardian has given the program written permission.

b. The child’s record includes instructions from the licensed health provider who has prescribed or recommended medication for that child; alternatively, the licensed health provider’s office may give instructions by telephone to the program staff.
c. Any administrator or teaching staff who administers medication has specific training and a written performance evaluation updated annually by a health professional on the practice of the five right practices of medication administration:
   (1) verifying that the right child receives the
   (2) right medication (3) in the right dose
   (4) at the right time (5) by the right method with documentation of each right each time the medication is given. The person giving the medication signs documentation of items (1) through (5) above. Teaching staff who are required to administer special medical procedures have demonstrated to a health professional that they are competent in the procedures and are guided in writing about how to perform the procedure by the prescribing health care provider.

d. Medications are labeled with the child’s first and last names, the date that either the prescription was filled or the recommendation was obtained from the child’s licensed health care provider, the name of the licensed health care provider, the expiration date of the medication or the period of use of the medication, the manufacturer’s instructions or the original prescription label that details the name and strength of the medication, and instructions on how to administer and store it.

e. All medications are kept in a locked container.

5.A.12 X To reduce the risk of sudden infant death syndrome (SIDS):
   a. Infants, unless otherwise ordered by a physician, are placed on their backs to sleep on a firm surface manufactured for sale as infant sleeping equipment that meets the standards of the United States Consumer Product Safety Commission. *(This indicator is required of all programs with infants.)*
   b. Pillows, quilts, comforters, sheepskins, stuffed toys, and other soft items are not allowed in cribs or rest equipment for infants younger than eight months.
   c. If a blanket is used, the infant is placed at the foot of the crib with a thin blanket tucked around the crib mattress, reaching only as far as the infant’s chest.
   d. The infant’s head remains uncovered during sleep.
   After being placed down for sleep on their backs, infants may then be allowed to assume any comfortable sleep position when they can easily turn themselves from the back position.
### NAEYC Accreditation Criteria for Health Standard

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>5.A.13</td>
<td>X</td>
<td>After each feeding, infant’s teeth and gums are wiped with a disposable tissue (or clean soft cloth used only for one child and laundered daily) to remove liquid that coats the teeth and gums. <em>(This criterion is an Emerging Practice.)</em></td>
<td>Emerging</td>
<td>O</td>
</tr>
</tbody>
</table>
| 5.A.14 | X X          | a. Infants unable to sit are held for bottle-feeding. All others sit or are held to be fed.  
b. Infants and toddler/twos do not have bottles while in a crib or bed and  
c. do not eat from propped bottles at any time.  
d. Toddler/twos do not carry bottles, sippy cups, or regular cups with them while crawling or walking.  
e. Teaching staff offer children fluids from a cup as soon as the families and teachers decide together that a child is developmentally ready to use a cup. | Random             | O, PP               |
| 5.A.15 | X X          | Infants and toddler/twos do not have access to large buckets that contain liquid. | Always             | O                   |
| 5.A.16 | X X X        | At least once daily in a program where children older than one year receive two or more meals, teaching staff provide an opportunity for tooth brushing and gum cleaning to remove food and plaque. *(The use of toothpaste is not required.)* | Random             | O; PP               |

#### Ensuring Children’s Nutritional Well-being

<table>
<thead>
<tr>
<th>Number</th>
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<th>Sources of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.B.01</td>
<td>X X X X X</td>
<td>If the program provides food for meals and snacks (whether catered or prepared on-site), the food is prepared, served, and stored in accordance with the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP) guidelines.</td>
<td>Random</td>
<td>PP</td>
</tr>
</tbody>
</table>
| 5.B.02 | X X X X X    | Staff take steps to ensure the safety of food brought from home:  
a. They work with families to ensure that foods brought from home meet the USDA’s CACFP food guidelines.  
b. All foods and beverages brought from home are labeled with the child’s name and the date.  
c. Staff make sure that food requiring refrigeration stays cold until served.  
d. Food is provided to supplement food brought from home if necessary.  
e. Food that comes from home for sharing among the children must be either whole fruits or commercially prepared packaged foods in factory-sealed containers. *(This indicator only is an Emerging Practice.)* | Random; Emerging   | O; FS; PP           |

#### AGE CATEGORIES
- U = universal
- I = infant
- T = toddler/two
- P = preschool
- K = kindergarten

#### SOURCES OF EVIDENCE
- O = Observable Criteria
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- TS = Teaching Staff Survey
- PP = Program Portfolio
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</tr>
</thead>
</table>
| 5.B.03 | X X X X X | The program takes steps to ensure food safety in its provision of meals and snacks.  
a. Staff discard foods with expired dates.  
b. The program documents compliance and any corrections that it has made according to the recommendations of the program’s health consultant, nutrition consultant, or a sanitarian that reflect consideration of federal and other applicable food safety standards. | Random | PP |
| 5.B.04 | X X X X X | For all infants and for children with disabilities who have special feeding needs, program staff keep a daily record documenting the type and quantity of food a child consumes and provide families with that information. | Random | O; FS; PP |
| 5.B.05 | X X X X X | a. For each child with special health care needs or food allergies or special nutrition needs, the child’s health care provider gives the program an individualized care plan that is prepared in consultation with family members and specialists involved in the child’s care.  
b. The program protects children with food allergies from contact with the problem food. The program asks families of a child with food allergies to give consent for posting information about that child’s food allergy and, if consent is given, then posts that information in the food preparation area and in the areas of the facility the child uses so it is a visual reminder to all those who interact with the child during the program day. | Random | O; FS; PP |
| 5.B.06 | X X X X X | Clean sanitary drinking water is made available to children throughout the day. (Infants who are fed only human milk do not need to be offered water.) | Random | O |
| 5.B.07 | X X X X X | Liquids and foods that are hotter than 110 degrees Fahrenheit are kept out of children’s reach. | Random | O; TS; PP |
| 5.B.08 | X | If the program provides food to infants, then the program staff work with families (who are informed by their child’s health care provider) to ensure that the food is based on the infants’ individual nutritional needs and developmental stage. | Random | FS; PP |
| 5.B.09 | X | The program supports breastfeeding by  
a. accepting, storing, and serving expressed human milk for feedings  
accepting human milk in ready-to-feed sanitary containers  
b. labeled with the infant’s name and date and  
c. storing it in a refrigerator for no longer than 48 hours (or no more than 24 hours if the breast milk was previously frozen) or in a freezer at 0 degrees Fahrenheit or below for no longer than three months. | Random | FS; TS; PP |

*continued on next page*
### NAEYC Accreditation Criteria for Health Standard

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<tbody>
<tr>
<td>5.B.10</td>
<td>X</td>
<td>d. ensuring that staff gently mix, not shake, the milk before feeding to preserve special infection-fighting and nutritional components in human milk; and e. providing a comfortable place for breastfeeding and f. coordinating feedings with the infant’s mother.</td>
<td>Random; O; TS; PP</td>
<td>Emerging</td>
</tr>
<tr>
<td>5.B.11</td>
<td>X</td>
<td>a. Except for human milk, staff serve only formula and infant food that comes to the facility in factory-sealed containers (e.g., ready-to-feed powder or concentrate formulas and baby food jars) prepared according to the manufacturer’s instructions. <strong>(This indicator only is an Emerging Practice.)</strong> b. Bottle feedings do not contain solid foods unless the child’s health care provider supplies written instructions and a medical reason for this practice. c. Staff discard after one hour any formula or human milk that is served but not completely consumed or is not refrigerated. d. If staff warm formula or human milk, the milk is warmed in water at no more than 120 degrees Fahrenheit for no more than five minutes. e. No milk, including human milk, and no other infant foods are warmed in a microwave oven.</td>
<td>O; TS; PP</td>
<td></td>
</tr>
<tr>
<td>5.B.12</td>
<td>X</td>
<td>a. Teaching staff do not offer solid foods and fruit juices to infants younger than six months, unless that practice is recommended by the child’s health care provider and approved by families. b. Sweetened beverages are avoided. c. If juice (only 100% fruit juice is recommended) is served, the amount is limited to no more than four ounces per child daily.</td>
<td>O; PP</td>
<td></td>
</tr>
<tr>
<td>5.B.13</td>
<td>X X</td>
<td>The program does not feed cow’s milk to infants younger than 12 months, and it serves only whole milk to children of ages 12 months to 24 months.</td>
<td>PP</td>
<td></td>
</tr>
<tr>
<td>5.B.14</td>
<td>X X X</td>
<td>a. Staff do not offer children younger than four years these foods: hot dogs, whole or sliced into rounds; whole grapes; nuts; popcorn; raw peas and hard pretzels; spoonfuls of peanut butter; or chunks of raw carrots or meat larger than can be swallowed whole. b. Staff cut foods into pieces no larger than ¼-inch square for infants and ½-inch square for toddler/twos, according to each child’s chewing and swallowing capability.</td>
<td>O; PP</td>
<td></td>
</tr>
</tbody>
</table>

**AGE CATEGORIES**

- **U** = universal
- **I** = infant
- **T** = toddler/two
- **P** = preschool
- **K** = kindergarten

**SOURCES OF EVIDENCE**

- **O** = Observable Criteria
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- **CP** = Classroom Portfolio
The program prepares written menus, posts them where families can see them, and has copies available for families. Menus are kept on file for review by the consultant described in criterion 5.A.02.

5.B.15  

5.B.16  

a. The program serves meals and snacks at regularly established times.
b. Meals and snacks are at least two hours apart but not more than three hours apart.

Maintaining a Healthful Environment

5.C.01  
a. The routine frequency of cleaning and sanitizing all surfaces in the facility is as indicated in the Cleaning and Sanitation Frequency Table, p. 27.
b. Ventilation and sanitation, rather than sprays, air freshening chemicals, or deodorizers, control odors in inhabited areas of the facility and in custodial closets.

5.C.02  

5.C.03  

5.C.04  

Procedures for standard precautions are used and include the following:
a. Surfaces that may come in contact with potentially infectious body fluids must be disposable or made of a material that can be sanitized.
b. Staff use barriers and techniques that minimize contact of mucous membranes or of openings in skin with potentially infectious body fluids and that reduce the spread of infectious disease.
c. When spills of body fluids occur, staff clean them up immediately with detergent followed by water rinsing.
d. After cleaning, staff sanitize nonporous surfaces by using the procedure for sanitizing designated changing surfaces described in the Cleaning and Sanitation Frequency Table, p. 27.
e. Staff clean rugs and carpeting by blotting, spot cleaning with a detergent-disinfectant, and shampooing or steam cleaning.
f. Staff dispose of contaminated materials and diapers in a plastic bag with a secure tie that is placed in a closed container.

A toy that a child has placed in his or her mouth or that is otherwise contaminated by body secretion or excretion is either to be washed by hand using water and detergent, then rinsed, sanitized, and air dried or washed and dried in a mechanical dishwasher before it can be used by another child.

Staff maintain areas used by staff or children who have allergies or any other special environmental health needs according to the recommendations of health professionals.
### NAEYC Accreditation Criteria for Health Standard

<table>
<thead>
<tr>
<th>Number</th>
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</tr>
</thead>
</table>
| 5.C.05 | X X X X X    | a. Classroom pets or visiting animals appear to be in good health.  
b. Pets or visiting animals have documentation from a veterinarian or an animal shelter to show that the animals are fully immunized (if the animal should be so protected) and that the animal is suitable for contact with children.  
c. Teaching staff supervise all interactions between children and animals and instruct children on safe behavior when in close proximity to animals.  
d. Program staff make sure that any child who is allergic to a type of animal is not exposed to that animal.  
e. Reptiles are not allowed as classroom pets because of the risk for salmonella infection. | Random | O; PP |
| 5.C.06 | X            | Before walking on surfaces that **infants use specifically for play**, adults and children remove, replace, or cover with clean foot coverings any shoes they have worn outside that play area. If children or staff are barefoot in such areas, their feet are visibly clean. | Random | O; PP |

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### Table 1. Teacher–Child Ratios within Group Size
(Assessed in Criterion 10.B.12)

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Group Size</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6</td>
</tr>
<tr>
<td><strong>Infant</strong></td>
<td></td>
</tr>
<tr>
<td>Birth to 15 months(^b)</td>
<td>1:3</td>
</tr>
<tr>
<td><strong>Toddler/Two (12–36 months)(^b)</strong></td>
<td></td>
</tr>
<tr>
<td>12 to 28 months</td>
<td>1:3</td>
</tr>
<tr>
<td>21 to 36 months</td>
<td>1:4</td>
</tr>
<tr>
<td><strong>Preschool(^b)</strong></td>
<td></td>
</tr>
<tr>
<td>2½-year-olds to 3-year-olds (30–48 months)</td>
<td>1:6</td>
</tr>
<tr>
<td>4-year-olds</td>
<td>1:8</td>
</tr>
<tr>
<td>5-year-olds</td>
<td>1:8</td>
</tr>
<tr>
<td><strong>Kindergarten(^d)</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1:10</td>
</tr>
</tbody>
</table>

**Notes:** In a mixed-age preschool group of 2½-year-olds to 5-year-olds, no more than four children between the ages of 30 months and 36 months may be enrolled. The ratios within group size for the predominant age category apply. If infants or toddlers are in a mixed-age group, then the ratio for the youngest child applies.

Ratios are to be lowered when one or more children in the group need additional adult assistance to fully participate in the program (1) because of ability, language fluency, developmental age or stage, or other factors or (2) to meet other requirements of NAEYC Accreditation.

A group refers to the number of children who are assigned for most of the day to a teacher or a team of teaching staff and who occupy an individual classroom or well-defined space that prevents intermingling of children from different groups within a larger room or area.

Group sizes as stated are ceilings, regardless of the number of staff.

Ratios and group sizes are always assessed during site visits for NAEYC Accreditation in criterion 10.B.12, which is not a required criterion. However, experience suggests that programs that exceed the recommended number of children for each teaching staff member and total group sizes will find it more difficult to meet each standard and achieve NAEYC Accreditation. The more these numbers are exceeded, the more difficult it will be to meet each standard.

\(^a\) Includes teachers, assistant teachers–teacher aides; some exceptions may apply; see TORCH (www.naeyc.org/selfstudy).

\(^b\) These age ranges purposefully overlap. If a group includes children whose ages range beyond the overlapping portion of two age categories, then the group is a mixed-age group. For mixed-age groups, universal criteria and criteria relevant to the age categories for that group apply.

\(^c\) Group sizes of 10 for this age category would require an additional adult.

\(^d\) Kindergarten refers to children enrolled in a public or private kindergarten program.
What is a group?
A group of children is those children who are assigned for most of the day to a specific teacher or team of teaching staff members and who occupy an individual classroom or well-defined space that prevents intermingling of children from different groups within a larger room or area. If children from different groups do intermingle within a larger room or area for more than two hours, if the composition of the original group of children changes by more than 50 percent, or if both occur, then this intermingled group is considered a separate group.

For example, if kindergartners join an all-day preschool group from 4:00 to 6:00 p.m., then the program would report one preschool group from 8:00 a.m. to 4:00 p.m. and one mixed-age group of kindergartners and preschool age children from 4:00 to 6:00 p.m.

When do I have a mixed-age group?
If a group includes children whose ages range beyond the overlapping portion of two age categories, then the group is a mixed-age group. For mixed-age groups, universal criteria and criteria relevant to the age categories for that group apply. For example, a group of children 24 to 48 months must meet universal, toddler/two, and preschool criteria.

What if we serve school age children?
For NAEYC Accreditation, please count only groups that include eligible children (within the ages of birth through kindergarten).

A mixed-age group that serves ages that are eligible and ages that are not eligible for NAEYC Accreditation must be included in the accreditation process if at least 50 percent of the children served in the group are eligible—from birth through kindergarten. (For example, if an after-school group includes kindergartners and those of school age, it must be included in the accreditation process if the kindergartners make up at least 50 percent of the children in the group.) Groups in which fewer than 50 percent of the children represent eligible ages may not be included in the NAEYC Accreditation process.

What does NAEYC consider a part-day group?
Full-day refers to more than five hours. Part-day refers to five hours or less.
### Table 2. Cleaning and Sanitation Frequency Table
(see 5.A.08, 5.C.01, 5.C.02, and 9.C.06)

<table>
<thead>
<tr>
<th>Area: Classrooms, child care, and food areas</th>
<th>Clean&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Sanitize&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Countertops, tables</td>
<td>X</td>
<td>X</td>
<td>Daily and when soiled</td>
</tr>
<tr>
<td>Food preparation and service surfaces</td>
<td>X</td>
<td>X</td>
<td>Before and after contact with food activity, between preparation of raw and cooked foods</td>
</tr>
<tr>
<td>Floors</td>
<td>X</td>
<td>X</td>
<td>Daily and when soiled</td>
</tr>
<tr>
<td>Door and cabinet handles</td>
<td>X</td>
<td>X</td>
<td>Daily and when soiled</td>
</tr>
<tr>
<td>Carpets and large area rugs</td>
<td>X</td>
<td>Daily: Vacuum when children are not present; clean with a carpet cleaning method consistent with local health regulations (and only when children will not be present until the carpet is dry) Monthly: Clean carpets at least monthly in infant areas and at least every three months in other areas and when soiled</td>
<td></td>
</tr>
<tr>
<td>Small rugs</td>
<td>X</td>
<td>Daily: Shake outdoors or vacuum Weekly: Launder</td>
<td></td>
</tr>
<tr>
<td>Utensils, surfaces, and toys that go into the mouth or have been in contact with saliva or other body fluids</td>
<td>X</td>
<td>X</td>
<td>After each child’s use (or use disposable, one-time use utensils or toys)</td>
</tr>
<tr>
<td>Toys</td>
<td>X</td>
<td>Weekly and when soiled</td>
<td></td>
</tr>
<tr>
<td>Dress-up clothes not worn on the head</td>
<td>X</td>
<td>Weekly</td>
<td></td>
</tr>
<tr>
<td>Sheets and pillowcases, individual cloth towels (if used), combs and hairbrushes, washcloths, and machine-washable cloth toys</td>
<td>X</td>
<td>Weekly and when visibly soiled (items are used by only one child)</td>
<td></td>
</tr>
<tr>
<td>Blankets, sleeping bags, and cubbies</td>
<td>X</td>
<td>Monthly and when soiled</td>
<td></td>
</tr>
<tr>
<td>Hats</td>
<td>X</td>
<td>After each child’s use (or use disposable hats that only one child wears.)</td>
<td></td>
</tr>
<tr>
<td>Cribs and mattresses</td>
<td>X</td>
<td>Weekly or before use by a different child</td>
<td></td>
</tr>
<tr>
<td>Mops and cleaning rags</td>
<td>X</td>
<td>Before and after a day of use, wash, rinse, and sanitize mops and cleaning rags.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area: Toilet and diapering areas</th>
<th>Clean&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Sanitize&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand-washing sinks, faucets, surrounding counters</td>
<td>X</td>
<td>X</td>
<td>Daily and when soiled</td>
</tr>
<tr>
<td>Soap dispensers</td>
<td>X</td>
<td>X</td>
<td>Daily and when soiled</td>
</tr>
<tr>
<td>Toilet seats, toilet handles, cubicle handles and other touchable surfaces, floors</td>
<td>X</td>
<td>X</td>
<td>Daily or immediately if visibly soiled</td>
</tr>
<tr>
<td>Toilet bowls</td>
<td>X</td>
<td>X</td>
<td>Daily</td>
</tr>
<tr>
<td>Doorknobs</td>
<td>X</td>
<td>X</td>
<td>Daily</td>
</tr>
<tr>
<td>Changing tables</td>
<td>X</td>
<td>X</td>
<td>After each child’s use</td>
</tr>
<tr>
<td>Potty chairs</td>
<td>X</td>
<td>X</td>
<td>After each child’s use. (Use of potty chairs in child care is discouraged because of high risk of contamination.)</td>
</tr>
<tr>
<td>Any surface contaminated with body fluids (i.e., saliva, mucus, vomit, urine, stool, or blood)</td>
<td>X</td>
<td>X</td>
<td>Immediately</td>
</tr>
</tbody>
</table>


<sup>a</sup> Cleaning is removing dirt and soil with soap (or detergent) and water.

<sup>b</sup> Sanitizing is removing dirt and certain bacteria so that the number of germs is reduced to such a level that the spread of disease is unlikely.
What Are the Connections between the Health Standard and the Other Standards?

Each standard represents an essential, interlocking element of high-quality programs for all children from birth through kindergarten. The criteria within each standard are organized by topic areas to make the meaning and the value of the standard more clear. For example, the topic area “Promoting and Protecting Children’s Health and Controlling Infectious Disease” addresses practices for health promotion and protection for children and adult staff in the program. The criteria provide the details for ensuring that programs include plans and policies for immunizations; communicable disease; CPR and first-aid training; standards for diapering, hand washing, feeding, and dispensing of medication; and the use of health professionals.

Standards are not independent of one another. Criteria not only are grouped within particular standards to make sense and to add context but also are connected across standards. Often, similar ideas appear in different standards, but each idea is expressed within the perspective of a particular standard. Looking at the criteria across standards therefore allows the examination of ideas from many perspectives. For example, consider again the topic area “Promoting and Protecting Children’s Health and Controlling Infectious Disease.” This topic area requires contributions from other standards to be fully achieved. With the exception of Standard 1: Relationships, each of the standards addresses specific issues related to the health and safety for children:

- **Standard 2: Curriculum**
  - 2.K.01—Children are provided varied opportunities and materials that encourage good health practices such as serving and feeding themselves, rest, good nutrition, exercise, hand washing, and tooth brushing.
  - 2.K.02—Children are provided varied opportunities and materials to help them learn about nutrition, including identifying sources of food and recognizing, preparing, eating, and valuing healthy foods.

- **Standard 3: Teaching**
  - 3.A.02—Teachers design an environment that protects children’s health and safety at all times.
  - 3.A.03—Teaching staff support children’s needs for physical movement, sensory stimulation, fresh air, rest, and nourishment.

- **Standard 4: Assessment of Child Progress**
  - 4.B.02—Assessments obtain information on all areas of children’s development and learning, including cognitive skills, language, social-emotional development, approaches to learning, health, and physical development (including self-help skills).

- **Standard 6: Teachers**
  - 6.A.03—Before working alone with children, new teaching staff are given an initial orientation that introduces them to fundamental aspects of program operation, including
    a. program philosophy, values, and goals;
    b. expectations for ethical conduct;
    c. health, safety, and emergency procedures;
    d. individual needs of children they will be teaching or caring for;
    e. accepted guidance and classroom management techniques;
    f. daily activities and routines of the program;
    g. program curriculum;
    h. child abuse and neglect reporting procedures;
    i. program policies and procedures;
    j. NAEYC Early Childhood Program Standards; and
k. regulatory requirements. Follow-up training expands on the initial orientation.

- Standard 7: Families
  - 7.C.05—Program staff provide families with information about programs and services from other organizations. Staff support and encourage families’ efforts to negotiate health, mental health, assessment, and educational services for their children.

- Standard 8: Community Relationships
  - 8.A.01—Program staff maintain a current list of child and family support services available in the community based on the pattern of needs they observe among families and based on what families request (e.g., health, mental health, oral health, nutrition, child welfare, parenting programs, early intervention–special education screening and assessment services, and basic needs such as housing and child care subsidies). They share the list with families and assist them in locating, contacting, and using community resources that support children’s and families’ well-being and development.

- Standard 9: Physical Environment
  - Topic Area “Environmental Health” addresses conditions that ensure children and adults a safe and healthy environment that is free from toxic substances, insects, poisonous plants, and smoke and that has procedures in place to address problems arising from air pollution, allergens, and noise levels.

- Standard 10: Leadership and Management
  - Topic Area “Health, Nutrition, and Safety Policies and Procedures” addresses policies, systems, and procedures that are needed to support safe and healthy conditions and practices.

In addition to the connections that exist among various standards and criteria, several key themes emerge across the 10 standards. These themes relate to the most fundamental aspect of NAEYC Accreditation—respect for each unique individual (child, parent or family member, and staff member)—and they address cultural and linguistic diversity, attention to special needs, and the importance of genuine partnerships between families and program staff. Specific information about each of the key themes is provided in the next section to help you consider how they are addressed in your program.

Each Self-Study book provides guidance throughout, emphasizing the key themes and highlighting certain connections to help programs interpret and link criteria. Ultimately, however, programs will also need to create their own linkages because the linkages are really about putting the pieces together to create a story of program quality. Each program must use the standards and criteria to tell its own story, and program staff must make their own links between criteria and across standards to make sense of the criteria for themselves.
The Self-Study process is self-paced and self-directed; there are no requirements, and the findings will not be reported to NAEYC. More information about Step 1: Enrollment/Self-Study is in Section 4. Section 3 offers guidance and information about the things you may want to consider as you study how your program develops and maintains health practices. The following questions organize the information and focus your thinking about your health practices and how they contribute to quality in your program:

- What will help you create shared understandings about quality health practices?
- How are children of different ages supported by your program’s health practices?
- How is sensitivity to diversity in culture and language demonstrated in your program’s health practices?
- How are your program’s health practices responsive to children’s special needs?
- What topic areas or criteria in the Health Standard are important to discuss?
- Are you open to changing how you develop and implement your health practices?

What Will Help You Create Shared Understandings about Quality Health Practices?

During the Self-Study process, programs should develop or strengthen structures that ensure genuine communication between family members and staff and then work to build shared understanding of basic information about choices, development, and implementation of health practices. The following topics can guide your thinking as you form your Self-Study team and can help to build understanding.

Forming a Self-Study Team

Partnering with families and including staff members in efforts toward program improvement are cornerstones of the NAEYC Self-Study and accreditation processes. It is important to develop a way for staff members and families to share both ideas and responsibility in Step 1: Enrollment/Self-Study, and it is required in Step 2: Application/Self-Assessment. More information about the requirements for Step 2 is in Section 5.

Every family and staff member should have the opportunity to participate in Self-Study and provide feedback about their perceptions of the program’s strengths and weaknesses. In addition, it is important to identify a smaller group to help lead the effort. When selecting this team, programs benefit by choosing individuals from both families and teaching staff who are:

- willing to participate in the additional tasks that are necessary to successfully completing the Self-Study and accreditation process,
- committed to maintaining a positive attitude toward learning, and
- open to constructive criticism and dialogue.
Finding and Using Resources

As a process, Self-Study encourages you to expand your vision and knowledge of early childhood practice beyond the scope of your own program. It is essential for programs to look to the early childhood field for knowledge, resources, and professional expertise. Linking with other professionals helps make the planning and implementation of program improvement strategies easier and helps to ensure that program practices are up to date. Fundamentally, Self-Study involves both program improvement and professional development. Keep track of your resources as part of efforts to document improvement and development.

Look to the early childhood field for knowledge, resources, and professional expertise about quality health practices. Early childhood experts have been thinking about the importance of these practices in quality programs for a long time. Information, resources, and strategies are available to help programs that need guidance in this area.

The following list suggests resources and strategies for programs to consider for help and support:

- Find a state or local NAEYC Affiliate or facilitation project working on similar issues.
- Join with local programs and share efforts.
- Meet or speak with consultants on health, nutrition, sanitation, and hazards to gather suggestions for improvement. Document your conversations, and include copies of their reports.
- Ask other people such as volunteers, board members, and community specialists who work with the program for input and ideas.
- Consult child development and early childhood education specialists to assist in developing strategies to improve the program and to conduct relevant training and staff development opportunities.

In addition to these suggestions, the Resources section in this book provides additional sources of potential support, including a form that guides the observations you will be making and a list of relevant Web sites that contain articles and publications about this standard. The literature review, also in the Resources section, provides a summary of evidence that supports the criteria included in the Health Standard. The references it mentions (see the Bibliography in Section 6) represent a range of sources: academic research; national reports; summaries of research, descriptive, survey, and interview data; and multi-authored position statements. These references provide support and rationale for the criteria, and they represent both national and international research. You can use this information to help program stakeholders (staff, families, and funders) understand why you are considering certain improvements and why those improvements are investments worth making.

Over the course of the Self-Study, the Self-Study team can take responsibility for the following tasks:

- Meet with family members, staff, and others to discuss the process, what is involved, and the status of the program improvement efforts.
- Determine priorities and timelines for program improvement.
- Determine roles and responsibilities for specific Self-Study tasks.
- Find and use resources that can support the Self-Study effort.

Frequently Asked Questions about Health

The frequently asked questions and the answers that are outlined here can be provided not only to program staff but also to family members and may be the basis for both formal and informal conversation, discussion, and elaboration.

What is a child care health consultant, and why do we need one? Preparing for NAEYC Accreditation provides an opportunity for early childhood programs to work with a Child Care Health Consultant, if they have not done so already. A child care health consultant is a health professional with expertise in child health and development as well as issues relating to health promotion and injury and illness prevention in early childhood settings. The position, duties, and qualifications are described in Caring for Our Children (CFOC; AAP 2002)* and in the summary version of the Child Care Health Consultants Standards that are online at http://nrc.uchsc.edu/SPINOFF/index.htm.

Child care health consultants can be pediatricians, family health physicians, pediatric nurse practitioners, community health nurses, or other health professionals. If they are assisting a program to achieve NAEYC Accreditation, then they must have familiarity

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* See Bibliography (p. 62) for references.
with the accreditation criteria. In addition, child care health consultants should be knowledgeable about CFOC Standard 1.041, which includes the following:

- Reference standards in *Caring for Our Children*
- Day-to-day operations of the program
- Child care licensing requirements
- Disease reporting requirements
- Immunization requirements for children and staff
- Injury prevention for children
- Staff health, including occupational health risks
- Oral health for children
- Nutrition for children
- Inclusion for children with special health needs
- Recognition and reporting requirements for child abuse and neglect
- Community resources for child and family health and mental health

Skills of a health consultant include the following:

- Conducting training and health education
- Providing advice on site, by phone, or both
- Assessing the need for and providing referrals to community resources
- Developing and updating policies for programs
- Reviewing health records of staff and children
- Assisting teaching staff with the inclusion of children with special health care needs
- Consulting with a child’s health care provider about prescribed medication or other special health needs
- Interpreting the standards or regulations and providing technical support to implement them

Locating a health consultant may be easier in those states that require visits by a health consultant as part of their licensing regulations. The Healthy Child Care America (HCCA) Campaign Web site maintains a list of state HCCA and American Academy of Pediatrics (AAP) contacts that may be useful in locating a consultant. Additional sources are other early childhood education programs that use consultants, local regulatory agencies, local health agencies, clinics and pediatric hospitals, the state chapter of the AAP or local Head Start programs that have a health consultant. Some programs have also used pediatric health care professionals who are parents of enrolled children. However, it is important to make sure that the consultant has knowledge of health issues specific to center and school settings, a public health perspective, and knowledge of confidentiality issues related to children, families, and staff.

Use of a child care health consultant is an Emerging Practice criterion. Programs are

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**Related NAEYC Accreditation Criterion**

**Criterion 5.A.02**—The program has and implements a written agreement with a health consultant who is either a licensed pediatric health professional or a health professional with specific training in health consultation for early childhood programs.

a. The health consultant visits at least two times a year and as needed. Where infants and toddler/twos are in care, the health consultant visits the program at least four times a year and as needed.

b. The health consultant observes program practices and reviews and makes recommendations about the program’s practices and written health policies to ensure health promotion and prevention of infection and injury. The consultation addresses physical, social-emotional, nutritional, and oral health, including the care and exclusion of ill children.

c. Unless the program participates in the United States Department of Agriculture’s Child and Adult Care Food Program, at least two times a year a registered dietitian or pediatric public health nutritionist evaluates the menus for nutritional content; portion sizes; nationally recommended limits on juice, sugar, sodium, and saturated fats; food service operations; special feeding needs to be met by the program; and procedures used for food brought from home.

d. The program documents compliance and implements corrections according to the recommendations of the consultant (or consultants). *(This criterion is an Emerging Practice.)*
encouraged to establish a working relationship with a child care health consultant because of the benefits that the relationship ensures for the health and well-being of children and staff in the program.

Do we have to use DEET? The criterion referencing DEET (5.A.07) specifically refers to situations in which public health officials are recommending the use of insect repellents because of a high risk of insect-borne disease. The existence and threat of the West Nile virus, which is transmitted by mosquitoes, has heightened awareness of the preventive function of insect repellent (AAP: Committee on Environmental Health 2003). Insect repellents containing the product DEET are the most effective mosquito repellents available, and they protect children from a host of insect bites. Products vary as to the amount of DEET contained within them, typically from 10 percent to 30 percent. Products containing lower concentrations need to be applied more frequently than products with higher concentration. Consistent with recommendations for sun exposure and use of sunscreen, insect repellent containing DEET is not recommended for infants younger than the age of two months. Parent consent is necessary before using products containing DEET or other chemicals.

How Are Children of Different Ages Supported by Your Health Practices?

Children need different health care depending on their age and developmental level. For this reason, each of the NAEYC Accreditation Criteria was carefully considered for its appropriateness across age categories—infant, toddler/two, preschool, and kindergarten. Many of the criteria have been determined to be important (universal) for all age category, but this designation does not mean that implementation of those criteria will be the same for each age category. This thinking is true for all criteria, but the examples of universal criteria that follow specifically refer to Health Standard criteria.

Age-appropriate health screening and assessment by health care professionals helps keep children well and safe. Health screening also identifies young children who are at risk for developing a number of health problems, including hearing or vision difficulties; chronic health problems such as asthma, lead poisoning, developmental delays; and injury. Early childhood programs support families by making sure children receive periodic health care, by knowing the schedule for preventive health care, and by reminding families when children are due for their health checkups. Early identification of medical conditions may help resolve them at an early age or at least limit later disability. Guidelines for routine preventive health care have been developed by the AAP and are available at aapolicy.aapublications.org. The AAP recommends that young children age six years and younger receive routine health care at 2, 4, 6, 9, 12, 15, 18, and 24 months and then annually through age six years.

Children in group care experience illness at higher rates than children who remain at home, and infants in group settings have more visits to a pediatrician and higher rates of hospitalization for illness. Careful attention to hand washing, environmental cleaning and sanitation, and proper toileting and diapering procedures can reduce the transmission of disease. Healthy and safe early childhood environments protect children from injury and illness at critical periods of development and when children have little control of their environment.
Age and development of children are of prime concern when considering the types of foods offered at early childhood programs. The types of food offered to children in high-quality programs are determined based on knowledge of children’s nutritional needs, physical capabilities, and preferences. For example, the recommended diet for infants consists of breast milk or formula. Cow’s milk is not considered appropriate for children younger than 12 months, after which time whole milk is recommended. For children younger than the age of two years, new guidelines are available to inform parents and caregivers about the nutritional needs of infants and toddlers (USDA Agricultural Research Service 2005). Team Nutrition, a division of the USDA Food and Nutrition Service has also contributed greatly to the information base on healthy and developmentally appropriate food choices for young children (USDA: Team Nutrition 2002). Their information on feeding infants provides a comprehensive and current reference related to all aspects of food preparation, choice, and developmental concerns with respect to food content. Informed staff members use their knowledge to develop safe meal plans for children. Experts in the medical and nutrition fields recommend that solid food and fruit juices not be served to children younger than the age of six months (AAP, APHA, & NRCHSCC 2003). It is also recommended that

- infants unable to sit are held for bottle-feeding and that all others sit or are held to be fed.
- infants and toddler/twos do not have bottles while in a crib or bed and do not eat from propped bottles at any time.
- toddler/twos do not carry bottles, sippy cups, or regular cups with them while crawling or walking.
- teachers offer children fluids from a cup as soon as the families and teachers decide together that a child is developmentally ready to use a cup.

In addition, programs should inform families about choking hazards. For example, hot dogs, carrots, and whole grapes are unsafe for children younger than the age of four years (for a more complete discussion of choking, visit www.globalhealthychildcare.org).

**How Is Sensitivity to Diversity in Culture and Language Demonstrated in Our Health Practices?**

Culture includes values, beliefs, and practices that stem from ethnic, racial, economic, religious, and political experiences. These historical dynamics affect the everyday experiences of families and profoundly influence the child’s development and relationship with the world.

The following health issues are those that program staff may want to explore more fully to better understand (a) the importance of family belief systems, (b) how deeply they are felt, and (c) how to reach compromise with families if needed to improve a child’s health and safety. A child care health consultant or the family’s primary health care provider can often assess and help mediate any unsafe practices.

**Causes of Physical Illness.** Among cultures, beliefs differ about why children get sick and include the following causes of illness: exposure to cold or rain, improper diet, excessive emotions, the system being out of balance, too much or too little wind, a curse, an evil eye, God’s will, and germs. Programs must be sensitive to beliefs while at the same time providing factual information.

**Treatment of Illness and Specific Symptoms.** The treatment of illness often corresponds to the beliefs about the cause of illness. Many “cures” exclude any other type of medical intervention. Many families, however, are agreeable to using complementary treatments by licensed health care professionals as long as they are not asked to give up their own beliefs. Some practices may be confused with child abuse, and fam-
Families may need to understand your concern when you see signs from practices such as “coining” or “cupping.” Some teaching staff may be asked to give herbal medication that has not been prescribed by a licensed health care professional. This practice is not allowed.

Beliefs about Immunization. Some families may not want to have their children immunized because of fears of needles or side effects, because of cultural or religious beliefs, or because of a misunderstanding about the importance of immunization. Although most state regulations allow for a waiver for personal or religious beliefs, early childhood program staff or a health consultant should make every effort to determine and respond to family reasons not to immunize.

Child-Rearing Practices. Differences in toileting; in eating, feeding, and nutrition; as well as in sleeping routines and discipline are those that are most likely to come to the attention of the program staff and will require mutual problem solving among the staff and then between the staff and the families in care.

Food. Communication with families can help identify a child’s food preferences as well as the values families hold around (a) food and eating (e.g., whether a child is raised in a vegetarian or kosher household) and (b) when children should feed themselves. Information obtained from families about food choices provides teachers with important information that then becomes incorporated into their daily plans for children.

Families have varied views on feeding young children. Some mothers choose to breast-feed, a method recommended by the AAP (AAP: Work Group on Breastfeeding 1997). In support of this decision, programs follow recommended practices for storing and preparing breast milk as well as providing space within the program for mothers to breast-feed. Discussion with family members about when to introduce certain foods, in what order to present foods at home, and other related issues support the partnership between parents and programs. If, for example, a family member chooses not to offer juice to his or her child, then programs are asked (and expected) to respect that choice. If meat products are not served at home, then teachers also support that choice.

Programs may need to seek support and assistance to ensure that health and safety information is available to family members who speak a language other than English. It is important that written materials about the health and safety of children be made available to families in multiple languages as needed. Alternatives can include making available someone who is able to orally translate important information.

Child care centers, preschools, and kindergartens provide a dynamic intersection for honoring cultural diversity and an opportunity to close the gap in the disparate and often unsatisfactory health status of children from various racial and ethnic groups. Knowledge of the health status and underlying factors for poor health in children helps to play an important role in supporting the healthy development of all children in early childhood settings.

How Are Your Program’s Health Practices Responsive to Children’s Special Needs?

Although teaching staff initially may feel uncomfortable caring for children with special health or medical needs, they will feel more prepared if they have training so they know what to expect and how to respond to the child’s needs. Examples of conditions that involve special health care needs include

What Are Coining and Cupping?

Coining and cupping are traditional forms of healing therapy from Asian cultures that are designed to restore health. In coining, a coin is used to firmly rub warm oil into the body until a mark appears. In cupping, a cup is applied to the skin with suction that can result in a bruise or lesion. For additional information about these and other cultural issues related to health among recent immigrants, see http://ethnomed.org.
(a) asthma and allergies, (b) chronic health conditions such as diabetes, and (c) seizure disorders. Whatever the need, the approach requires teamwork with other health professionals and possibly the involvement of an inclusion specialist.

It is important for program staff to remain current on state and federal laws that relate to working with children with health problems. Program staff also need an understanding of the laws related to inclusion and the development of an inclusion plan. The inclusion plan will include what adaptations need to be made in the usual activities, equipment, routines (feeding, sleeping, toileting, communicating), and policies. The legal requirements and the goals of an inclusion plan are to promote successful participation, develop competence, promote peer acceptance, and avoid overprotection. The plan also will prepare the program to respond to emergencies and to seek the advice of the child's health care provider.

Food allergies are an important factor in determining healthful food options for children. A significant percentage of young children have food allergies (AAP 2002; Burks & Stanley 1998). Programs, working with families, can help prevent potentially life threatening allergic reactions by ensuring continuous communication with parents and making sure that staff are well trained, prepared, and knowledgeable (including being able to recognize symptoms) about the specific allergies that children have.

When children have special health needs that require the program to provide accommodations (e.g., children who have feeding tubes, use wheel chairs, or experience medical conditions such as cerebral palsy or any of a variety of syndromes), program staff need to be fully trained and confident in their abilities to meet the needs of children, always keeping in mind that the child is, first, a child.

What Topic Areas or Criteria in the Health Standard Are Important to Discuss?

Some of the criteria in the Health Standard need to be discussed and thought about more than others. Some may be harder to understand, may produce different interpretations by different staff, and may seem at first to be inconsistent with program or personal philosophy. Considering the following discussion topics and deciding on some discussion topics for yourselves will contribute to efforts to gain shared understanding of the health practices in your program.

When engaging in discussion, the following strategies ensure that the discussion will be productive:

- Designate a leader who sets the ground rules and manages the discussion.
- Set specific times for discussion.
- Have everyone help decide on the topic.
- Ensure that everyone has an opportunity to talk.
- Emphasize that all points of view are important.
- Designate someone to be responsible for keeping track of ideas for later use.

Related NAEYC Accreditation Criteria

Criterion 5.B.04—For all infants and for children with disabilities who have special feeding needs, program staff keep a daily record documenting the type and quantity of food a child consumes and provide families with that information.

Criterion 5.B.05—a. For each child with special health care needs or food allergies or special nutrition needs, the child's health care provider gives the program an individualized care plan that is prepared in consultation with family members and specialists involved in the child's care. 
b. The program protects children with food allergies from contact with the problem food. The program asks families of a child with food allergies to give consent for posting information about that child's food allergy and, if consent is given, then posts that information in the food preparation area and in the areas of the facility the child uses so it is a visual reminder to all those who interact with the child during the program day.
The following questions introduce possible discussion topics that are linked to specific criteria in the Health Standard:

- Does our program mission, our values, or both cause us to think differently about some of the health criteria? If so, how can we work to resolve this difference and stay true to our philosophy as well as maintain healthy practices?
- What resources do we need to find to support our work on the health criteria?
- When we struggle with some of the criteria, what are the underlying reasons? Does it have to do with cost, the limitations of our community, the limitations of our facility, or something else? How will we resolve these problems?

Are You Open to Changing Your Health Practices?

Regardless of how a program approaches Self-Study, it requires something very difficult—change. Because the object of Self-Study is for programs to commit to a process of continuous improvement, it may be helpful for you to think about and keep track of how your program approaches and is affected by change. Consider these questions:

- How important is tradition to you? Are you open to change, or do you usually prefer to keep things the same?
- Are you willing to think about yourselves and your work honestly, speak candidly, listen to the ideas of everyone, and consider program improvement an ongoing endeavor?
- Are you willing to gather evidence that will help you determine your strengths and weaknesses and do the work that will improve your program?
- How does change in the development and implementation of health practices affect other aspects of the program?

Self-Study encourages you to reflect on your current practices and to really think about what is working and what could work better. This type of reflection can (a) help you gain new ways of seeing children, (b) develop new insights about the effectiveness of your own practices in light of children’s responses to the learning environment and the people in it, and (c) develop deeper understandings of children’s experiences, including their feelings and development.

Teachers who take the time and effort to explore their own practice become more able to decide what they want to know about their work as well as better able to describe what they do and why they do it.
Step 1: Enrollment/Self-Study is the first of four steps toward achieving NA EYC Accreditation. It is an essential step toward achieving NA EYC Accreditation, but programs also may enroll and engage in Self-Study even if they have no intention of seeking NA EYC Accreditation.

The purpose of Self-Study is to encourage programs to engage in a structured approach to program improvement that considers all of the necessary components of a high-quality program. The Self-Study process requires programs to methodically discern and document actual program practices and then determine how to improve them if necessary.

Pursuing NA EYC Accreditation and engaging in Self-Study demonstrates a commitment to best practice and continuous program quality improvement, including ongoing reflection on classroom and program practices. To make the most of the Self-Study process, NA EYC recommends six tasks:

1. Creating shared understandings of key concepts about accreditation, the standards, the criteria, and implications for the program
2. Gathering information by using the tools
3. Determining strengths and weaknesses
4. Developing improvement plans as needed
5. Making improvements and documenting progress
6. Evaluating results and determining next steps

Programs that complete these tasks in Self-Study will be better prepared for the formal Self-Assessment of program quality that occurs at Step 2: Application/Self-Assessment. The differences between Self-Study and Self-Assessment will be explored further in Section 5. Note that although NA EYC provides programs with guidelines, there are no requirements for Self-Study. Programs are not required to submit their Self-Study findings to NA EYC.

Create Shared Understandings

Creating shared understandings of key concepts about NA EYC Accreditation, the standards, the criteria, and implications for the program is an important component of a successful Self-Study process. Members of the program staff and leadership should understand the steps and requirements of the NA EYC Accreditation process. At a minimum, this group includes the program administrator, teachers and other teaching staff members, and representatives of the program’s governance structure. Teaching staff members and program leadership should thoughtfully consider how their program policies and procedures demonstrate the 10 NA EYC Early Childhood Program Standards and Accreditation Criteria. The criteria are statements of best practice for children and families. They are sometimes complex statements that may seem open to multiple interpretations. NA EYC has developed guidance to help programs further understand the criteria and how they will be assessed. The guidance is regularly updated.
and may be found at TORCH (see www.naeyc.org/selfstudy for details).

The following are suggested questions for programs to ask in Self-Study:

- What are we trying to achieve in our classrooms?
- Do our program policies and procedures help us achieve these goals?
- How do our program policies and procedures as well as classroom practices demonstrate that the criteria are met?
- Which criteria are not met?

More strategies for creating shared understandings were discussed in detail earlier in Section 3 of this book.

**Gather Evidence**

Evidence is a critical concept for NAEYC Accreditation. The process is designed to focus on evidence of a program’s ability to meet the program standards and accreditation criteria consistently over time. Evidence includes observable evidence that can be directly seen—in classroom practices or as part of the program facility; survey evidence that reflects the opinions of key program stakeholders, including families and teaching staff members; and portfolio evidence that is specifically collected by members of the program staff to document the policies, procedures, and practices for not only individual classrooms but also the overall program.

NAEYC has developed specific tools to help you (a) assess your strengths and weaknesses as they relate to each standard and its associated criteria and (b) begin collecting evidence that your program is meeting the criteria and is likely to do so regularly in the future. Some of the tools are designed primarily to assist in your program improvement efforts; others are specific to the NAEYC Accreditation process and must be followed in Steps 2 and 3. Regardless of your program’s intent about pursuing NAEYC Accreditation, the information you gather will provide tangible evidence to families and others in your community of how your program meets this important standard.

This section provides information about the tools that are available. The specific tools, as well as other resource information, are available at TORCH (see www.naeyc.org/selfstudy for more details).

**Teaching Staff Survey and Family Survey**

Opinions and thoughts from members of the teaching staff and families will inform program efforts to develop and improve child outcomes and program quality. Programs may choose to use surveys during Self-Study. However, they are not required to report to NAEYC the findings of the surveys conducted during Self-Study. Please note that if your program plans to seek NAEYC Accreditation, you will be required to conduct surveys as part of the Self-Assessment process.

The Teaching Staff Survey can help you collect information about the program from the staff perspective, and the Family Survey can help you collect information about how families perceive program practices. The surveys are designed to provide you with information from several anonymous viewpoints. Sometimes, members of the staff and families are not comfortable openly offering suggestions or ideas for fear of retaliation against them or their child; consequently, programs seeking the full range of ideas and concerns that truly represent members of the families and staff need to offer the opportunity for privacy by asking a trusted intermediary to collect the information or by taking other steps to ensure anonymity. (Steps to ensure anonymity are required during Self-Assessment.) The Teaching Staff Survey and Family Survey are available at TORCH (www.naeyc.org/selfstudy).
**Teaching Staff Survey.** The Teaching Staff Surveys may be used to survey teaching staff members and gain their perspectives with respect to the program’s strengths and weaknesses. You may choose to ask staff members to complete different sections at different times or to complete the entire survey at once. You may decide to use one or more of the statements as a springboard for discussion among groups of teaching staff members. Results of these discussions or surveys completed during Self-Study are strictly for the use of your program.

Providing an envelope with each survey and a box to which they are returned in a common staff area (and not the administrator’s office) is one strategy that can help to ensure anonymity.

**Family Survey.** The Family Survey is designed to gather family perspectives on specific criteria. During Self-Study, you may choose to ask families to complete different sections at different times or to complete the entire survey. You may also adapt the survey questions and use them as a springboard for discussion with parents and family members. The results of your findings during Self-Study are strictly for the use of your program.

**Survey Summary Forms.** Once the surveys are completed by the staff members and families and collected, there are resources online to help your program summarize the data gathered to determine which criteria are met. The summary forms can be used to record information about the number of teaching staff and families surveyed and the percentage of those returning surveys. The more teaching staff and families return the surveys, the more representative the information will be. The summary forms can be used to help you identify key findings from the Teaching Staff Survey and the Family Survey. Make any notes concerning areas of strength and improvement after compiling and reviewing the feedback from the teaching staff and family members. It can be especially helpful to review the findings of both surveys in conjunction with one another to identify common issues, concerns, and areas where perceptions of strengths or weaknesses vary. These resources are available online at TORCH at www.naeyc.org/selfstudy.

**Observable Criteria**

Observable criteria are those criteria that can actually be seen in practice or as part of a tour of the program facility. Classroom observations provide the most direct evidence of program quality and the results of program improvement efforts. During Self-Study, it is useful to provide teaching staff members the opportunity to observe one another’s classrooms and give feedback to one another. Supervisory staff members can also conduct regular observations as a way of supporting teachers’ ongoing professional growth and development.

As program staff members become more familiar with the criteria, it becomes easier to notice the number of ways observable criteria are fulfilled. Observable criteria should be apparent to an administrator who is visiting a classroom or other program areas, to a teacher who is evaluating his or her work, or to a parent who is visiting his or her child’s classroom.

When conducting observations during Self-Study, you may want to consider

- focusing on learning activities during the program day.
- targeting specific age groups.
- observing the classroom at different times throughout the day, for example, when children arrive or depart, during indoor or outdoor time, during planned activities or free play, etc.
Guidelines for Observing

Following these general guidelines for conducting classroom observations will enhance your ability to collect valid information about program practices:

1. **Be unobtrusive.** You are here to observe others in the classroom, not to participate in the activities yourself.

2. **Take time to absorb what you are seeing and understand the context of what is going on.** This step may seem unnecessary when you know the program well, but it can be important to simply observe what is happening before starting your ratings. Plan on spending at least one hour observing to get a real sense of what is happening in the classroom.

3. **Consider what you are seeing from the perspective of individual children.** What is each child experiencing? Even if the experiences are positive for most children most of the time, what is happening to the child for whom things are not positive?

4. **Observe at different times of day and consider how the level of quality is maintained.** High-quality programs need to be consistently strong over the course of the day. Programs are often “best” in the morning, when teachers and children are well rested and eager to learn, but what happens later in the day when people are tired is equally important to the quality of children’s overall experience.

- focusing on a specific standard, or even a specific Topic Area within a standard, for example, using criteria from Topic Area 2.G. “Curriculum Content for Area of Cognitive Development: Science” when observing a science activity.

As you conduct observations, it is helpful for you to make comments related to each criterion. When reflecting on the observation, consider the following:

1. **What materials were used or accessible that are consistent with those identified in the criteria?**
2. **What affirming examples of the criteria were observed?**
3. **What opportunities to fulfill criteria were missed?**
4. **What criteria were not met? What were the contributing factors?**
5. **Did I observe conflicting evidence?**

Programs enrolled in Self-Study can access specific forms for documenting observable evidence at TORCH at www.naeyc.org/selfstudy.

**Portfolio Evidence**

Portfolios were introduced as formal sources of evidence for the NAEYC Accreditation process as part of the reinvented system in 2005. Portfolios provide a systematic way of documenting policies, procedures, and practices that reflect how individual classrooms and the program as a whole are meeting specific criteria. A Classroom Portfolio is maintained for each individual classroom or defined group of children, and a Program Portfolio is maintained for the overall program. Each portfolio is organized around the 10 standards.

**Classroom Portfolio Evidence.** The Classroom Portfolio is an opportunity for programs to present evidence of each group’s capacity to meet the accreditation criteria over time. It is a mechanism for documenting classroom practices and recording events to provide current evidence of implementation of specific criteria or indicators within criteria.

NAEYC defines a group or classroom as the number of children who are assigned for most of the day to a teacher or a team of teaching staff members and who occupy an individual classroom or well-defined space that prevents intermingling of children from different groups within a larger room or area. In most instances, it is expected that the Classroom Portfolio will be developed for a specific classroom or group by the teaching team responsible for that group. However, when the responsibility for planning and implementing classroom activities is shared among several teaching teams for multiple groups of children, then a single portfolio may be used to document the evidence for each of the groups included in the shared planning and implementation.
Classroom Portfolios are used by NAEYC Assessors as part of the site visit to supplement information gathered during the classroom observations (only a sample of classrooms is observed and has portfolios reviewed during the site visit). Specific guidelines for assembling portfolios to meet requirements for evidence as part of the site visit are available at TORCH (www.naeyc.org/selfstudy).

Program Portfolio Evidence. The Program Portfolio is an opportunity for programs to present evidence of the program’s capacity to meet the NAEYC Early Childhood Program Standards and Accreditation Criteria over time. It is a mechanism for tracking policies and recording events that provides current evidence of implementation of the standards and criteria. Many programs have reported that it is helpful to begin working on the Program Portfolio as one early task in the Self-Study process. Simply making sure that your program has policies and procedures documented can be an important first step; then consider whether the policies and procedures specifically address what is stated in the criteria. Most programs have found that they need to give careful attention to this part of the process to ensure that policies and procedures are in place and align with the standards and criteria.

The Program Portfolio is used by NAEYC Assessors as part of the site visit to gather information used to determine the NAEYC Accreditation decision. Specific guidelines, including checklists, for assembling the Program Portfolio to meet requirements for evidence as part of the site visit are available at TORCH (www.naeyc.org/selfstudy).

Determine Strengths and Weaknesses
The purpose of this task is to identify your program’s areas of strength and areas of weakness. Using the 10 NAEYC Early Childhood Program Standards and Accreditation Criteria as your measure of quality, consider the evidence you gathered, using the tools to help identify areas that need to be addressed. Is there a theme across the standards that you are not meeting? Is one standard particularly difficult for your program? For example, you may notice that your program is not meeting many criteria in the Curriculum Standard but that your program is meeting many criteria in the Relationships Standard. You may identify broad areas where improvement is needed during this step. You will also want to take this time to celebrate the program’s strengths with others in the program.

Taking an honest and careful look at your current practices is essential for an effective Self-Study. It is easy to look at the criteria and say, of course we do that. But do you really? What did your families say? What did the teaching staff members say? What did you not see that you expected to see when observing each group? Is your program fully meeting each criterion, including all indicators?

During Self-Study, challenge your staff and leadership to provide evidence of your program’s policies and practices, using the accreditation criteria as your measure of quality. You will need to be open to thinking seriously about all aspects of your program practices as well as many of your personal and professional beliefs and behaviors. Being open to the possibility of needing to change is a critical factor in quality improvement.
Develop Program Improvement Plans

This period is the time to thoughtfully consider how you can use the 10 NAEYC Early Childhood Program Standards and Accreditation Criteria to truly inform practices in your program and create structures that will support quality over time. It may require some creative brainstorming and true collaboration from members of the program staff, but it will result in higher quality programming for the children and families you serve.

Using the results from your Self-Study, create a plan for program improvement. You will need to identify resources to address the challenges for your program. To help you get started, use the ideas identified in Sections 3 and 6 of this volume. Brainstorm with staff members and families about additional resources available in your local community and state. Be creative. Link up with other early childhood programs to share training resources.

Be sure to keep track of your resources as part of your program improvement and development efforts. Describe who will be involved, how you will gather further information and evidence, and how you will use the results. Your improvement plan should also include time to implement changes and to assess your progress as you move forward.

Tips on Portfolios

Here are some ideas to help get you started with your portfolios.

- Provide each teaching team with a copy of the Classroom Portfolio checklist with related criteria (available at TORCH at www.naeyc.org/selfstudy).
- Form a team to work on the Program Portfolio, and make sure that all the team members have a copy of the Program Portfolio checklist (available at TORCH at www.naeyc.org/selfstudy). Use this team or form another committee to review your policy manual and other documentation against the checklist and the criteria.
- Start by brainstorming: What evidence do we already have?
- Plan time to document! Set aside time to work on the portfolios.
- Do not limit yourself to one type of evidence! Photos can work, but also consider lesson plans, family newsletters, a list of materials and equipment, and much more.
- When using photos, include a description to make clear connections with the criteria or the specific indicator within a criterion that the photo is illustrating.
- Designate a place (e.g., a crate, shelf, or drawer) for storing evidence for future use in a portfolio.
- Have a teaching team that serves a different age group review another team’s Classroom Portfolio for a fresh perspective.
- Keep a list of things that you should keep in mind for future documentation.
- Remember, one piece of evidence can meet multiple criteria, but be sure that it fully reflects each of the criteria for which you use it as evidence.

Make Improvements and Document Your Efforts

Put your plans into action. Depending on the plans and the area of improvement, start making the identified changes. This phase is where you will begin to see the results of your improvement efforts, which can be an exciting time for your program. Be sure to encourage members of the program staff in their efforts and celebrate their accomplishments one step at a time.

Evaluate Results and Determine Next Steps

Program improvement efforts are ongoing. Staff members, families, program administrators, and other stakeholders need to evaluate the effects of the changes after sufficient time has passed for the changes to be fully implemented and thoroughly tested. Discuss the effects of the changes on the children, teachers, and family members. Examine the changes for both positive and potentially negative effects. If necessary, make modifications.

Document your evaluation efforts and the modifications that you make. Your next steps depend on the context of your efforts and the nature of your findings. If you are exploring the standards one by one, this
might be a good time to begin reviewing the next standard. If you are enrolled in Self-Study and your findings suggest that further improvement is needed to meet the standards and their criteria, then you can repeat the cycle to plan improvements, make improvements, document your efforts, and evaluate your results.

When the program staff members and families are confident that the program can document that it meets each of the 10 NAEYC Early Childhood Program Standards, then the program is ready to proceed to the next step and become an Applicant for NAEYC Accreditation (Step 2 in seeking NAEYC Accreditation). In the application, the program will select a Candidacy due date, 3 to 12 months from the date of application. Programs are not required to submit documentation of their Self-Study process to the NAEYC Academy in their application. However, the program that applies for NAEYC Accreditation is making the commitment to complete a formal Self-Assessment and to report these results to the NAEYC Academy by the Candidacy due date chosen in the application. Programs that are accepted as Candidates for NAEYC Accreditation will receive a site visit within six months of the selected Candidacy due date.

Programs that are currently NAEYC Accredited should refer to the timeline for currently accredited programs at TORCH (www.naeyc.org/selfstudy) to determine what due dates they must meet to maintain their NAEYC Accreditation status with no lapse while pursuing re-accreditation. Currently accredited programs may choose to allow their NAEYC Accreditation to lapse if they believe that they need more time to conduct a thorough and meaningful Self-Study and to be successful during the next steps of the accreditation process. Programs that choose to allow their accreditation to lapse are not penalized for doing so, but their accreditation expires after their current accreditation expiration date has passed.

Getting Started with Your Classroom Portfolio

Here is a brief list of items to get you started thinking about the types of documentation that could be used as evidence.

- Copy of classroom daily schedule
- Copy of written curriculum
- Copies of assessment forms, anecdotal observations of children, developmental checklists
- Copies of letters, e-mails, or notes sent to parents
- Information shared with parents on enrollment in the program
- Copies of lesson plans, planning webs, or other planning sheets
- Photographs or written documentation of children participating in activities
- Examples of work samples from children
- Photographs or other documentation of classroom displays of children’s work
- Lists or photographs of materials and equipment available to children in the classroom space or additional supply closets
- Other items specific to your individual program
The formal Self-Assessment process is used to document that the program’s administration (program administrator and members of the governing body or ownership), teaching staff members, and families all believe that the program meets each of the 10 NAEYC Early Childhood Program Standards and is ready for a site visit by the NAEYC Academy.

What Is the Difference between Self-Study and Self-Assessment?

The purpose of Self-Study is primarily program improvement. There is no one way to complete Self-Study, and the results need not be shared with the NAEYC Academy. In contrast, the Self-Assessment must follow the specific guidelines outlined in the Guide to Self-Assessment that is available at TORCH (www.naeyc.org/selfstudy) to all enrolled programs. In addition, programs must be prepared to share their Self-Assessment findings with the NAEYC Academy and must be sure that all families, teaching staff members, and members of the program’s governance structure have the opportunity to participate in the assessment process.

Through Self-Assessment, programs prepare documentation that demonstrates their belief that they meet each of the 10 NAEYC Early Childhood Program Standards. Documentation is based on specific sources of evidence for each criterion. Evidence includes the results of observable evidence as well as information in Classroom Portfolios, the Program Portfolio, and summaries of the Family Survey and Teaching Staff Survey results. Evidence collected as part of Self-Study may be used as evidence in Self-Assessment as long as the evidence is not more than 12 months old as of the program’s Candidacy due date and complies with the guidelines outlined in the Guide to Self-Assessment.

During Self-Assessment, the program will also need to spend time documenting how their program meets the Candidacy Requirements. These requirements are discussed in detail in Getting Started, in the NAEYC Self-Study Kit, and they include documentation of the qualifications of a designated program administrator and teaching staff members as well as evidence that the program maintains good standing with its licensing/regulatory body.

By systematically documenting evidence that they meet each of the 10 NAEYC Early Childhood Program Standards and the Candidacy Requirements, programs will be prepared to complete their Candidacy Materials at Step 3: Candidacy. The NAEYC Academy provides programs with Candidacy Materials approximately eight weeks before their Candidacy due date in their online program record; this Candidacy due date is selected by the program in its application at Step 2 of the accreditation process. The completed Candidacy Materials and applicable fees must be submitted to the NAEYC Academy by the program’s Candidacy due date.
date. The Candidacy Materials request general program information needed to arrange the site visit and sample evidence from the program’s completed Self-Assessment.

**What Do Programs Need to Do during Self-Assessment?**

This section includes additional notes and requirements about the sources of evidence specific to Self-Assessment and supplements the information in Section 4. Note that these guidelines are general. Programs must follow the specific requirements outlined in the Guide to Self-Assessment that is available to enrolled programs at TORCH (see www.naeyc.org/selfstudy). Requirements may change over time, so it is important to verify that the program is using current information and following the current requirements in their Self-Assessment. Please refer to TORCH or contact the NAEYC Academy should you need further assistance.

**Observable Criteria**

Observation results for a specific class-room or group should be agreed upon by all members of the teaching team and the program administrator(s) as an accurate reflection of what typically happens in that classroom or group. New observations may be conducted specifically for Self-Assessment, or observations conducted for Self-Study may be used if they are agreed upon by the teaching team and the program administrator(s) and the results are not more than 12 months old at the Candidacy due date.

**Guidelines for Preparing the Classroom Portfolio and Program Portfolio**

Guidelines are available for preparing the Classroom Portfolio and the Program Portfolio to meet the requirements for Self-Assessment. Programs should ensure that their portfolios include evidence for each criterion for which the portfolio is a source of evidence (see the charts in Section 2 or refer to TORCH at www.naeyc.org/selfstudy). One piece of evidence may be used to document more than one criterion. In such cases, multiple copies of the evidence do not need to be included in the portfolio; however, it is important to clearly label the evidence with any and all applicable criteria numbers. It is also helpful in these cases to have an index of the included criteria, referencing the location of the evidence.

Things to keep in mind:

- Many of the criteria clearly articulate the specific evidence required, while other criteria comprise multiple indicators. Carefully review each criterion to be sure that the in either the Classroom or Program Portfolio truly and fully supports its intent.

- Each document or other evidence included within a Classroom or Program Portfolio must be clearly labeled with the number of the criterion it supports. If your program is submitting a document that is several paragraphs or pages in length and only a portion is the actual evidence for that criterion, please highlight or flag that portion. Highlighting will assist Assessors in their review of the particular portfolio during the site visit.

- Not all evidence needs to be copied and placed in the Classroom or Program Portfolio if it can be readily provided to the Assessor along with the portfolio. However, if evidence is provided along with a particular portfolio, then a “place holder” should be added to the portfolio in the appropriate section, listing the criterion number and a detailed explanation of where the evidence is located.

- It is critical to refer to the full language of a criterion when selecting evidence to demonstrate that it is met.
Some of the activities presented in the Classroom or Program Portfolio will demonstrate evidence of multiple criteria. This situation is an opportunity to provide the Assessor with examples of the richness of the classroom community over time. Evidence should be selected to provide an authentic reflection of children’s classroom experience.

Most important, remember that Assessors will use the Classroom and Program Portfolios to determine whether or not criteria are met. Therefore, anything you can do to help Assessors efficiently locate needed evidence will make the site visit process an easier experience for both the program and the Assessor(s).

Instructions for Collecting Family and Teaching Staff Surveys

Perspectives of families and teaching staff members are important sources of evidence in the Self-Assessment, just as they were in Self-Study. The surveys are quantitative (Yes/No format) and do not provide the more open-ended options to give feedback for program improvement that is an option for programs during Self-Study.

Programs are responsible for making sure that all teaching staff members and all families served by the program are informed in advance of the survey and have the opportunity to provide anonymous responses to the survey. Programs are asked to document their compliance with the survey requirements as part of the summary forms. Your program will report findings from the summary forms as part of your Candidacy Materials.

Specific Instructions for Family Surveys. The Family Survey may be distributed at any point in the program’s school year. For programs operating on a school-year calendar, results from the previous year’s families may be used as long as the survey was completed within 12 months of the Candidacy due date. For the survey results to be considered valid, at least 50 percent of all families enrolled (at the time of the survey distribution) must have responded.

As part of their Candidacy Materials, programs must provide documentation of how they publicized the opportunity for families to respond to the survey and how they made sure that families could provide a confidential, anonymous response to the survey.

Specific Instructions for Teaching Staff Surveys. Guidelines for the distribution and reporting of the Teaching Staff Survey are similar to those for the Family Survey, with the following exception: at least 80 percent of all teaching staff members must have responded to the survey for the results to be considered valid.
This section on resources provides various documents and sources of information that will support your efforts to complete the Self-Study process. In it, you will find the following:

- Selected Publications and Web Sites, including TORCH (www.naeyc.org/selfstudy)
- Literature Review
- Bibliography

The Web sites will provide you with additional information and will lead you to other valuable resources. The literature review will give you a thorough background for the concepts, issues, and research that pertain to the area of teaching. The bibliography will enable you to access particular relevant work that has been done in this area.

Selected Publications and Web Sites

NAEYC offers a wide range of publications through its online catalog at www.naeyc.org. Here we highlight a few especially pertinent to the Teaching Standard. These are presented as resource information only, and are not required for the Self-Study process.

Healthy Young Children: A Manual for Programs, 4th edition, edited by Susan S. Aronson and compiled with Patricia M. Spahr (NAEYC #704)
An essential resource for promoting and protecting the health and safety of children, staff, and families in early childhood programs.

Managing Infectious Disease in Child Care and Schools: A Quick Reference Guide, edited by Susan S. Aronson and Timothy R. Shope (NAEYC #750)
An easy-to-use guide with helpful reference sheets, “signs and symptoms” and sample letters and forms. Published by the American Academy of Pediatrics.

Web Sites

Programs enrolled in Self-Study should check TORCH (www.naeyc.org/selfstudy). TORCH includes resources for early childhood programs in all steps of the NAEYC Accreditation process. At TORCH you can:

- Search for criteria, FAQs, and additional resources by keyword
- View a calendar of important NAEYC due dates and chart your own due dates on a personalized calendar
- Access valuable NAEYC resources and link to other helpful Web sites
- Submit questions directly to the NAEYC Academy Information Center

In addition, you may find the following sites of interest.

American Academy of Pediatrics has a variety of information on health issues targeted to families as well as medical professionals. Early childhood educators will find many of the family-oriented materials of interest. www.aap.org

Healthy Child Care America is a collaborative effort of health professionals, child care providers, and families seeking to improve the health and well-being of children in child care that offers information regarding physical activity and nutrition useful for curriculum planning. www.healthychildcare.org
National Resource Center for Health and Safety in Child Care is funded by the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. The Web site includes national health and safety performance standards for child care programs and maintains a database of all state licensing regulations. http://nrc.uchsc.edu/

Centers for Disease Control, U.S. Department of Health and Human Services Web site provides information on health and safety topics, offers publications and products, and data and statistics. Users can view all material in Spanish or English. www.cdc.gov

U.S. Consumer Product Safety Commission Web site provides the most recent information on product recalls. The goal of the Commission is to reduce injury and death from contact with unsafe products. Spanish version available. www.cpsc.gov

Food and Nutrition Information Center Web site provides resources for child care and preschool professionals, including staff training resources in the area of nutrition. www.nal.usda.gov

Literature Review

This literature review was prepared by Brandt Chamberlain and Ellen Smith under the direction of Carollee Howes. The evidence base for the Health Standard supports the belief that attention to health practices in all aspects of early childhood programs contributes to quality. This text supplies a comprehensive set of references and research evidence that provide support for the criteria included in the Health Standard. Together, this information represents a range of sources—academic research; national reports; summaries of research, descriptive, survey and interview data; and multiauthored position statements—that provides support and rationales for the criteria.

Of the six elements listed by Cryer (2003) in the professional definition of early care and education quality, two deal directly with health and safety: (1) safe care, with sufficient diligent adult supervision appropriate for children’s ages and abilities as well as safe toys, equipment, and furnishings, and (2) healthful care, in a clean environment where sanitary measures are taken to prevent the spread of illness and where children have sufficient activity, rest, hygiene, and nutrition. In Caring for Our Children, the American Academy of Pediatrics (AAP 2002) establishes research-based standards for out-of-home care facilities in health and safety, including a discussion of supervision and hygiene. That book and its companion collection of guidelines, Stepping Stones (AAP, APHA, & NRCHSCC 2003), constitute the authoritative reference, with carefully documented research evidence for each standard and guideline. Given the availability of recent, detailed, and comprehensive supporting materials such as these, this literature review will provide only a brief overview highlighting particular concerns in the health area.

The Health Standard addresses many fundamental aspects of promoting and ensuring a healthy environment in which young children can thrive and learn. The development of the criteria within this standard was guided by a wealth of research, policy statements, and guidelines on health and safety in child care settings (AAP 2002; AAP, APHA, & NRCHSCC 2003; Centers for Disease Control and Prevention 1996; USDA Food Safety Inspection Service 2000; U.S. DHHS 2000). In particular, AAP, APHA, and NRCHSCC developed a set of national health and safety performance standards for out-of-home child care programs. Review of those documents is recommended for those readers interested in further information. Additionally, the Center for Child Health Research has compiled a compendium of research studies devoted to the topic of day care and health (Duncan, Mitchell, & Weitzman n.d.). Many useful resources are...
also available through the Internet. These resources are identified in the Web site listing earlier in this section.

Because the health and safety of children is of paramount concern to parents, to teachers, and to the larger community, numerous research and public policy guidelines have been generated to ensure that children are kept safe. To that end, the criteria contained within the NAEYC Health Standard are both comprehensive and detailed. The intent of the Health Standard is to provide a rigorous set of expectations that serve to secure the health and safety of not only young children while they are cared for in early childhood environments but also the staff and family members who regularly work at or visit the program. These criteria are stringent enough that programs will likely need to modify their program practices to substantially comply with them.

Three major themes emerge from the health criteria: safety, prevention, and promotion of healthy practices. Clearly, health and safety have been identified as essential elements in the providing of high-quality early care and education (Cryer 2003; Harms, Cryer, & Clifford 2003; Harms, Clifford, & Cryer 1998). The criteria within the Health Standard correspond to and expand professional and research-based definitions of quality of care. As is true for all standards, the topic areas and criteria that constitute the Health Standard must be considered in relation to other accreditation standards and topic areas.

In general, the criteria within this standard are worded with great detail and, thus, are less open to interpretation and variability than other sets of criteria. The objective is to provide guidance and parameters for programs to create healthy and safe environments for children, environments in which children are protected from physical and environmental hazards. A healthy and safe environment contributes to children’s development and learning.

The work of the American Academy of Pediatrics (AAP) (www.aap.org) provides rationale and support for the vast majority of criteria within the Health Standard. They offer well-respected policy statements and current health recommendations for a variety of topics relevant to caring for young children, including use of DEET (bug repellent), prevention of sudden infant death syndrome (SIDS), and the importance of hand washing in reducing the spread of germs, as well as requirements for sleeping and eating.

**Topic Area A: Promoting and Protecting Children’s Health and Controlling Infectious Disease**

Among the NAEYC criteria for promoting health are practices for diapering; hand washing; supervising at all times, especially near water; and protecting children from unhealthy or extreme weather conditions. Support for these practices is based in decades of work in public health and disease prevention (for a recent overview, see Zinkernagel 2003). For example, proper handling of soiled diapers is essential to preventing either gastrointestinal tract disease caused by bacteria, viruses, and parasites or hepatitis A virus infections of the liver (Gorski 1999; Kubiak et al. 1993; Van et al. 1991). Sanitation of diaper-changing surfaces must be completed after each time a child is changed. Soiled diapers should be stored in a lined garbage container and regularly removed from the facility. Children should not have access to the diaper-changing area except during the time that they are being changed, and then they should immediately be removed from the area. Caregivers are encouraged to wear plastic disposable gloves and to prepare the diaper-changing area before the arrival of the child in need of a change. All materials such as wipes and diaper creams should be removed from their containers before any contact with the soiled diaper to avoid contaminating the containers (Gorski 1999; Kubiak et al. 1993; Van et al. 1991).

Frequent and thorough hand washing is crucial for both adults and children to pre-
vent the spread of disease. Hands should be
washed when children and staff first arrive at
the facility and whenever they move to a
new group. Hands should be washed before
and after handling food or feeding, giving
medication, and playing in water that is used
by multiple children. Hands should be
washed after diapering, using the toilet, help-
ing a child use the toilet, handling bodily flu-
ids, handling uncooked food, handling pets,
playing in the sandbox, cleaning, or handling
garbage. Hand-washing is the most important
way to reduce the spread of infection
(Donowitz 1996; Gorski 1999).

Continuous and alert supervision of
children is the most basic way to protect
them from harm. Direct supervision means
that adults can see and hear the children at
time, including when the children are in
sleeping areas. Active supervision includes
(a) knowing each child’s abilities, (b) estab-
lishing clear and simple safety rules, (c)
being aware of potential safety hazards, (d)
standing in a strategic position, (e) scanning
play activities and circulating, and (f) focus-
ning on the positive rather than the negative
to teach a child what is safe. Whenever
young children are near water, the supervis-
ing adult should not engage in any activity
other than watching the children (U.S.
Consumer Product Safety Commission
1997), because small children can drown
within 30 seconds in as little as two inches
of liquid (AAP Committee on Injury and
Poison Prevention 1993).

Although children thrive when playing
outdoors, they also need to be protected
from various weather conditions that may
create health risks. According to Caring for
Our Children (AAP 2002), children should
be protected from exposure to moisture,
dust, and temperature extremes. Both wind
chill at or below 15 degrees Fahrenheit and
a heat index of above 90 degrees Fahrenheit
are identified as conditions involving signifi-
cant health risks for children. Frostbite is a
danger in extremely cold conditions, and
heat-related illnesses such as dehydration
can result from overexposure to extreme
heat. The AAP Committee on Sports
Medicine and Fitness (2000) reports that
children have a greater ratio of surface area
to body mass than adults and, consequently,
do not effectively adapt to extremes of tem-
perature. In addition, when exercising, chil-
dren produce more metabolic heat per unit
of mass than adults, which when combined
with a lower sweating capacity, reduces the
rate of dissipating body heat by evaporation.

An additional source of concern for
outdoor play is poor air quality conditions,
which can pose a significant health risk, par-
ticularly for children with asthma. The AAP
(2002) recommends providing shady areas in
the outdoor environment, which both
reduces the buildup of heat on metal play
equipment that could then potentially burn
children and protects children from sunburn.
Research reports that a child’s skin can
become sunburned in less than 10 minutes
and that severe childhood burns increase the
risk of skin cancer (National Coalition for
Skin Cancer Protection 2000). The
American Academy of Dermatology (2000)
states that 80 percent of a person’s lifetime
sun damage occurs before the age of 18.
However, carefully monitored exposure to
light from the sun can be healthful for chil-
dren because it promotes the production of
vitamin D, which growing children require.

In the Health Standard, the criteria
within Topic Area A, “Promoting and
Protecting Children’s Health and Controlling
Infectious Disease,” address a wide variety of
practices that promote and protect children’s
health. Many of the criteria require the exis-
tence and administration of program level
policies and practices, whereas others refer to
individual teacher behavior that supports a
healthy and safe environment. In addition,
communication between staff and families
about health issues is suggested in many of
the criteria.

Several key areas emerge from the crite-
ria. These areas are briefly discussed here
because they relate to the health and safety of children enrolled in early childhood programs.

**Health Information.** Written documentation showing the health status for program staff and children helps to ensure the maintenance of a healthy environment for all participants in an early childhood program (Aronson & Shope 2005; Zinkernagel 2003). Young children build up immunities over time, not only through interaction with the environment but also through immunizations. Because young children are more vulnerable than older children and adults, they rely on the adults in their lives to protect them. As Aronson and Shope (2005) note, “The risk of exposure to vaccine-preventable diseases is increased when children gather in groups for any reason” (3). Thus, parents and early childhood programs share the responsibility to provide healthy environments for children, which includes ensuring current immunizations. Criteria within this topic area address the need for programs to secure and maintain thorough and up-to-date health records for all employees and volunteers as well as for all children enrolled in the program. The procurement of health information for staff, volunteers, and children supports the objective of preventing the spread of disease within the early childhood environment. Identification and organization of these materials for purposes of accreditation is recommended.

The criteria indicate that immunization and health records need to be kept current, which means that staff and families must provide up-to-date information over the course of their employment and enrollment at the program. Clear communication and procedures will assist programs in securing necessary health information.

**Ability to Handle Medical Emergencies and Illness.** Although programs do their best to prevent injuries and the spread of illness and disease, children do require medical attention and intervention on occasion. Consistent with the National Health and Safety Performance Standards (AAP, APHA, NRCHSCC 2003), programs must have a staff member trained in pediatric first-aid available at all times in case of emergency. When swimming or wading is made available, a staff member certified in CPR shall be on the premises at all times. Thus, health and safety training is essential to ensure the well-being of children.

In addition to emergency situations, staff members may encounter children who become ill. Detection of signs of illness or communicable disease is incorporated into teachers’ daily assessments of children. If, for example, a child scratches her head excessively, the teacher should recognize the possible symptom, know how to check her hair for head lice, and actually do the examination. To protect other individuals from illness and disease, programs should have a designated, separate location for ill and contagious children. Thus, criteria within the Health Standard relate to criteria within the Teacher Standard (Standard 6, content on staff training), the Assessment of Child Progress Standard (Standard 4), and the Physical Environment Standard (Standard 9). In addition, communication with parents about children’s health status relates to the Relationships Standard (Standard 1), the Families Standard (Standard 7), and the Community Relationships Standard (Standard 8).

**Sudden Infant Death Syndrome (SIDS) Prevention.** The American Academy of Pediatrics (2003) notes that 20 percent of SIDS cases occurred while infants were cared for in child care settings. In response to this alarming figure, they launched a campaign to avoid SIDS (for more information, see www.healthychildcare.org). The Consumer Product Safety Commission (1995) reports findings from a study saying that soft products such as comforters and pillows could be responsible for child suffocation. Although the commission noted that soft products have not been determined to be the cause of SIDS, increased incidence of SIDS in the presence of these items is cause for serious concern and for a change in practices for all adults who care for young children. The criteria in the NAEYC Health Standard reflect these findings and recom-
recommendations. In addition, professionals recommend that children sleep with their back, not their face, on the mattress. This position can reduce suffocation by keeping the mouth and nose away from the bedding.

**Oral Hygiene.** The U.S. Surgeon General identified oral tooth decay in early childhood as a “silent epidemic,” affecting more children than asthma. Even though tooth decay affects significant numbers of young children, it is preventable. The Academy of General Dentistry (2005) attributes the high rates of early childhood tooth decay to misinformation. Specifically, parents can prevent tooth decay by bringing children to the dentist six months after the eruption of the first tooth, by wiping teeth and gums, and by limiting exposure to sugary liquids. Early childhood providers can share the responsibility by wiping children’s gums and teeth and by limiting exposure to sugary liquids to prevent a phenomenon called “baby bottle tooth decay.” Two criteria (5.8 and 5.9) address the goal of promoting oral health by identifying the need for programs to provide opportunities for gum and teeth cleaning after meals. These criteria are relevant only to programs that offer two or more meals for children over the age of one year and to programs that care for infants younger than the age of one year and that provide infant care.

**Protection from the Environment.** Opportunities to play outdoors have the potential to support children’s development in many ways (Rivkin 1995). Outside play supports children’s physical development in that children often participate in gross-motor activities such as running and riding wheel toys while in outdoor play spaces. They also have the opportunity to interact with and observe elements of nature, contributing to their science education. However, children’s health may be compromised if proper precautions are not taken to prevent injury or harm from the environment.

There are many ways in which programs can protect children from potential harmful elements in the environment. First, knowledge of local weather, air quality conditions, and strength of the sun at given times of the day can inform teachers about whether and when outside play is appropriate on a given day. As mentioned above, children’s bodies are less able to adapt to extreme temperatures (AAP 2002; AAP Committee on Sports Medicine and Fitness 2000). Consequently, children should be protected from exposure to extreme environmental conditions. Programs can take measures to protect children, for example, by providing shady areas in the outdoor play environment, offering and promoting use of sun-protective clothing, ensuring appropriate attire outdoors (e.g., a heavy jacket in winter), and applying sunscreen and bug repellent when appropriate.

The existence and threat of the West Nile virus, which is transmitted by mosquitoes, has heightened awareness of the preventive function of insect repellent (AAP 2003). Insect repellents containing the product DEET are the most effective mosquito repellents available, according to the AAP, and protect children from a host of insect bites. Products vary in the amount of DEET they contain, typically ranging in amounts from 10 percent to 30 percent. Products containing lower concentrations need to be applied more frequently than products with a higher concentration. Consistent with recommendations for sun exposure and use of sunscreen, guidelines for the use of insect repellent containing DEET state that it is not recommended for infants younger than the age of two months. Parental consent is necessary before using products containing chemicals such as these. (For more information on safety precautions when using DEET on children, visit www.aap.org). Because mosquitoes deposit larvae in pools of water, programs can protect children by practicing diligence in emptying standing water from containers, mopping up spills, and so forth.

**Diapering and Toileting.** Another area addressed by the criteria in the Health Standard relates to proper toileting and diapering
procedures. As mentioned above, proper handling of soiled diapers, regular sanitation of diaper-changing surfaces, restricted access to diaper-changing areas, and proper care of diaper-changing supplies such as wipes and diaper rash ointment all contribute to the creation of a healthy environment (Gorski 1999; Kubiak et al. 1993; Van et al. 1991).

**Hand Washing.** Frequent and thorough hand washing is a highly effective health practice that has been shown to prevent the spread of disease. The U.S. Department of Agriculture Food Safety Inspection Service (2000) notes that, “children in diapers present special health challenges for other children and as well for child care providers.” As identified in the literature review cited above, many daily circumstances occur for which hand washing is recommended as a way of reducing the transmission of germs and bacteria (e.g., before and after feedings, after diapering, after playing in the sandbox). Research has demonstrated the efficacy of hand washing as a means to reduce the spread of infection (Donowitz 1996; Gorski 1999; Niffenegger 1997). Research has also demonstrated the effectiveness of hand-washing instruction on the reduction of colds among preschoolers enrolled in a child care center (Niffenegger 1997). In addition, the use of liquid soap and disposable, one-use towels contributes to the benefits of hand washing (Aronson & Shope 2005).

**Water Safety.** Water play is an engaging activity for children, one that can contribute to their knowledge of science, provide a “prop” for pretend play, and a context for meaningful social interactions. Programs can take advantage of many opportunities for children to play with water, both indoors and outdoors. Water tables, inflatable pools, and access to drinking fountains and hoses are some common ways in which children engage in water play in early childhood programs. Although programs are encouraged to provide water play for children, the criteria within this topic area reflect concerns, as described earlier in this review, about safety and health as they relate to water play.

**Topic Area B: Ensuring Children's Nutritional Well-Being**

The prevention of food-borne illness transmission begins with the preparation and storage of food (Cowell & Schlosser 1998). Food should be prepared in an area separate from the eating, play, laundry, and toileting areas. Additionally, animals should not be permitted in food preparation areas. Children should have no access to food preparation areas, a strategy that prevents the contamination of the food and injury to children. A common way for children to be burned is from scalding hot liquids that spill in the kitchen (Morrow, Smith, & Cairns 1996; Rieg & Jenkins 1991). Perishable food must be stored either in refrigerators that maintain a maximum food temperature of 40 degrees Fahrenheit in all food storage areas or in freezers that maintain a maximum food temperature of 0 degrees Fahrenheit (AAP 2002). Storing food at these recommended temperatures (or lower) reduces bacterial growth (Food Marketing Institutes 1996).

Food-borne illness can also be prevented through consistent and appropriate hygiene and sanitation methods. Program staff should be educated on these methods and procedures to reduce incidences of illness (Cowell & Schlosser 1998). An important example is the use of bottles. To prevent cross-infection or exposure, families or program staff should label all bottles with the full name of the child and the date that either the formula was prepared or the breast milk was collected (Kleinmen 1998; U.S. DHHS 1999). Even minor differences in the components of formula or breast milk can cause gastrointestinal problems (AAP Work Group on Breastfeeding 1997). Bottles must be stored in refrigerators or freezers and discarded (or cleaned and sterilized) after use. Excessive heating with a microwave is damaging to breast milk and may cause inconsistent temperatures that increase the risk of burning (Dixon, Burd, & Roberts 1997; Nemethy & Core 1990).
Further, thawing breast milk or formula for extended periods promotes the growth of bacteria (AAP 2002). Used bottles, including the bottle caps and the nipples, must be washed and sanitized after each feeding.

The AAP (2002) reports that from 2 percent to 8 percent of infants and children have food allergies (Burks & Stanley 1998). Allergic reactions range from mild to severe and, at worst, are life-threatening. Therefore, it is critical that settings in which children spend large portions of their time, including mealtimes, take precautions to prevent exposure to known allergens. The AAP (2002) recommends that every facility have a special care plan that includes written instructions with respect to specific allergies and a treatment plan in the event of a reaction. The staff need to be trained on preventing exposure, recognizing the symptoms of a reaction, and treating the allergic reactions quickly and appropriately. This information may necessarily include learning how to store and administer life-saving medications. Both parents and health care providers must be informed when children have a severe allergic reaction; therefore, this information should be accessible and included in the written plan (Kleinmen 1998; Samour, Hein, & Lang 1999; U.S. DHHS 1999).

Good nutrition affects the health, learning, and development of young children (AAP Work Group on Breastfeeding 1997; USDA Team Nutrition 2002; USDA Agricultural Research Service 2005). The United States Department of Agriculture (USDA) has developed an authoritative guide and food pyramid that provide information on healthful nutrition for individuals the age of two years and older. The department recently revised the food pyramid (USDA Agricultural Research Service 2005) to reflect the current state of knowledge in the area and have stressed the importance of exercise in their discussion of consumption of the food groups. For children younger than the age of two years, new guidelines have been developed to inform parents and caregivers about the nutritional needs of infants and toddlers (USDA Agricultural Research Service 2005). Team Nutrition, a division of the USDA Food and Nutrition Service (2002), has also contributed greatly to the information base on healthy and developmentally appropriate food choices for young children. Their information on feeding infants provides a comprehensive and up-to-date reference related to all aspects of food preparation and food choice as well as developmental concerns with respect to food content. Taken together, these sources provide the rationale and basis for the criteria within this topic area.

Food allergies are an important factor in determining healthy food options for children. As noted above, a significant percentage of young children have food allergies (AAP 2002; Burks & Stanley 1998). Programs can help prevent potentially life threatening allergic reactions by maintaining continuous communication with parents and by ensuring that staff are well trained, prepared, and knowledgeable about the specific allergies children have (including recognition of symptoms). These approaches to health and safety relate to the Relationships Standard, the Families Standard (with an emphasis on communication), and to the Teachers Standard (with respect to staff training and education).

The age of children is of prime concern when determining or evaluating the types of foods offered at early childhood programs. The types of food offered to children in high-quality programs are determined based on knowledge of children’s nutritional needs, physical capabilities, and preferences. For example, the recommended diet for infants consists of

Types of Food. A wealth of information is available today about what constitutes sound nutrition for young children (USDA Agricultural Research Service 2005).
breast milk or formula. Cow’s milk is not con-
sidered appropriate for children younger than
the age of 12 months; after that age, whole
milk is recommended. In addition, certain
foods have been shown to pose a choking
hazard for young children. Informed staff
members use their knowledge to develop safe
meal plans for children. Even if programs do
not provide food, they still can inform families
about choking hazards. For example, hot dogs,
carrots, and whole grapes are unsafe for chil-
dren younger than the age of four years (for a
more complete discussion of choking, visit
www.globalhealthychildcare.org).

Experts in the fields of medicine and
nutrition recommend that solid food and fruit
juices not be served to children younger than
the age of six months (AAP, APHA, &
NRCHSCC 2003). Discussion with parents
about when to introduce certain foods, the
order in which foods are presented at home,
and other related issues support the partner-
ship between parents and programs. If, for
example, a parent chooses not to offer juice
to his or her child, then programs are asked,
and expected, to respect that choice. If meat
products are not served at home, then
teachers also support that choice.

If programs provide food for meals and
snacks, then they are encouraged to follow
the guidelines found in the USDA Child
and Adult Care Food Program requirements.

Food Preparation. Improper handling,
storage, and preparation of food can endan-
ger children’s health (Aronson & Shope
2005; USDA Food and Nutrition Service
2000). These concerns have motivated the
development of guidelines to ensure proper
handling, storage, and preparation of food.
The USDA Food and Nutrition Service
(2000) has developed a guide for child care
providers directly addressing these issues.
The criteria within this topic area on nutri-
tion reflect these guidelines.

Communication with and Support for
Families. There are a variety of ways in
which programs communicate with and
support parents in the program practices
related to nutrition. Families have a vested
interest in what their children consume
because they are concerned about their
children’s health, development, and cultural
identity. When programs provide food to
children, the criteria stipulate that menus be
posted in a convenient location so families
remain informed about what children are
eating throughout the day. Allergies and food
preferences can be identified through conver-
sation with parents; for example, parents can
share that a child may be raised in a vegetar-
ian household or have an allergy to peanut
products. This communication with families
around nutrition issues provides teachers
with important information that they incor-
porate into their daily plans for children.

Parents have different practices and
perspectives on feeding young children.
Some mothers choose to breast-feed, a
method recommended by the AAP Work
Group on Breastfeeding (1997). In support
of this type of parental decision, programs
follow recommended practices for storing
and preparing breast milk. Providing space
within the program for mothers to breast-
feed supports families.

Topic Area C: Maintaining a
Healthful Environment

Children will touch any surface that
is within their reach, including floors.
Therefore, all surfaces may be contaminated
and can spread infectious disease and must
be sanitized. Secretions from the respiratory
tract may contain viruses that can continue
to contaminate environmental surfaces for
variable periods of time, and infection can
be acquired by touching objects or surfaces
that are contaminated through sneezes,
coughs, or runny noses (Butz, Fosarelli, &
Dick 1993). The transmission of disease can
be reduced through the regular cleaning of
all surfaces and toys (Centers for Disease
Control and Prevention 1996).

Health, nutrition, and sanitation, together
with child and adult safety (addressed in
Standard 9: Physical Environment, and in
Standard 10: Leadership and Management), make up the sine qua non of quality in early care and education settings. These most basic concerns must be met for a setting to reach a minimal threshold level of adequacy, even to permit the ethical placement of children in the environment. The basic physical adequacy of a setting alone, however, is not enough to ensure those features of structural and process quality that are needed to create an environment that is beneficial, rather than detrimental, to children’s growth and advancement in the broad range of developmental domains.

Clean environments promote children’s health and learning. With children’s well-being as a central focus, high-quality programs take great care to maintain a clean and healthy environment. There are many materials and surfaces in early childhood programs that require regular care to prevent the spread of illness, germs, and bacteria.

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Because young children are curious and are still learning about health and safety issues, the adults in the environment are expected to engage in practices that maintain a healthful environment. For example, young children often explore toys by putting them in their mouths or on other body parts, what Aronson and Shope (2005) refer to as “hand to mouth activity.” Teachers can reduce the transmission of disease from children’s exploration of objects by regularly cleaning toys (Aronson & Shope 2005; Centers for Disease Control and Prevention 1996). In addition, because children may not consistently cough into their sleeve, wash hands regularly, or use tissues consistently, many surfaces within the early childhood environment may contain a range of potentially harmful bacteria and germs. Program staff can reduce the spread of infectious diseases by regularly sanitizing objects and surfaces within the environment.

Water tables in a child care environment provide an unlimited source of learning in the multiple developmental domains; however, there are concerns about the extent to which water table play can contribute to the transmission of illness between children and about the need for diligent supervision during any type of water play. Caring for Our Children (AAP 2002) emphasizes that water table play should occur only under the constant supervision of an adult. Drowning is of course the foremost health concern related to water play, but there are also important considerations for limiting the spread of infectious illness. For example, children should be prevented from drinking the water. Further, the water table should be filled only with fresh, potable water immediately before children begin to play or be supplied with freely flowing fresh, potable water during the activity. The basin that holds the water and any toys that are used in the water should be washed and sanitized before the water table is used again. Additionally, children who have any cuts, scratches, or sores on their hands or who have colds or runny noses should not be permitted to play in a communal water table. Research indicates that properly washing hands before and after water table play, supervising children, and cleaning and sanitizing the water table will prevent the transmission of disease (Churchill & Pickering 1997; Van et al. 1991).

According to the National Institutes of Health (NIH)—National Institute of Environmental Health Sciences (2005), early childhood environments are a “significant source of indoor allergens.” The Institute describes findings from a recent report that documented the existence of allergens found in child care centers in North Carolina. The results were obtained through questionnaires, observations, and collection of dust samples. They found significant levels of allergens from cats, dogs, and fungus, which they assume were brought to the facilities on the children’s clothing. These data are significant because “exposure to indoor allergens has been shown in previous studies to increase the likelihood of developing asthma or allergic diseases, especially in vulnerable children.” Regular maintenance of flooring and
the general environment (e.g., vacuuming) can reduce negative effects.

Early childhood programs often choose to incorporate pets into their classrooms because they have the potential for teaching children about nature, science, and responsibility. Children’s health is a factor in the process of choosing the most appropriate pet for a given classroom. Certain types of animals can harbor disease, allergens, or both, which can affect children’s health (Kaplan 2003). For example, reptiles can harbor salmonella disease, which can lead to grave consequences for young children. Careful selection of classroom pets, combined with consistent and proper hand washing, can minimize the chance of any health risks.

Bibliography


Since the first edition in 1986, NAEYC’s book Developmentally Appropriate Practice in Early Childhood Programs has been an essential resource for the field. Based on what the research says about how children develop and learn and what experience tells us about teaching effectiveness, developmentally appropriate practice articulates the principles that should guide our decision making. Chapters describe children from birth through age 8, with extensive examples of appropriate and inappropriate practices for infant/toddler, preschool, kindergarten, and primary levels. The completely revised and expanded 2009 edition comes with a CD containing supplemental readings on key topics, plus video vignettes showing developmentally appropriate practice in action. Based on NAEYC’s 2009 position statement. Edited by Carol Copple and Sue Bredekamp.

NAEYC’s new magazine, TYC, is designed especially for preschool teachers. Teaching Young Children highlights current thinking on best practices in early childhood education, innovations in the field, research and its implications, and interesting ideas for and from preschool teachers. The articles and other features reinforce the accreditation criteria for the NAEYC Early Childhood Program Standards on Relationships and Teaching and encourage effective teaching practices.

Order online at www.naeyc.org/shoppingcart or call 800-424-2460 or 202-232-8777 (option 6)

Programs seeking NAEYC Accreditation are not required to become members of NAEYC or to purchase additional NAEYC publications. These publications and services are optional resources that can help early childhood educators continue to improve the experiences they provide for young children.