KANSAS ADJUTANT GENERAL'S DEPARTMENT
INFANT AT WORK PROGRAM
(Attachment A)

INDIVIDUAL PLAN

_____ New Plan _____ Revised Plan

I. General Information

Name of Employee: _____ Work Phone: ___-___-____

Name of Parent/Guardian: _____ Phone Number: ___-___-___

Name of Infant: _____ Infant's Date of Birth __/__/___

Infant begins program: __/__/____ Infant ends program: __/__/__

Indicate days and times infant will be present in the workplace:

Mon. _____ Tues. _____ Wed. _____ Thurs _____ Friday _____

II. Care Providers

The following persons have agreed to be Care Providers, responsible for providing care for my infant in the workplace when I become temporarily unavailable to provide care. (Provider care is not to exceed 1.5 hours in a four-hour period).

1. Care Provider Name: _____ Division:_____

Work Phone: ___-___-____ Home Phone: ___-___-____ Mobile: ___-___-____

2. Care Provider Name: _____ Division:_____

Work Phone: ___-___-____ Home Phone: ___-___-____ Mobile: ___-___-____

Attach completed Care Provider Agreements to this individual plan. (Attachment B)

III. Specific Information

Include any specific care information or requirements related to the Infant and/or plan in the space below:

IV. In case of emergency, please contact:

1. Name of person to contact in an emergency: _____

Relationship: _____

Address: _____

Work phone: _____

Home phone: _____ Cell phone: _____

2. Name of person to contact in an emergency: _____

Relationship: _____

Address: _____

Work phone: _____

Home phone: _____ Cell phone: _____

V. Agreement

By signing the *Agreement* hereunder, I certify that I have read the Attached Policy Guidelines. I understand and agree to comply with the terms and conditions set forth in the Policy Guidelines. I further understand and agree that, in the event I fail to comply with such terms and conditions, or otherwise fail to meet any Program criteria, whether or not such criteria are set forth therein these Guidelines, my Program eligibility may be terminated, requiring me to remove my infant from the workplace.

I acknowledge the Kansas Adjutant General's Department is offering participation in the "Infant at Work" Program to employees who are new mothers, fathers, or grandparents who are employed by the Department and not as an employee benefit.

Accordingly, I further acknowledge that the Department reserves the right to terminate a participant's eligibility, with or without cause, or to cancel or retire the Program in part or in its entirety, with or without cause, requiring me to remove my infant from the workplace immediately.

I have discussed this plan with my supervisor and Division Director. I understand that I can bring my infant to the workplace upon final approval of this plan by the State HR Director. If my plan changes, I agree to complete a revised plan for discussion and approval immediately.

Submitted and signed by:

_____ Date: _____
Signature of Parent/Employee

Approved by:

_____ Date: _____
Supervisor

_____ Date: _____
Division Director

_____ Date: _____

State Human Resource Director

VI. Consent and Waiver

By signing this Consent and Waiver, I hereby consent to the release of the Kansas Adjutant General's Department, and any employee, from any/all liability arising from any harm or injury that occurs to my infant in the workplace, as a result of my participation in the "Infant at Work" Program, and hereby waive any rights I accrue as a result thereof.

_____ Date: _____

Signature of Parent/Guardian

KANSAS ADJUTANT GENERAL'S DEPARTMENT
INFANT AT WORK PROGRAM
(Attachment B)

CARE PROVIDER AGREEMENT

As a care provider, I understand and agree to the following:

1. When necessary, I will provide care for _____ (infant) when _____ (parent/guardian) is unavailable. (Provider care not to exceed 1.5 hours in a four-hour period).

2. I will move to _____ (parent's/guardian's) workstation, or the infant will be brought to my workstation, whichever is most convenient.

3. I understand my provider care does not relieve me of my responsibilities as an employee of the Kansas Adjutant General's Department.

4. I understand there is another designated care provider with these same duties who I may contact if I require assistance in the absence of the parent/guardian.

5. I will be notified by _____ (parent/guardian) if there is any change in care providers under this Agreement.

6. No persons will be responsible for the infant except for _____ (parent/guardian) or _____ (care provider) and the undersigned.

7. I will not release the baby under my care to any individual other than _____ (parent/guardian) or _____ (care provider).

8. If at any time I no longer agree to act as a care provider for _____ (infant), I shall give written notice to _____ (parent/guardian).

The undersigned hereby agrees to act as a care provider as described above. I acknowledge that I have read and understand the terms of this care provider agreement.

_____ Date_____
Signature of Care Provider

_____ Date _____
Signature of Immediate Supervisor

KANSAS ADJUTANT GENERAL'S DEPARTMENT
Infant at Work Program
Attachment C

Center for Disease Control
Recommendations for Inclusion or Exclusion" of Children
from out-of-home child care setting.

Chapter 3: Health Promotion and Protection

3.6 Management of Illness

3.6.1 Inclusion/Exclusion Due to Illness

Standard 3.6.1.1: Inclusion/Exclusion/Dismissal of Children
(Adapted from: Aronson, S. S., T. R. Shope, eds. 2009. Managing infectious diseases in child care and schools: A quick reference guide, 39-43. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics.)

Preparing for managing illness:

Caregivers/teachers should:

a. Encourage all families to have a backup plan for child care in the event of short or long term exclusion;
b. Review with families the inclusion/exclusion criteria and clarify that the program staff (not the families) will make the final decision about whether children who are ill may stay based on the program's inclusion/exclusion criteria and their ability to care for the child who is ill without compromising the care of other children in the program;
c. Develop, with a child care health consultant, protocols and procedures for handling children's illnesses, including care plans and an inclusion/exclusion policy;
d. Request the primary care provider's note to readmit a child if the primary care provider's advice is needed to determine whether the child is a health risk to others, or if the primary care provider's guidance is needed about any special care the child requires (1);
e. Rely on the family's description of the child's behavior to determine whether the child is well enough to return, unless the child's status is unclear from the family's report.

Daily health checks as described in Standard 3.1.1.1 should be performed upon arrival of each child each day. Staff should objectively determine if the child is ill or well. Staff should determine which children with mild illnesses can remain in care and which need to be excluded.

Staff should notify the parent/guardian when a child develops new signs or symptoms of illness. Parent/guardian notification should be immediate for emergency or urgent issues. Staff should notify parents/guardians of children who have symptoms that require exclusion and parents/guardians should remove the child from the child care setting as soon as possible. For children whose symptoms do not require exclusion, verbal or written notification of the parent/guardian at the end of the day is acceptable. Most conditions that require exclusion do not require a primary care provider visit before reentering care.

Conditions/symptoms that do not require exclusion:
a. Common colds, runny noses (regardless of color or consistency of nasal discharge);
b. A cough not associated with a infectious disease (such as pertussis) or a fever;
c. Watery, yellow or white discharge or crusting eye discharge without fever, eye pain, or eyelid redness;
d. Yellow or white eye drainage that is not associated with pink or red conjunctiva (i.e., the whites of the eyes);

e. Pink eye (bacterial conjunctivitis) indicated by pink or red conjunctiva with white or yellow eye mucous drainage and matted eyelids after sleep. Parents/guardians should discuss care of this condition with their child's primary care provider, and follow the primary care provider's advice. Some primary care providers do not think it is necessary to examine the child if the discussion with the parents/guardians suggests that the condition is likely to be self-limited. If two unrelated children in the same program have conjunctivitis, the organism causing the conjunctivitis may have a higher risk for transmission and a child health care professional should be consulted;
f. Fever without any signs or symptoms of illness in children who are older than six months regardless of whether acetaminophen or ibuprofen was given. Fever (temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) is an indication of the body's response to something, but is neither a disease nor a serious problem by itself. Body temperature can be elevated by overheating caused by overdressing or a hot environment, reactions to medications, and response to infection. If the child is behaving normally but has a fever of below 102°F per rectum or the equivalent, the child should be monitored, but does not need to be excluded for fever alone;
g. Rash without fever and behavioral changes;
h. Lice or nits (exclusion for treatment of an active lice infestation may be delayed until the end of the day);
i. Ringworm (exclusion for treatment may be delayed until the end of the day);
j. Molluscum contagiosum (do not require exclusion or covering of lesions);
k. Thrush (i.e., white spots or patches in the mouth or on the cheeks or gums);
l. Fifth disease (slapped cheek disease, parvovirus B19) once the rash has appeared;
m. Methicillin-resistant Staphylococcus aureus, or MRSA, without an infection or illness that would otherwise require exclusion. Known MRSA carriers or colonized individuals should not be excluded;
n. Cytomegalovirus infection;
o. Chronic hepatitis B infection;
p. Human immunodeficiency virus (HIV) infection;
q. Asymptomatic children who have been previously evaluated and found to be shedding potentially infectious organisms in the stool. Children who are continent of stool or who are diapered with formed stools that can be contained in the diaper may return to care. For some infectious organisms, exclusion is required until certain guidelines have been met. Note: These agents are not common and caregivers/teachers will usually not know the cause of most cases of diarrhea;
r. Children with chronic infectious conditions that can be accommodated in the program according to the legal requirement of federal law in the Americans with Disabilities Act. The act requires that child care programs make reasonable accommodations for children with disabilities and/or chronic illnesses, considering each child individually.

Key criteria for exclusion of children who are ill:

When a child becomes ill but does not require immediate medical help, a determination must be made regarding whether the child should be sent home (i.e., should be temporarily "excluded" from child care). Most illnesses do not require exclusion. The caregiver/teacher should determine if the illness:

a. Prevents the child from participating comfortably in activities;
b. Results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;
c. Poses a risk of spread of harmful diseases to others.

If any of the above criteria are met, the child should be excluded, regardless of the type of illness.

Decisions about caring for the child while awaiting parent/guardian pick-up should be made on a case-by-case basis providing care that is comfortable for the child considering factors such as the child's age, the surroundings, potential risk to others and the type and severity of symptoms the child is exhibiting. The child should be supervised by someone who knows the child well and who will continue to observe the child for new or worsening symptoms. If symptoms allow the child to remain in their usual care setting while awaiting pick-up, the child should be separated from other children by at least 3 feet until the child leaves to help minimize exposure of staff and children not previously in close contact with the child. All

who have been in contact with the ill child must wash their hands. Toys, equipment and surfaces used by the ill child should be cleaned and disinfected after the child leaves.

Temporary exclusion is recommended when the child has any of the following conditions:

a. The illness prevents the child from participating comfortably in activities;
b. The illness results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;
c. An acute change in behavior - this could include lethargy/lack of responsiveness, irritability, persistent crying, difficult breathing, or having a quickly spreading rash;
d. Fever (temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea). An unexplained temperature above 100°F (37.8°C) axillary (armpit) or 101°F (38.3°C) rectally in a child younger than six months should be medically evaluated. Any infant younger than two months of age with any fever should get urgent medical attention. See COMMENTS Below for important information about taking temperatures;
e. Diarrhea is defined by watery stools or decreased form of stool that is not associated with changes of diet. Exclusion is required for all diapered children whose stool is not contained in the diaper and toilet-trained children if the diarrhea is causing soiled pants or clothing. In addition, diapered children with diarrhea should be excluded if the stool frequency exceeds two or more stools above normal for that child, because this may cause too much work for the caregivers/teachers. Readmission after diarrhea can occur when diapered children have their stool contained by the diaper (even if the stools remain loose) and when toilet-trained children are continent. Special circumstances that require specific exclusion criteria include the following (2):
    1. Toxin-producing E. coli or Shigella infection, until stools are formed and the test results of two stool cultures obtained from stools produced twenty-four hours apart do not detect these organisms;
    2. Salmonella serotype Typhi infection, until diarrhea resolves. In children younger than five years with Salmonella serotype Typhi, three negative stool cultures obtained with twenty-four-hour intervals are required; people five years of age or older may return after a twenty-four-hour period without a diarrheal stool. Stool cultures should be collected from other attendees and staff members, and all infected people should be excluded;
f. Blood or mucus in the stools not explained by dietary change, medication, or hard stools;
g. Vomiting more than two times in the previous twenty-four hours, unless the vomiting is determined to be caused by a non-infectious condition and the child remains adequately hydrated;
h. Abdominal pain that continues for more than two hours or intermittent pain associated with fever or other signs or symptoms of illness;
i. Mouth sores with drooling unless the child's primary care provider or local health department authority states that the child is noninfectious;
j. Rash with fever or behavioral changes, until the primary care provider has determined that the illness is not a infectious disease;
k. Active tuberculosis, until the child's primary care provider or local health department states child is on appropriate treatment and can return;
l. Impetigo, until treatment has been started;
m. Streptococcal pharyngitis (i.e., strep throat or other streptococcal infection), until twenty-four hours after treatment has been started;
n. Head lice until after the first treatment (note: exclusion is not necessary before the end of the program day);
o. Scabies, until after treatment has been given;
p. Chickenpox (varicella), until all lesions have dried or crusted (usually six days after onset of rash);
q. Rubella, until six days after the rash appears;
r. Pertussis, until five days of appropriate antibiotic treatment;
s. Mumps, until five days after onset of parotid gland swelling;
t. Measles, until four days after onset of rash;
u. Hepatitis A virus infection, until one week after onset of illness or jaundice if the child's symptoms are mild or as directed by the health department. (Note: immunization status of child

care contacts should be confirmed; within a fourteen-day period of exposure, incompletely immunized or unimmunized contacts from one through forty years of age should receive the hepatitis A vaccine as post exposure prophylaxis, unless contraindicated.) Other individuals may receive immune globulin. Consult with a primary care provider for dosage and recommendations;

v. Any child determined by the local health department to be contributing to the transmission of illness during an outbreak.

Procedures for a child who requires exclusion:

The caregiver/teacher will:

a. Make decisions about caring for the child while awaiting parent/guardian pick-up on a case-by-case basis providing care that is comfortable for the child considering factors such as the child's age, the surroundings, potential risk to others and the type and severity of symptoms the child is exhibiting. The child should be supervised by someone who knows the child well and who will continue to observe the child for new or worsening symptoms. If symptoms allow the child to remain in their usual care setting while awaiting pick-up, the child should be separated from other children by at least 3 feet until the child leaves to help minimize exposure of staff and children not previously in close contact with the child. All who have been in contact with the ill child must wash their hands. Toys, equipment and surfaces used by the ill child should be cleaned and disinfected after the child leaves;
b. Discuss the signs and symptoms of illness with the parent/guardian who is assuming care. Review guidelines for return to child care. If necessary, provide the family with a written communication that may be given to the primary care provider. The communication should include onset time of symptoms, observations about the child, vital signs and times (e.g., temperature 101.5°F at 10:30 AM) and any actions taken and the time actions were taken (e.g., one children's acetaminophen given at 11:00 AM). The nature and severity of symptoms and or requirements of the local or state health department will determine the necessity of medical consultation. Telephone advice, electronic transmissions of instructions are acceptable without an office visit;
c. Follow the advice of the child's primary care provider;
d. Contact the local health department if there is a question of a reportable (harmful) infectious disease in a child or staff member in the facility. If there are conflicting opinions from different primary care providers about the management of a child with a reportable infectious disease, the health department has the legal authority to make a final determination;
e. Document actions in the child's file with date, time, symptoms, and actions taken (and by whom); sign and date the document;
f. In collaboration with the local health department, notify the parents of contacts to the child or staff member with presumed or confirmed reportable infectious infection.

The caregiver/teacher should make the decision about whether a child meets or does not meet the exclusion criteria for participation and the child's need for care relative to the staff's ability to provide care. If parents/guardians and the child care staff disagree, and the reason for exclusion relates to the child's ability to participate or the caregiver's/teacher's ability to provide care for the other children, the caregiver/teacher should not be required to accept responsibility for the care of the child.
Reportable conditions:

The current list of infectious diseases designated as notifiable in the United States at the national level by the Centers for Disease Control and Prevention (CDC) are listed athttp://wwwn.cdc.gov/nndss/conditions/notifiable/2015/infectious.

The caregiver/teacher should contact the local health department:

a. When a child or staff member who is in contact with others has a reportable disease;
b. If a reportable illness occurs among the staff, children, or families involved with the program;
c. For assistance in managing a suspected outbreak. Generally, an outbreak can be considered to be two or more unrelated (e.g., not siblings) children with the same diagnosis or symptoms in the same group within one week. Clusters of mild respiratory illness, ear infections, and certain dermatological conditions are common and generally do not need to be reported.

Caregivers/teachers should work with their child care health consultants to develop policies and procedures for alerting staff and families about their responsibility to report illnesses to the program and for the program to report diseases to the local health authorities.

RATIONALE:

Excluding children with mild illnesses is unlikely to reduce the spread of most infectious agents (germs) caused by bacteria, viruses, parasites and fungi. Most infections are spread by children who do not have symptoms. They spread the infectious agent (germs) before or after their illnesses and without evidence of symptoms. Exposure to frequent mild infections helps the child's immune system develop in a healthy way. As a child gets older s/he develops immunity to common infectious agents and will become ill less often. Since exclusion is unlikely to reduce the spread of disease, the most important reason for exclusion is the ability of the child to participate in activities and the staff to care for the child.

The terms contagious, infectious and communicable have similar meanings. A fully immunized child with a contagious, infectious or communicable condition will likely not have an illness that is harmful to the child or others. Children attending child care frequently carry contagious organisms that do not limit their activity nor pose a threat to their contacts. Hand and personal hygiene is paramount in preventing transmission of these organisms. Written notes should not be required for return to child care for common respiratory illnesses that are not specifically listed in the excludable condition list above. For specific conditions, Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide, 2nd Edition has educational handouts that can be copied and distributed to parents/guardians, health professionals, and caregivers/teachers. This publication is available from the American Academy of Pediatrics (AAP) at http://www.aap.org.

For more detailed rationale regarding inclusion/exclusion, return to care, when a health visit is necessary, and health department reporting for children with specific symptoms, please see Appendix A, Signs and Symptoms Chart.

State licensing law or code defines the conditions or symptoms for which exclusion is necessary. States are increasingly using the criteria defined in Caring for Our Children and the Managing Infectious Diseases in Child Care and Schools publications. Usually, the criteria in these two sources are more detailed than the state regulations so can be incorporated into the local written policies without conflicting with state law. In this edition of Caring for Our Children, the exclusion criteria for bacterial conjunctivitis (pink eye) and diarrhea have changed. Exclusion is no longer required for pink eye and treatment is not required. This change reflects the recognition that conjunctivitis is a self-limiting infection and there is not any evidence that treatment or exclusion reduces its spread. Children with diarrhea may remain in care as long as the stool is contained in the diaper or the child can maintain continence. If additional criteria are met, such as an inability to participate in activities or requiring more care than staff can provide, then a child should be excluded until the criteria for return of care are met. A provision was included that if the stool frequency is two or more stools per day above the normal then exclusion could be indicated. This accounts for the increased staff time involved in diaper changing. Infants should routinely receive rotavirus vaccine, which has been the most common cause of viral diarrhea in this age group.

COMMENTS:

When taking a child's temperature, remember that:

a. The amount of temperature elevation varies at different body sites;
b. The height of fever does not indicate a more or less severe illness;
c. The method chosen to take a child's temperature depends on the need for accuracy, available equipment, the skill of the person taking the temperature, and the ability of the child to assist in the procedure;
d. Oral temperatures are difficult to take for children younger than four years of age;
e. Rectal temperatures should be taken only by persons with specific health training in performing this procedure and permission given by parents/guardians;

f. Axillary (armpit) temperatures are accurate only when the thermometer remains within the closed armpit for the time period recommended by the device;
g. Electronic devices for measuring temperature require periodic calibration and specific training in proper technique;
h. Any device used improperly may give inaccurate results;
i. Mercury thermometers should not be used;
j. Aural (ear) devices may underestimate fever and should not be used in children less than four months.

TYPE OF FACILITY:
Small Family Child Care Home, Center, Large Family Child Care Home

RELATED STANDARDS:
3.1.1.1 Conduct of Daily Health Check
3.6.1.2 Staff Exclusion for Illness
3.6.1.3 Thermometers for Taking Human Temperatures
3.6.1.4 Infectious Disease Outbreak Control
7 Chapter 7: Infectious Diseases
Appendix A: Signs and Symptoms Chart

REFERENCES:
Aronson, S. S., T. R. Shope, eds. 2009. *Managing infectious diseases in child care and schools: A quick reference guide*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics.
Pickering, L. K., C. J. Baker, D. W. Kimberlin, S. S. Long, eds. 2009. *Red book: 2009 report of the Committee on Infectious Diseases*. 28th ed. Elk Grove Village, IL: American Academy of Pediatrics.

NOTES:
Content in the STANDARD was modified on 04/16/2015.