

# Recognizing the Ill Child: Inclusion/Exclusion Criteria





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### Daily Health Check

Teachers/caregivers in an early education/child care program or school who are familiar with the behavior and appearance of the enrolled children can easily assess each child's health status when the child arrives and periodically throughout the day. This assessment involves a warm, relaxed, respectful greeting of the child and any accompanying family member. During the greeting, the teacher/caregiver should observe and interact with the child and whoever is bringing the child that day. The teacher/caregiver should ask if there are any symptoms of illness or injury or any change in the child's status from the last time the child participated in the program. A health consultant can explain and demonstrate how to conduct a health check. These checks will soon become routine for teachers/caregivers. Doing the daily health check and keeping a daily record of symptoms are good ways for teachers/caregivers to monitor trends and watch for signs of an infectious disease outbreak or epidemic.

The Symptom Record Form in Chapter 8 can be used by teachers/caregivers and families to record attendance and inform each other about and document symptoms or suspected illness for an individual child. To make it easy to spot an early trend of illnesses occurring in a group of children or repeatedly for an individual child, consider using the Enrollment/Attendance/Symptom Record in Chapter 8. A teacher/caregiver or teaching team can use this form to take daily attendance for all children in a group and note any illness symptoms daily across a month. Having a month of attendance and symptom information collected in one place helps to recognize patterns of illness for individual children and groups of children.

### Elements to Observe and Information to Gather

The following elements should be observed and supplemented by information shared by the family or other staff members who have been with the child:

- Changes in behavior or appearance, such as sleepiness or fatigue and decreased playfulness or appetite
- Any runny nose, cough, or breathing trouble (fast breathing, flaring nostrils, belly breathing)
- Any new skin rashes or itchy skin or scalp
- Any new bumps or bruises
- Any open sores or weeping skin rashes
- Signs of fever, such as flushed appearance or shivering (Checking a child's temperature in the absence of behavior change is not recommended.)

- Increased irritability; complaints of pain or not feeling well
- Vomiting, diarrhea, or stomachache
- Any irritation or drainage from the eye(s)
- Whether the child has received any medication at home or needs any special care during the day
- Whether the family reveals that the child or the child's family member has been exposed to a harmful communicable disease

Routinely sharing this information with the child's teachers/caregivers and the child's family helps everyone remain on the lookout for signs and symptoms of illness. The program staff can use the information from this health check to decide whether the child is well enough to participate in the activities planned for the day or whether the child might need special attention or more attention than the staff can responsibly provide. If the child seems well enough to stay, the information and observations from the health check enable the staff to plan how to meet the needs of the child and what to observe about how the child does during the day. The Signs and Symptoms Chart in Chapter 5 lists conditions that require exclusion from child care and school programs. The Quick Reference Sheets in Chapter 6 review the information about each type of infection in more detail.

### Situations That Require Medical Attention Right Away

Teachers/caregivers in early education/child care programs and schools must be able to recognize and respond to situations that are medical emergencies and distinguish those from others that require urgent, but not emergency, action. Preparation for such circumstances includes that staff members will

- Know how to access emergency medical services (EMS) in the area where the program is located. In most communities, calling 911 works. Some communities still lack the 911 system. Some facilities have phone systems that are unique or depend on staff always having a mobile phone available. The procedure and number to call should be posted in every occupied location in the facility and staff should be trained in the proper procedure.
- Know how to call Poison Help at 800/222-1222. Calling this number automatically connects the caller with the poison center in the area of the caller. This number should be posted in every occupied location in the facility and staff should be trained in the proper procedure.

**Call Emergency Medical Services (EMS) (911) Immediately If**

- The child's life seems to be at risk or there is a risk of permanent injury.
  - The child is acting strangely, much less alert, or much more withdrawn than usual.
  - The child has difficulty breathing or is unable to speak.
  - The child's skin or lips look blue, purple, or gray.
  - The child has rapidly spreading raised red skin areas with throat-closing, tongue swelling, trouble breathing or wheezing, or decreased consciousness (severe allergic reaction— anaphylaxis).
  - The child has rhythmic jerking of arms and legs and loss of consciousness (seizure).
  - The child is unconscious.
  - The child is becoming less and less responsive.
  - After a head injury, the child has any of the following conditions: decrease in level of alertness, confusion, headache, vomiting, irritability, difficulty walking.
  - The child has increasing or severe pain anywhere.
  - The child has a cut or burn that is large or deep or won't stop bleeding.
  - The child is vomiting blood.
  - The child has a severe stiff neck, headache, and fever.
  - The child is significantly dehydrated (eg, sunken eyes, lethargic, not making tears, not urinating).
  - Multiple children are affected by injury or serious illness at the same time.
  - When in doubt about whether to call EMS (911), make the call.
  - After calling EMS (911), call the child's parent/legal guardian.
- Educate all staff members about recognizing an emergency medical situation (see “Call Emergency Medical Services [EMS] [911] Immediately If” and “Get Medical Attention Within 1 Hour” boxes). **When in doubt, always call EMS.**
  - Know how to contact each child's parent/legal guardian at any time when the child is in the early education/child care facility. If the parent/legal guardian doesn't carry a mobile device or has a schedule that may interfere with being available, have contact information for someone who will be able to reach the parent or temporarily take responsibility at any time. Health professionals may delay providing care if the situation is not life-threatening and the parent/legal guardian is unavailable to give consent for care. It's a good idea to test a batch of contact numbers on a rotating basis so all are tested at least every 6 months. If a contact number doesn't work to connect with the family member, this information should be updated.

- For children with special needs, make plans with the family and the usual source of health care for handling any special types of emergencies that may affect these children.
- Document what happened in an emergency—day, date, and time, along with observed symptoms and actions taken.
- Put into family and staff handbooks and prominently post in all rooms the 2 lists of situations that require medical attention right away: those that require calling EMS (911), and those that require getting medical attention within an hour (see Situations That Require Medical Attention Right Away in Chapter 8 for this content).

**Get Medical Attention Within 1 Hour**

Some children may have urgent situations that do not necessarily require emergency medical services (EMS) (911) for ambulance transport but still need medical attention without delay. For the following conditions, the teacher/caregiver may first call the parent/legal guardian. If the parent/guardian is immediately available to pick up the child and take the child to a source of urgent pediatric health care within an hour, the parent/legal guardian should be instructed to do so. EMS (911) should be called to bring the child to a pediatric health professional if the parent/legal guardian cannot do so. When EMS is transporting the child, if possible, a staff member who knows the child should accompany the child until the parent/legal guardian can be present to provide information and reassure the child. Program policies should be clear about how such situations will be handled given local resources. Staff should develop contingency plans for emergencies or disaster situations when it may not be possible or feasible to follow standard or previously agreed on emergency procedures. The situations that require medical attention within an hour are

- Any infant or child older than 2 months who looks more than mildly ill with a temperature above 101°F (38.3°C) taken by any method (Note: Rectal temperatures in early education/child care or schools should be taken only by persons with specific health training in performing this procedure and with permission by parents/guardians. Do not “correct” for an axillary temperature by adding 0.5 or 1 degree.)
- Temperature above 100.4°F (38.0°C) by any method in an infant younger than 2 months (8 weeks)
- A quickly spreading purple or red rash or a rapidly spreading rash that raises concern for an allergic reaction (eg, hives)
- A large volume of blood in stools
- A cut that may require stitches
- Any medical condition specifically outlined in a child's care plan that requires immediate action and/or notification of the child's parent/legal guardian

## Conditions That Do Not Require Exclusion to Control Spread of Disease to Others

- Common colds, runny noses (regardless of color or consistency of nasal discharge), and coughs.
- Yellow, white, or watery eye discharge without fever, eye pain, or eyelid redness.
- Pinkeye (bacterial conjunctivitis) usually associated with pink or red conjunctiva (ie, “whites of the eyes”) with white or yellow/green eye mucus drainage; often also associated with matted eyelids after sleep. (See the Pinkeye [Conjunctivitis] Quick Reference Sheet.)
- Fever (for this purpose, defined as temperature above 101°F [38.3°C] by any method) without any signs or symptoms of illness in infants and children who are older than 4 months. (See the Fever Quick Reference Sheet). Devices to measure body temperatures include thermometers intended for use in the mouth, armpit, ear canal, rectum, or skin that overlies an artery next to the outside corner of the eye. To read more about how to take a child’s temperature and the special issues associated with each method, go to <https://www.healthychildren.org/English/health-issues/conditions/fever/Pages/How-to-Take-a-Childs-Temperature.aspx> (available in English and Spanish). **Note:** Do not adjust the reading for the location in which the temperature was taken. Simply record the temperature and the location where it was taken.
- Rash without fever and without behavioral changes. The exception for letting the child with a new rash stay in the program is that EMS (911) should be called for rapidly spreading bruising or small blood spots under the skin.
- Impetigo. Lesions should be covered, but treatment may be delayed until the end of the day. As long as treatment is started before return the next day, no exclusion is needed.
- Lice or nits without lice. Treatment may be delayed until the end of the day. As long as treatment is started before return the next day, no exclusion is needed, even if nits are still present.
- Ringworm. Treatment may be delayed until the end of the day. As long as treatment is started before return the next day, no exclusion is needed.
- Scabies. Treatment may be delayed until the end of the day. As long as treatment is started before return the next day, no exclusion is needed.
- Thrush (ie, white spots or patches in the mouth).
- Fifth disease (slapped cheek disease, parvovirus B19) in someone with a normal immune system and without an underlying blood disorder like sickle cell disease.

- Staphylococcal colonization or carrier state in children without an illness that would otherwise require exclusion (see Boil/Abscess/Cellulitis and *Staphylococcus aureus* [Methicillin-Resistant (MRSA) and Methicillin-Sensitive (MSSA)] Quick Reference Sheets).
- Molluscum contagiosum. Exclusion or covering of lesions is not required.
- Cytomegalovirus infection.
- Chronic hepatitis B virus infection.
- HIV infection.
- Children who have no symptoms but are known to have a germ in their stools that causes disease do not need to be excluded, except when they have an infection with a Shiga toxin-producing *Escherichia coli* (STEC), *Shigella*, or *Salmonella* serotype Typhi. In these cases, exclusion is warranted as follows: for STEC, until results of 2 stool cultures are negative; for *Shigella* species, until at least 1 stool culture is negative (varies by state); and for *S* Typhi, until 3 stool cultures are negative. Other types of *Salmonella* do not require negative test results from stool cultures.

**Note:** During an outbreak of a harmful infectious disease (eg, *Shigella*) or vaccine-preventable disease (eg, measles), children determined to be contributing to the spread of the illness or who are unvaccinated may be excluded until the risk of spread is no longer present or the unvaccinated child receives the necessary vaccine. This is usually determined by the local health department.

## Conditions Requiring Temporary Exclusion

### Three 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 about whether the child should be sent home (ie, should be temporarily excluded from child care or school). Most illnesses do not require exclusion. A designated staff member should determine whether the child’s illness meets the following criteria for exclusion:

- Prevents the child from participating comfortably in activities as determined by staff members of the early education/child care program or school
- Results in a need for care that is greater than staff members can provide without compromising the health and safety of other children
- Poses a risk of spread of harmful disease to others based on the list of specific excludable conditions

If any of these criteria are met, the child should be excluded, regardless of the type of illness, unless a health professional determines the child’s condition does not require exclusion.

### Specific Excludable Conditions

Exclude if the child has

- A severely ill appearance. This could include lethargy or lack of responsiveness, irritability, persistent crying, difficulty breathing, or having a quickly spreading rash.
- Fever with behavior change or other signs and symptoms. (See the Fever Quick Reference Sheet in Chapter 6 for more detail.)
- Diarrhea. *Diarrhea* is defined by stool that is occurring more frequently or is less formed in consistency than usual in the child and 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 “accidents.” Exclude children whose stool frequency exceeds 2 stools above normal for that child while the child is in the program or whose stool contains more than a drop of blood or mucus. For diapered children, the increased frequency of stool may cause too much work for the teacher/caregiver and thereby challenge the teacher’s/caregiver’s ability to maintain sanitary diaper-changing techniques. For toilet-trained children, this greater frequency of having bowel movements poses a significant risk for accidents and contamination of toilet facilities. Readmission after onset of diarrhea can occur when all the following conditions are met:
  - Diapered children have their stool contained by the diaper (even if the stools remain loose).
  - Toilet-trained children do not have toileting accidents.
  - The frequency of passage of stool is no more than 2 stools above what was normal for that child during the time the child was in the program, before the diarrhea began.
  - A health professional has cleared the child for readmission for all cases of bloody diarrhea and diarrhea caused by *Shigella*, *S Typhi*, and STEC. See Quick Reference Sheets in Chapter 6 for specific guidelines for these uncommon types of diarrhea. State laws may govern exclusion for these conditions and should be followed by the health professional who is clearing the child for readmission.
- Vomiting 2 or more times in the previous 24 hours, unless the vomiting is determined to be caused by a non-communicable or noninfectious condition (eg, healthy infants with reflux).
- Abdominal pain that continues for more than 2 hours or intermittent abdominal pain associated with fever or other signs or symptoms.
- Mouth sores with drooling that the child cannot control unless the child’s primary health professional or local health department authority states the child is noninfectious.

### Temperature Tips

When taking a child’s temperature, remember

- Higher body temperatures do not necessarily indicate a more severe infection. The child’s activity level and sense of well-being are far more important than the temperature reading. A child who is smiling and running around is generally not a concern; a child who is listless and not responsive is always a concern, even if the child’s temperature is normal.
  - If a child has been in a very hot environment and heatstroke (hot, dry, red skin with lethargy) is suspected, a higher temperature is more serious.
  - 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.
  - Oral temperatures usually are not reliable for children younger than 4 years.
  - Rectal temperatures should be taken only by persons with specific health training in performing this procedure.
  - Axillary (armpit) temperatures are accurate only when the thermometer remains within the closed armpit for the period recommended by the manufacturer of the device.
  - Only digital thermometers, not mercury thermometers, should be used.
  - Any device used improperly may give inaccurate results.
- Rash with fever or behavioral changes, until a primary health professional has determined the illness is not a communicable disease.
  - Skin sores that are weeping fluid and are on an exposed body surface that cannot be covered with a waterproof dressing.
  - Other conditions with specific diagnoses as follows:
    - Streptococcal pharyngitis (ie, strep throat or other streptococcal infection): exclusion until the child has received an appropriate antibiotic for 12 hours.
    - Head lice: only if child has not been treated after notifying family at the end of the prior program day. (**Note:** Exclusion is not necessary before the end of the program day.)
    - Scabies: only if child has not been treated after notifying family at the end of the prior program day. (**Note:** Exclusion is not necessary before the end of the program day.)
    - Ringworm: only if child has not been treated after notifying family at the end of the prior program day. (**Note:** Exclusion is not necessary before the end of the program day.)
    - Impetigo: only if child has not been treated after notifying family at the end of the prior program day. (**Note:** Exclusion is not necessary before the end of the program day as long as lesions are covered.)

- Chickenpox (varicella): until all lesions have dried or crusted (usually 6 days after onset of rash) and no new lesions have appeared for at least 24 hours.
- Rubella: until 7 days after the rash appears.
- Pertussis: until 5 days of appropriate antibiotic treatment (21 days from onset of cough, if untreated).
- Mumps: until 5 days after onset of parotid gland swelling.
- Measles: until 4 days after onset of rash.
- Hepatitis A virus infection: until 1 week after onset of illness or jaundice or as directed by the health department (if the child's symptoms are mild).

In addition to the conditions listed previously, see the box titled “Three Key Criteria for Exclusion of Children Who Are Ill.” For more details and other diseases, see the Signs and Symptoms Chart in Chapter 5.

### Procedures for a Child Who Requires Exclusion

While the child waits to be picked up from the group care facility, the teacher/caregiver should

- Move the child to a familiar and comfortable place where the child will be observed and cared for by someone who knows the child well and where the child who is ill will not expose people who have not already been exposed to the child's illness. This is usually best accomplished by keeping the ill child in a comfortable corner of the child's usual care room, with as much separation from other children as can easily be arranged. If the child is coughing and sneezing, a separation of at least 3 feet will allow the heavy respiratory droplets to fall to the floor. Although the smaller aerosolized droplets may travel farther, the children in the group have already been exposed to these and little will be gained by moving the child to a space where new individuals may be exposed.
- If child to staff ratio cannot be met by providing care for the ill child in the usual group space, it may be possible for supplemental staff to come into the group space to help care for the other children in the group until a family member or designated emergency contact person can pick up and provide care elsewhere for the child who is ill. Putting the ill child in the care of an unfamiliar caregiver and/or in a different space from where the child usually receives care may make it difficult to provide supportive care for the child and may expose previously unexposed individuals to infectious disease. Facilities that routinely provide care for ill children in a facility space designated for such care must follow special procedures for equipping and staffing this service, as defined in *Caring for Our Children*, Standard 3.6.2.2 (<http://nrckids.org/CFOC>).
- Continue to observe the child for new or worsening symptoms.
- Ask the parent/legal guardian to pick up the child as soon as possible as specified in written exclusion policies for the program.
- Share with the adult who picks up the ill child observations made by program staff members of the child's symptoms. Explain what is required for the child to return. The Symptom Record Form in Chapter 8 can be used to document information collected from all staff members involved that day in the child's care about the child's symptoms. This form will make it easier for the family to share valuable information with the child's health professional if the child's condition requires health professional advice.
- If the child seems well to the family and no longer meets criteria for exclusion, there is no need to ask for further information from the health professional when the child returns to care. Children who have been excluded from care do not necessarily need to have an in-person visit with a health professional.
- Ask the family member to share with the child's teacher/caregiver any advice received from the child's health professional during an office visit, by phone, or by any electronic transmission of information. Follow the advice of the child's health professional. If more information is needed to describe special care required by the returning child, the early educator should obtain the parent/legal guardian's consent to contact the child's health professional to let the health professional know what information the program staff are seeking. This sharing of information with education program staff requires written parent consent. Note that if the family needs the health professional's advice, they may receive it electronically without needing an office visit. (See Sample Health Information Consent Form in Chapter 8.)
- Contact the local health department if there is a question about a condition on the list of reportable communicable diseases. If there are conflicting opinions from different health professionals about the management of a child with a reportable communicable disease, the health department has the legal authority to make a final determination. (See 2019 nationally notifiable conditions at <https://www.cdc.gov/nndss/conditions/notifiable/2019>.)
- Follow the advice provided by the child's health professional or by local public health officials about whether there is a need to inform others in the facility about a possible exposure to an infectious disease. The identity of the child should not be shared, but key elements of the risk to others may make early recognition and treatment of the disease in others possible. Prompt notification reduces the risk of spread of misinformation. Consider notifying families and staff members using the Sample

Letter to Families About Exposure to Communicable Disease in Chapter 8, accompanied by the Quick Reference Sheet from Chapter 6 for that condition.

- Document actions in the child's file with date, time, symptoms, and actions taken (and by whom); sign and date the document.
- Sanitize toys and other items the child may have handled or put in his or her mouth and continue to practice good hand-hygiene techniques. (See the Glossary for the definition of *sanitize* and Chapter 2 for a discussion of the procedures to use.)

### Reportable/Notifiable Conditions

The Centers for Disease Control and Prevention designates infectious diseases that require notification of public health authorities in the United States at the national level. Additional conditions may be designated as needing to be reported to local and state public health authorities. (See 2019 nationally notifiable conditions at <https://wwwn.cdc.gov/nndss/conditions/notifiable/2019>.) Although laboratories and health professionals are expected to report these notifiable diseases, their reporting may not alert health authorities that the child attends a group care program or is enrolled in school and may have exposed others. Delayed notification may preclude prompt responses to prevent illness among those exposed to the child in the group setting. If in doubt about whether to report, contact the local health department.

Generally, a designated staff member should contact the local health department and discuss what to do with a health consultant under the following circumstances:

- When a child or staff member has a reportable disease
- If a reportable illness occurs among staff members, children, or families involved with the program
- For assistance in managing a suspected outbreak (**Note:** Generally, an outbreak is considered to be 2 or more unrelated [ie, not siblings or members of the same household] children with the same diagnosis or symptoms in the same group within 1 week. Clusters of mild respira-

tory illness and ear infections are common and generally do not need to be reported.)

Designated staff members (eg, the program's Child Care Health Advocate) should work with a Child Care Health Consultant to develop policies and procedures for alerting staff members and families about their responsibility to report illnesses to the program and for the program to report diseases to the local health authorities. A Sample Letter to Families About Exposure to Communicable Disease is in Chapter 8.

### Preparing for Managing Illness

Staff members should

- Prepare families for inevitable illnesses ahead of time.
- At the time of enrollment and as necessary thereafter, review with families the inclusion/exclusion criteria in the facility's written policies. Make clear to family members that designated program staff members (not families) make the final decision about whether children who are ill may stay. Such decisions will be based on inclusion/exclusion criteria and staff ability to care for the child who is ill without compromising the care of other children in the program.
- Develop, with a health consultant, protocols and procedures for handling children's illnesses, including care plans and an inclusion/exclusion policy.
- 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. Only ask for a health professional's note to readmit a child if the health professional's advice is needed to determine whether the child is a health risk to others or the health professional's guidance is needed about any special care the child requires. See the Signs and Symptoms Chart in Chapter 5 for specific recommendations about visits to health professionals.
- Encourage families to develop a plan for times when their child may need to stay home.