



take-home sheet for parents/guardians on which the caregiver/teacher records the food consumed each day or, for breastfed infants, the number of breastfeedings, and other important notes on the infant. Caregivers/teachers should continue to consult with each infant's parents/guardians concerning foods they have introduced and are feeding. In this way, the caregiver/teacher can follow a schedule of introducing new foods one at a time and more easily identify possible food allergies or intolerances. Caregivers/teachers should let parents/guardians know what and how much their infant eats each day. Consistency between home and the early care and education setting is essential during the period of rapid change when infants are learning to eat age-appropriate solid foods (1,4,6).

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 4.3.1.1: General Plan for Feeding Infants

Standard 4.3.1.11: Introduction of Age-Appropriate Solid Foods to Infants

Standard 4.5.0.8: Experience with Familiar and New Foods

**REFERENCES:**

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**STANDARD 4.2.0.10: Care for Children with Food Allergies**

When children with food allergies attend the early care and education facility, the following should occur:

- a) Each child with a food allergy should have a care plan prepared for the facility by the child's primary care provider, to include:
  - 1) Written instructions regarding the food(s) to which the child is allergic and steps that need to be taken to avoid that food;
  - 2) A detailed treatment plan to be implemented in the event of an allergic reaction, including the names, doses, and methods of administration of any medications that the child should receive in the event of a reaction. The plan should include

specific symptoms that would indicate the need to administer one or more medications;

- b) Based on the child's care plan, the child's caregivers/teachers should receive training, demonstrate competence in, and implement measures for:
  - 1) Preventing exposure to the specific food(s) to which the child is allergic;
  - 2) Recognizing the symptoms of an allergic reaction;
  - 3) Treating allergic reactions;
- c) Parents/guardians and staff should arrange for the facility to have necessary medications, proper storage of such medications, and the equipment and training to manage the child's food allergy while the child is at the early care and education facility;
- d) Caregivers/teachers should promptly and properly administer prescribed medications in the event of an allergic reaction according to the instructions in the care plan;
- e) The facility should notify the parents/guardians immediately of any suspected allergic reactions, the ingestion of the problem food, or contact with the problem food, even if a reaction did not occur;
- f) The facility should recommend to the family that the child's primary care provider be notified if the child has required treatment by the facility for a food allergic reaction;
- g) The facility should contact the emergency medical services system immediately whenever epinephrine has been administered;
- h) Parents/guardians of all children in the child's class should be advised to avoid any known allergens in class treats or special foods brought into the early care and education setting;
- i) Individual child's food allergies should be posted prominently in the classroom where staff can view and/or wherever food is served;
- j) The written child care plan, a mobile phone, and the proper medications for appropriate treatment if the child develops an acute allergic reaction should be routinely carried on field trips or transport out of the early care and education setting.

**RATIONALE:** Food allergy is common, occurring in between 2% and 8% of infants and children (1). Food allergic reactions can range from mild skin or gastrointestinal symptoms to severe, life-threatening reactions with respiratory and/or cardiovascular compromise. Hospitalizations from food allergy are being reported in increasing numbers (5). A major factor in death from anaphylaxis has been a delay in the administration of life-saving emergency medication, particularly epinephrine (6). Intensive efforts to avoid exposure to the offending food(s) are therefore warranted. The maintenance of detailed care plans and the ability to implement such plans for the treatment of reactions are essential for all food-allergic children (2-4).

**COMMENTS:** Successful food avoidance requires a cooperative effort that must include the parents/guardians, the child, the child's primary care provider, and the early care and education staff. The parents/guardians, with the help



of the child's primary care provider, must provide detailed information on the specific foods to be avoided. In some cases, especially for children with multiple food allergies, the parents/guardians may need to take responsibility for providing all of the child's food. In other cases, the early care and education staff may be able to provide safe foods as long as they have been fully educated about effective food avoidance.

Effective food avoidance has several facets. Foods can be listed on an ingredient list under a variety of names, such as milk being listed as casein, caseinate, whey, and/or lactoglobulin. Food sharing between children must be prevented by careful supervision and repeated instruction to the child about this issue. Exposure may also occur through contact between children or by contact with contaminated surfaces, such as a table on which the food allergen remains after eating. Some children may have an allergic reaction just from being in proximity to the offending food, without actually ingesting it. Such contact should be minimized by washing children's hands and faces and all surfaces that were in contact with food. In addition, reactions may occur when a food is used as part of an art or craft project, such as the use of peanut butter to make a bird feeder or wheat to make play dough.

Some children with a food allergy will have mild reactions and will only need to avoid the problem food(s). Others will need to have an antihistamine or epinephrine available to be used in the event of a reaction. For all children with a history of anaphylaxis (severe allergic reaction), or for those with peanut and/or tree nut allergy (whether or not they have had anaphylaxis), epinephrine should be readily available. This will usually be provided as a pre-measured dose in an auto-injector, such as the EpiPen or EpiPen Junior. Specific indications for administration of epinephrine should be provided in the detailed care plan. Within the context of state laws, appropriate personnel should be prepared to administer epinephrine when needed. In virtually all cases, Emergency Medical Services (EMS) should be called immediately and children should be transported to the emergency room by ambulance after the administration of epinephrine. A single dose of epinephrine wears off in fifteen to twenty minutes and many experts will recommend that a second dose be available for administration.

For more information on food allergies, contact the Food Allergy and Anaphylaxis Network or visit their Website at <http://www.foodallergy.org>.

Some early care and education/school settings require that all foods brought into the classroom are store-bought in their original packaging so that a list of ingredients is included, in order to prevent exposure to allergens.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 4.2.0.2: Assessment and Planning of Nutrition for Individual Children

Standard 4.2.0.8: Feeding Plans and Dietary Modifications

Appendix P: Situations that Require Medical Attention Right Away

**REFERENCES:**

1. Burks, A. W., J. S. Stanley. 1998. Food allergy. *Curr Opin Pediatrics* 10:588-93.
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**STANDARD 4.2.0.11: Ingestion of Substances that Do Not Provide Nutrition**

All children should be monitored to prevent them from eating substances that do not provide nutrition (often referred to as Pica). The parents/guardians of children who repeatedly place non-nutritive substances in their mouths should be notified and informed of the importance of their child visiting their primary care provider.

**RATIONALE:** Children who ingest paint chips or contaminated soil can develop lead toxicity which can lead to developmental delays and neurodevelopmental disability. Children who regularly ingest non-nutritive substances can develop iron deficiency anemia. Eating soil or drinking contaminated water could result in an infection with a parasite.

In collaboration with the child's parent/guardian, an assessment of the child's eating behavior and dietary intake should occur along with any other health issues to begin an intervention strategy. Dietary intake plays an important role because certain nutrients such as a diet high in fat or lecithin increase the absorption of lead which can result in toxicity (1).

Currently there is consensus that repeated ingestion of some non-food items results in an increased lead burden of the body (1,2). Early detection and intervention in non-food ingestion can prevent nutritional deficiencies and growth/developmental disabilities.

The occasional ingestion of non-nutritive substances can be a part of everyday living and is not necessarily a concern. For example, ingestion of non-nutritive substances can occur from mouthing, placing dirty hands in the mouth, or eating dropped food. Pica involves the recurrent ingestion of substances that do not provide nutrition. Pica is most prevalent among children between the ages of one and three years (1). Among children with intellectual developmental disability and concurrent mental illness, the incidence exceeds 50% (1).